SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Critical Care Bed Management Procedure
TYPE OF DOCUMENT	Procedure
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DATE OF PUBLICATION	January 2020
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1 – Clinical Governance Standard 6 – Communicating for Safety
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FORMER REFERENCE(S)	PD 171
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Critical Care Clinical Stream Director
AUTHOR	Clinical Stream Manager – Critical Care
POSITION RESPONSIBLE FOR THE DOCUMENT	Critical Care and Cardiac/Respiratory Clinical Stream Manager
KEY TERMS	Intensive Care, Critical Care, Exit Block, Patient Flow, Discharge Planning
SUMMARY	Timely and appropriate access to and from the critical care service has been evidenced to have a positive impact on survival rates and a reduction in length of stay. The procedure outlines principles to optimise the management of critical care beds.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

1. POLICY STATEMENT

The document provides a framework for safe patient flow and the management of critical care beds. In situations of extreme demand, demand for beds may exceed capacity. This document outlines strategies to implement when beds are unavailable within the facility and processes to follow (non-time urgent patients) when no capacity is available within South Eastern Sydney Local Health District (SESLHD).

The procedure should be read in conjunction with PD2018_011 NSW Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS) and Agency for Clinical Innovation *Guiding Principles to Optimise Intensive Care Capacity – a Whole of Hospital Approach to Improving Patient Flow*.

The procedure is applicable to Intensive Care (Critical Care), Emergency Department Units, Patient Flow Coordinators, Pre-Admission staff, Hospital Executive and District Executive.

2. BACKGROUND

The intensive care unit provides complex clinical management and sophisticated technologies for the most complex and/or critically ill patients in the health system.

The College of Intensive Care Medicine defines intensive care as *"a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management of patients with life-threatening illnesses, injuries and complications, and monitoring of potentially life-threatening conditions. It provides special expertise and facilities for support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems"*.

Critical care beds and workforce are funded to accommodate intensive care patients. Utilising these resources for non-critical care patients (i.e. due to exit block to the ward) is not cost efficient and can result in inter-hospital transfers of critically ill patients, delay emergency department admissions or cancellation or postponement of elective major surgery.

Intensive Care services are a district and state-wide resource. Critical care beds are managed at a local level to meet facility clinical priorities and demand within SESLHD. Critical care beds are also a statewide resource providing definitive tertiary care to networked facilities across NSW. Referral pathways and networks have been developed to enable transfers to tertiary facilities. NSW facilities that are networked to POWH and SGH are listed in the NSW Critical Care Tertiary Referral Networks and Transfer of Care PD2018_011 (page 25).

Adult Intensive care units in SESLHD are located at POWH, SGH and TSH.

3. OVERARCHING PRINCIPLES

Demand and Escalation Plan

- Each facility should have a capacity and escalation plan which includes mechanisms to support the network and state-wide role of tertiary ICUs plus strategies to increase critical care capacity during periods of high demand i.e. seasonal activity and planning for potentially serious events, incidents or disasters.
- Escalation plans should also outline processes regarding how to obtain timely clinical advice/support to expedite review, referral and appropriate placement of critically ill patients.

Inter-facility Transfers

- All inter-hospital transfers of critically ill patients should be minimised to mitigate risk to patients, distress to patients and families and provide a cost efficient service. Therefore, internal patient flow mechanisms (including surge plans) and internal escalation methods for resolution of issues should be agreed and available at all facilities – as recommended by the PD2018_011 NSW Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS).

Safety Considerations / Impact of Exit Block

- Intensive Care exit block can result in delays to an incoming critical care admission, a prolonged stay in the Emergency Department, postponement or cancellation of elective surgery or an after-hours transfer of a cleared critical care patient.
- Patients who are transferred after hours have an increased risk of deterioration, unplanned readmission and adverse outcomes including mortality (Duke 2009) (Elliot 2012). A synthesis of the literature indicates patients transferred after hours from critical care areas frequently become outliers in inappropriate wards at a time when staffing, resources and expertise are limited (Abbenbroek 2018).

Bed Allocation for Patients Transferring from Critical Care Areas to Wards

- When patients no longer warrant critical care services and are cleared for transfer from the critical care unit they should be moved to the next most appropriate environment as soon as possible.
- If there is a delay in allocating a ward bed for a cleared critical care unit patient (i.e. unavailability of ward bed), this should be communicated to the critical care team early.
- Patient Flow Coordinators should prioritise transfer of signed out/cleared ICU patients to occur within hours (i.e. before 5:00pm) to allow for comprehensive clinical handover and review at ward level. See Safety Considerations.

Transfer of Complex Critical Care Patients

- Some patients transferring from critical care will require comprehensive discharge planning to ensure the ward can meet the patient's clinical requirements on the day of transfer. Planning the ward transfer for long term or complex patients should start well in advance of the estimated discharge date. Patients, relatives and ward staff also need time to prepare for the discharge. Good forward planning will prevent the patient remaining in ICU once critical care is no longer required.

Surgical Admissions

- Surgical patients who require critical care services as part of their care pathway are a planning priority. Cancellation of surgical cases due to lack of availability of an ICU bed should be avoided.
- Any surgical patient cancelled because of critical care capacity should be escalated to the facility Executive via the hospital escalation process.
- To improve forward planning for surgical cases and reduce cancellation rates critical care beds should be requested at the time of preadmission or if not attending preadmission, as soon as possible.
- To ensure surgical admissions to critical care beds are appropriate, consultation with the Intensivist regarding the patient's critical care requirements must occur. Once critical care suitability has been confirmed by the Intensivist, a request for a critical care bed can be progressed:
  - Ideally an electronic ICU Bed request and the front sheet of the Anaesthetic chart should be forwarded to Critical Care by the preadmission staff.
  - To ensure all key staff are aware of the booking, facilities could consider establishing a facility ICU/Critical Care Booking email distribution list i.e. ICU team, patient flow coordinator/s, NUM of theatres, NUM of Anaesthetics, NUM of Recovery, Director of Anaesthetics, ICU ward clerk, other staff as per facility requirements.

Creating Critical Care Capacity

- Good forward planning includes ensuring critical care beds are available to meet the demand for the next 24 hour period. This process should include estimating the number of probable available critical care beds for the next 24 hours with the number of required critical care beds (i.e. booked admissions, plus anticipated emergency admissions).
- In situations when anticipated demand is greater than critical care capacity, strategies should be invoked to create capacity. This should include ICU specific and whole of hospital strategies. See Appendix 1.

Patient Flow Portal and Estimated Date of Discharge

- All critical care patients should have an estimated critical care date of discharge documented on the Patient Flow Portal and in the patient's notes. The estimated date of discharge (EDD) should be monitored on an ongoing basis and the Patient Flow Portal updated to reflect revised EDDs.

Infection control

- Patients in critical care have an increased infection risk due to the critical illness of the patient, exposure to devices and increased interventions being undertaken. Risk minimisation strategies include transfer of patients to appropriate clinical areas as soon as possible. This includes transfer of 'clean' surgical cases to ensure they do not acquire a multi resistant organism (MRO)
- NSW Infection Prevention and Control Policy PD2017_13 provides greater detail on managing these infections.

4. RESPONSIBILITIES

- Critical care services are managed locally but service the needs of the facility, Local Health District and NSW. Local governance is through the General Manager, Clinical Group Managers/Co-Directors, Service Line Managers and Critical Care Directors and Critical Care Nurse Managers/Nursing Unit Manager.
- The IC Specialist on-duty/on-call is accountable for the clinical management and triage, admission and transfer of patients to and from the ICU.
- Operationally the senior clinician and senior nurse are responsible for making decisions around critical care capacity and clinical decisions that affect patient flow. The local management of critical care areas should include regular reviews of patient dependency, nursing skill mix, and capacity and demand factors to ensure the service can be provided safely and in a timely manner.

4.1 Emergency Department Medical Staff will:

- Consult Intensive Care for any critically ill patient or patient identified as requiring probable admission to Intensive Care.
- If an **ICU bed is available within the facility** provide a comprehensive medical and handover to the intensive care team.
- If an **ICU bed is not available within the facility** and **patient is time urgent** and **critically ill,** the referring ED medical team is responsible for contacting and handing over to the Aeromedical Control Centre to book transport as per PD2018_11 (page 10).
- Hand over to the ICU team at the receiving hospital.

4.2 Emergency Department Nursing Management and Nursing Staff will:

- Inform the Patient Flow Coordinator/After Hours Nurse Manager of the decision to admit the patient to ICU.
- Provide a comprehensive nursing handover to the intensive care team for patients transferred to the Critical Care Service.

4.3 Intensive Care Medical Staff will:

- Implement strategies/solutions to optimise intensive care capacity, patient flow and reduce intensive care exit block. See Appendix 1 Guiding Principles to Optimise Intensive Care Capacity.
- Triage admissions and timely transfers of all patients to and from the ICU.
- Review critically ill patients from wards (i.e. Code Blue) or Emergency Department.
- If an **ICU bed is not available within the facility** and **patient is time urgent** and **critically ill:**
  - the referring ICU medical team is responsible for contacting and handing over to the ICU team at the receiving hospital.
  - provide clinical support and guidance to the treating team or Emergency team until the patient is transferred.
- If an **ICU bed is required and is available within SESLHD** (i.e. not available at the facility), and patient is **non-time urgent** contact the ICU team at the receiving hospital to handover the patient and make a plan for the transfer.

- Provide clinical support and guidance to the treating team or Emergency team until the patient is transferred.
- Identify and document an estimated date for discharge (EDD) for all patients in the critical care unit and document on the electronic patient journey board.
- In preparation for expedient patient flow at least one cleared critical care patient will need to be ready for ward transfer by 10.00 am each morning. To enable an efficient, safe and timely transfer of the patient, ensure the patient is medically prepared in advance (i.e. medication reconciliation, medical documentation complete), and document a discharge preparation plan to enable nursing staff to remove lines etc. from 6.00 am onwards on the day of transfer.

Overview of responsibilities when facility critical care unavailable

<table>
<tr><th>Patient Status</th><th>Patient Flow Manager / After Hours Manager</th><th>Emergency Staff</th><th>ICU Medical Staff</th></tr>
<tr><td rowspan="2">Non time urgent patient* – no facility critical care bed</td><td rowspan="2">• Determine critical care bed availability within SESLHD
• Communicate bed location to ED and ICU team

Refer to flow chart section 5 page 8</td><td>• Contact Aeromedical Control Centre / Ambulance Service NSW to book transport to transfer patient
• Update the local ICU team of any changes in the patient’s condition and/or management</td><td>• Contact the ICU team at the receiving hospital to handover the patient and make a plan for the transfer
• Provide clinical support and guidance to the treating team or Emergency team until the patient is transferred
• Update the ICU receiving team of any changes in the patient’s condition and/or management</td></tr>
<tr><td colspan="2">NB In situations when significant time has elapsed between Critical Care/ICU consult and patient transfer or if the patient’s condition has deteriorated/changed the receiving facility should receive an updated handover by the team currently managing the patient’s condition</td></tr>
<tr><td>Time urgent critically ill patient*– no facility critical care bed

*Patient in ED</td><td></td><td>• Contact and hand over to the Aeromedical Control Centre to book transport</td><td>• Contact the ICU team at the receiving hospital to handover the patient and make a plan for the transfer
• Provide clinical support and guidance to the treating team or Emergency team until the patient is transferred
• Update the ICU receiving team of</td></tr>
</table>

			any changes in the patient's condition and/or management

4.4 Intensive Care Nursing Management will:

- Implement strategies/solutions to optimise intensive care capacity patient flow and reduce intensive care exit block. See Appendix 1 Guiding Principles to Optimise Intensive Care Capacity.
- Monitor and report delays in admissions, transfers from the service or cancellation of planned patients as per the escalation matrix.
- Communicate all planned admissions and transfers with the Patient Flow Coordinator in advance (i.e.2:00 pm assessment for the following day), so that forward planning of capacity can be supported. Any short-falls can then be proactively managed early with the appropriate stakeholders for resolution and decision-making with alternative management pathways being explored.
- Communicate to Patient Flow Coordinator any unexpected demand for booked critical care beds.
- At least one cleared critical care patient will need to be ready for ward transfer by 10.00 am each morning. ICU nursing management staff will ensure systems are in place to enable this transfer to occur safely and within the timeframe (lines etc. to be removed from 6am onwards as per the medical discharge plan).
- If the ICU is unable to transfer a patient within one hour of the bed becoming available this should be escalated to the Patient Flow Coordinator.
- Update the Patient Flow Portal with the ICU bed status every four hours and as changes occur. Key fields in the portal, requiring updates, include ICU bed status (staffed and available), patient acuity (mechanical ventilation status and patient nursing dependency).
- The estimated date for ICU discharge (EDD) should be identified and document on the electronic patient journey board. See Quick Guide ICU Bed Status electronic Patient Journey Board in Appendix 2.
- To ensure timely patient flow from ICU, probable IC discharges for the following day should be noted on the Patient Flow Portal. This will enable stakeholders to be aware of the pending ICU transfers.

Lightfoot data can be used as a tool to help predict demand for critical care beds
Lightfoot Viewers are available for the following ICU data sets:

- Number of admissions to ICU
- ICU bed occupancy (midnight snapshot)
- ICU admissions by hour of day (last 12 months)
- ICU admissions by day of week

Access via (https://www.sfn08.com/sfn_SESLHD/viewer)

4.5 Patient Flow Coordinator / After Hours Nurse Manager will:

- On a daily basis assist critical care areas to manage patient flow by timely ward bed finding/allocation. **NB:** ICU patient transfers to a ward bed should be arranged to occur before 5.00 pm where possible (see Section 3 Safety Considerations/Impact of Exit Block).
- To maximise availability of critical care beds, Patient Flow Coordinators should aim to allocate at least one ward bed each morning by 10:00 am for an intensive care transfer. Ideally this bed should be identified at 6am by the After Hours Nurse Manager.
- To optimise critical care patient flow the ward should be ready to accept the ICU transfer at 10.00 am i.e. the bed should be cleared and cleaned.
- Inform ICU NUM of any impending admissions.
- When **no facility ICU beds are declared available**, ensure all avenues have been reviewed as per the facility escalation plan.
- Determine availability of ICU beds at other SESLHD facilities via Patient Flow portal (ICU fields) and Patient Flow Coordinator/After Hours Managers at other SESLHD facilities. Advise ICU team of available ICU beds within SESLHD.
- If there is a patient, who is non time urgent and unable to be accommodated at the facility, and there is no availability within SESLHD, escalate to facility Executive as per the Escalation Process and Expectations of the Executive On-Call SESLHDPR/410.

4.6 Facility Executive will:

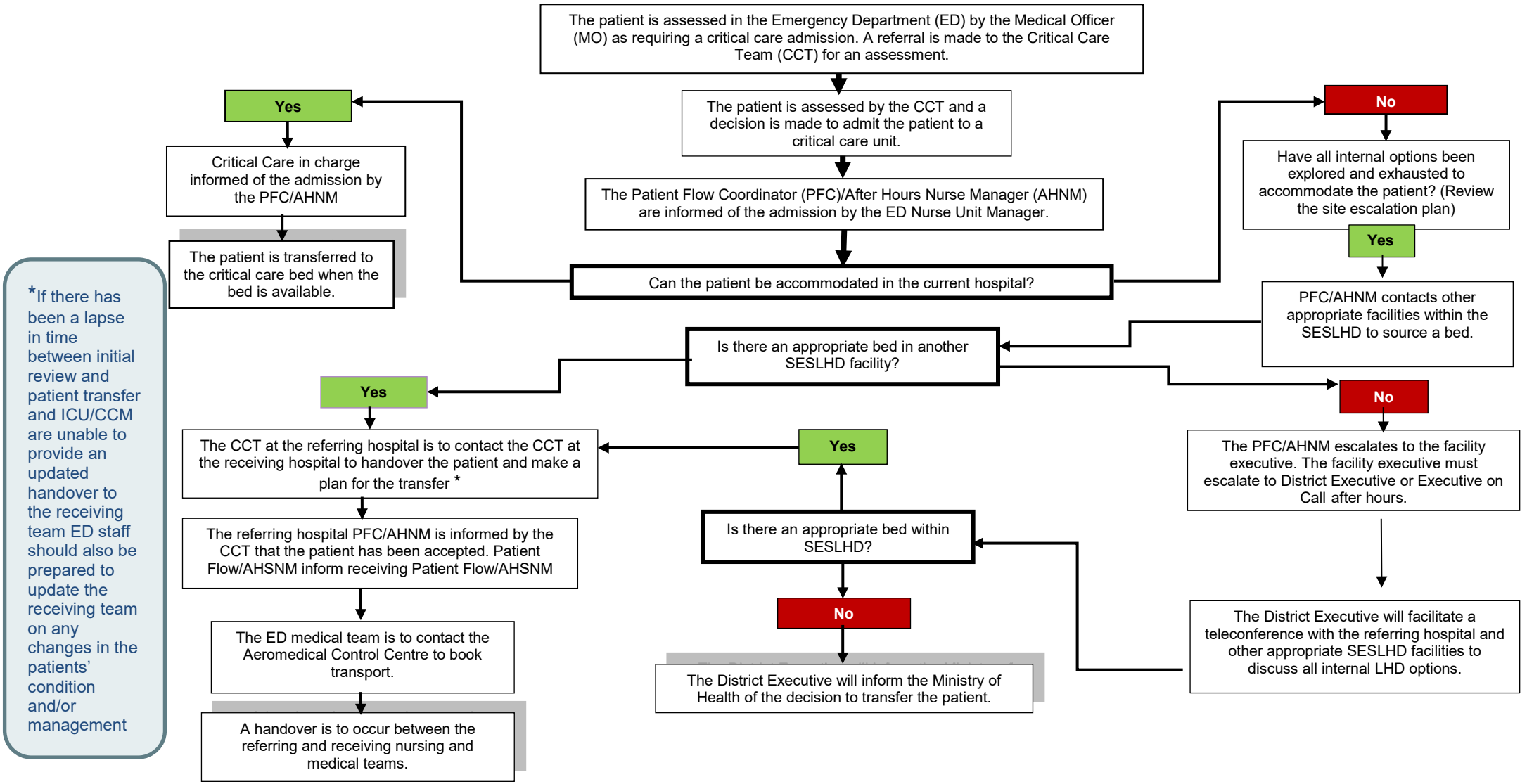
- If a patient is escalated due to no ICU capacity within SESLHD, the facility executive will escalate to District Executive as outlined in Escalation process and Expectations of the Executive on-call SESLHDPR/410.

4.7 District Executive will:

- When ICU beds are unavailable for non-time critical transfers, District Executive will facilitate a teleconference with the referring hospital ED or ICU team and SESLHD facilities to discuss all internal SESLHD options.
- If no IC bed is sourced as a result of the teleconference, District Executive will source an available bed external to SESLHD at the nearest appropriate hospital.

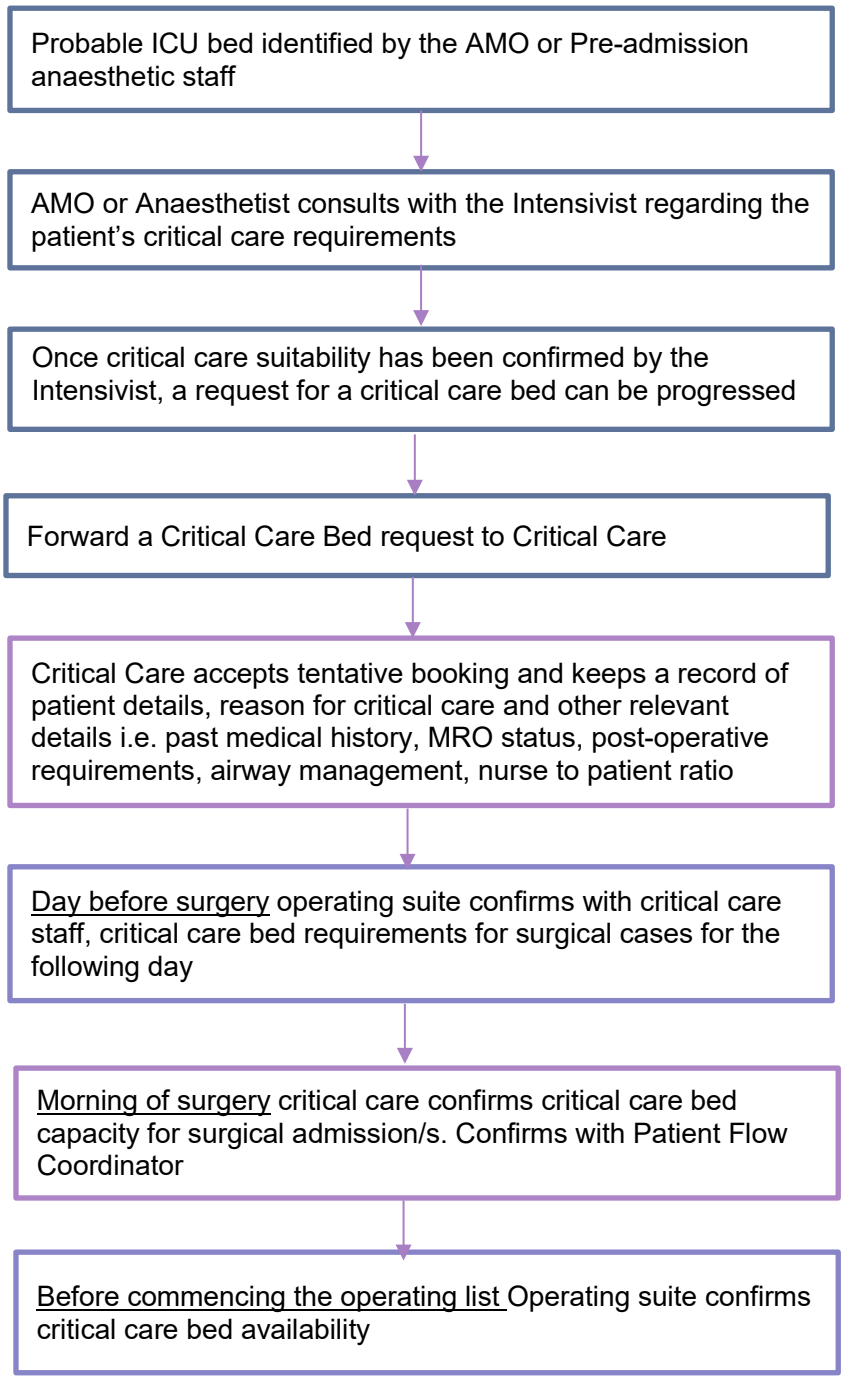
5. Arranging Emergency Admission to an Intensive Care Bed for Non-time Critical Patients

"Non-time Critical" (Stable) patients and patients requiring critical care "specialist care"



6. Booking Critical Care Beds (Surgical Admissions)

Suggested recommended process



7. DEFINITIONS

After hours ICU discharge: an ICU transfer occurring between 6.00pm and 6.00am, generally of an exit blocked patient to enable admission of a critically ill patient.
Aeromedical Control Centre: responsible for state-wide coordination of adult medical retrieval services for time urgent critically ill or injured patients.
Capacity and Demand: a hospital wide approach to admissions and discharge processes that allows both forward planning and operational expertise around bed management decisions. Critical care services should be appraised regularly of the hospital-wide capacity and demand factors and should be able to flex critical care capacity.
Default: when a facility is on 'default' the facility can potentially receive intra-District or intra-State admissions.
Escalation matrix: Facility based matrix used to identify flow, hot spots and actions to mitigate potential demand and capacity issues.
Intensive Care Unit: a specially staffed and equipped, separate and self-contained section of the hospital for the management of patients with life-threatening or potentially life-threatening, and reversible or potentially reversible organ failure. ICU Beds are staffed on a 1:1 or 1:2 nursing ratio depending on the acuity of the patient. Some patients have a higher nursing requirement and will require a 2:1 nursing ratio (i.e. patients requiring ECMO). ICU 1 (Bed type 91): Bed occupied by a patient in a designated ICU where nursing care is provided by a nurse who is caring for only one patient. ICU 2 (Bed Type 92): Bed occupied by a patient in a designated ICU where nursing care is provided by a nurse who is caring for two patients. ICU 2 care was previously referred to as High Dependency Care.
ICU Exit Block: a limitation of patient outflow due to the lack of access to ward beds or other accommodation/disposition. ICU exit block occurs when a patient is signed out for ICU discharge but remains in ICU.
Patient Flow Portal: Information about adult ICU beds is available via the Electronic Patient Journey Board, a module of the Patient Flow Portal. Intensive care fields provide information about available adult critical care beds across NSW. The Portal can be used to inform coordination and the appropriate placement of critically ill patients.

8. REFERENCES

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9. REVISION AND APPROVAL

Date	Revision No.	Author and Approval
July 2007	0	Brendan Docherty, Clinical Stream Manager – Critical Care & Cardiac Services and approved by Dr Steven Katz, Director Critical Care Clinical Stream and Susan Browbank, Acting Director Clinical Operations. Approved by Area Clinical Council Committee 25 July 2007 and Area Executive Committee 31 July 2007.
September 2008	1	Renumbered from a Clinical Stream Procedure to a SESIH Procedure and minor formatting to cover sheet and header. No changes made to content.
November 2013	2	Updated to current SESLHD Template
September 2015	3	Reviewed by Clinical Stream Manager. Endorsed by Executive Sponsor.
October 2015	3	Endorsed by Clinical and Quality Council to publish.
March 2019	4	Major Review – endorsed by Executive Sponsor. Draft for Comment period.
May – June 2019	4	Further Draft for Comment period. Feedback collated and considered by author.
June 2019	4	Processed by Executive Services prior to submission to Clinical and Quality Council for approval prior to publishing.
July 2019	4	Approved by Clinical and Quality Council.
December 2019	5	Minor Review – endorsed by Executive Sponsor. Section 4.3 'PACE Tier 2' changed to 'Code Blue'. Review date to remain as July 2022. Published by Executive Services.
January 2020	6	Removed reference 'currently in draft format', as the *ACI Guiding Principles to Optimise Intensive Care Capacity* document final version has been released. Link updated.

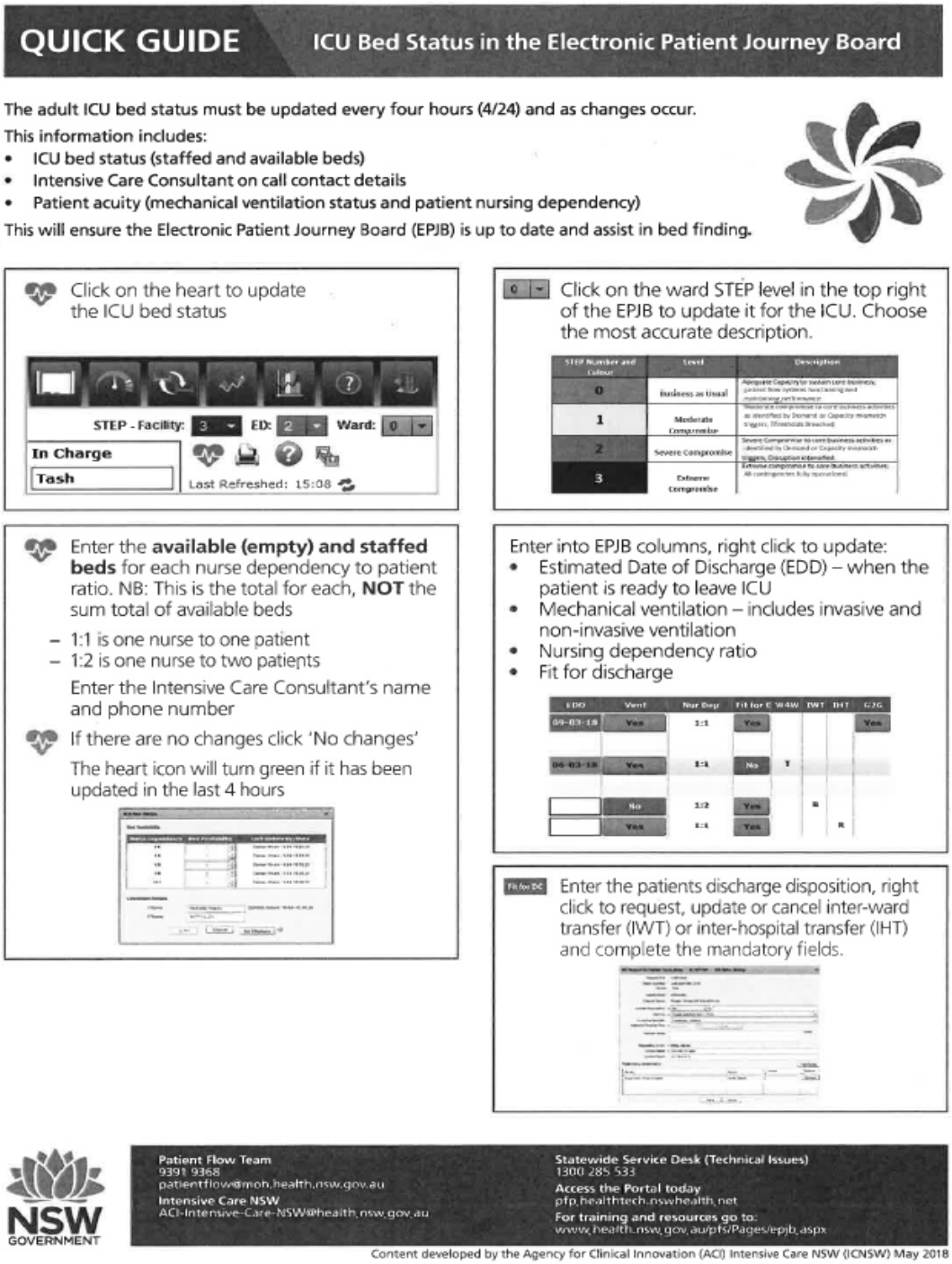
Appendix 1

Guiding Principles to Optimise Intensive Care Capacity
Agency for Clinical Innovation

Whole of hospital principles	ICU specific principles
1. Streamlining facility patient flow processes	6. Adequate planning for ICU discharge
2. Optimising access to intensive care capacity	7. Timely medical clearance for discharge from ICU
3. Resourcing to achieve effective patient flow	8. Standardising ICU rounding to inform discharge processes
4. Agreed prioritisation for patient discharge from intensive care	9. Efficient preparation of patient for ICU discharge
5. Ensuring the right care, for the right patient, in the right place	

Appendix 2
Electronic Patient Journey Board (EPJB) quick Links

https://www.health.nsw.gov.au/pfs/Pages/epjb.aspx



QUICK GUIDE ICU Bed Status in the Electronic Patient Journey Board

The adult ICU bed status must be updated every four hours (4/24) and as changes occur.

This information includes:

- ICU bed status (staffed and available beds)
- Intensive Care Consultant on call contact details
- Patient acuity (mechanical ventilation status and patient nursing dependency)

This will ensure the Electronic Patient Journey Board (EPJB) is up to date and assist in bed finding.

Click on the heart to update the ICU bed status

STEP - Facility: 3 ED: 2 Ward: 0

In Charge

Tash

Last Refreshed: 15:08

Click on the ward STEP level in the top right of the EPJB to update it for the ICU. Choose the most accurate description.

STEP Number and Colour	Level	Description
0	Business as Usual	
1	Moderate Compromise	
2	Severe Compromise	
3	Extreme Compromise	

Enter the **available (empty) and staffed beds** for each nurse dependency to patient ratio. NB: This is the total for each, **NOT** the sum total of available beds

- 1:1 is one nurse to one patient
- 1:2 is one nurse to two patients

Enter the Intensive Care Consultant's name and phone number

If there are no changes click 'No changes'

The heart icon will turn green if it has been updated in the last 4 hours

Enter into EPJB columns, right click to update:

- Estimated Date of Discharge (EDD) – when the patient is ready to leave ICU
- Mechanical ventilation – includes invasive and non-invasive ventilation
- Nursing dependency ratio
- Fit for discharge

EDD	Vent	Nur Dep	Fit for E W4W	IWT	IHT	G2G
09-03-18	Yes	1:1	Yes			Yes
08-03-18	Yes	1:1	No	T		
	No	1:2	Yes		R	
	Yes	1:1	Yes			

Fit for DC Enter the patients discharge disposition, right click to request, update or cancel inter-ward transfer (IWT) or inter-hospital transfer (IHT) and complete the mandatory fields.

NSW GOVERNMENT

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Intensive Care NSW
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Statewide Service Desk (Technical Issues)
1300 285 533
Access the Portal today
pfp.healthtech.nswhealth.net
For training and resources go to:
www.health.nsw.gov.au/pfs/Pages/epjb.aspx

Content developed by the Agency for Clinical Innovation (ACI) Intensive Care NSW (ICNSW) May 2018

Appendix 3

Polices / Procedures document refers to:	
PD2018_011 NSW Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS)	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2018_011
NSW Infection Prevention and Control Policy PD2017_13	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017_013
Escalation Process and Expectations of the Executive On-Call SESLHDPR/410	Corporate Governance functional group https://www.seslhd.health.nsw.gov.au/policies-and-publications/functional-group/63

Resources document refers to:	
Agency for Clinical Innovation *Guiding Principles to Optimise Intensive Care Capacity – a Whole of Hospital Approach to Improving Patient Flow*	https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0016/552130/0178-ICNSW-Exit-Guiding-Principles_06.pdf
Electronic Patient Journey Board (EPJB) Quick Links	https://www.health.nsw.gov.au/pfs/Pages/epjb.aspx