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Author / Title: Dr Rachel Markham, Clinical Lead for Critical Care Claire Mead, Critical Care Matron Ms Wendy Craig, Clinical Director, Surgery and Critical Care	**Responsibility:**
Replaces: Please add the full title of the document that is being replaced	**Head of Department:**
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Ratified By:	**Date:** DD/MM/YYYY
Review dates may alter if any significant changes are made	**Review Date:** DD/MM/YYYY

- Does this document meet the requirements under the Equality Act 2010 in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation? ***Yes / No** * Please delete as required
- Does this document meet our additional commitment as a Trust to extend our public sector duty to carers, veterans, people from a low socioeconomic background, and people with diverse gender identities? ***Yes / No** * Please delete as required

Document for Public Display: ***Yes / No** * Please delete as required

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1. SUMMARY

This SOP has been developed to support the operational management of patients requiring critical care during an interim period to reflect the medical staffing challenges.

Adult critical care/intensive care unit (ICU) at Furness General Hospital (FGH) will only admit Level 1 and 2 critical care patients from 23 September 2024.

Level 3 patients will be transferred to the ICU at Royal Lancaster Infirmary (RLI), or another local ICU. Level 3 patients will not be admitted to FGH ICU.

If accepted for admission for Level 1 or 2 care, the patient should be transferred and admitted to ICU without delay.

If the patient requires Level 3 care they should be transferred to the Stabilisation Bay, located within the ICU footprint where immediate necessary care, including intubation/ventilation if required will be provided, and the patient prepared for transfer when adequately stable.

Deteriorating patients within the hospital will continue to be escalated as per trust policy (Escalation of Acutely Unwell Patients CORP/GUID/018). If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient and the intensive care consultant. Out-of-hours, this may involve contacting the intensive care consultant at RLI via Switchboard.

This SOP has been developed to support the operational management of patients requiring critical care during an interim period to reflect the medical staffing challenges.

2. PURPOSE

The purpose of this Standard Operating Procedure is to outline the treatment pathway for critically ill patients at FGH.

3. SCOPE

This guideline is for use by all staff involved in the care and transfer of critically ill patients, cross specialty, and not limited to anaesthetics/ITU.

Critically ill patients are those requiring a level of care that is greater than that normally provided on a hospital ward, and levels 1,2 and 3 care are defined by the Intensive Care Society's Consensus Statement on Levels of Adult Critical Care (2021).

Briefly, Level 1 patients require more detailed observations including basic support for a single organ system.

Level 2 patients required basic support for two or more organ systems, or advanced support of one organ system (other than advanced respiratory support).

Level 3 patients require advanced respiratory support (intubation and ventilation); or advanced support of two or more organ systems.

3.1 Roles and Responsibilities

Role	Responsibilities

Click here for a guide to completing this section of the procedural document template

4. PROCEDURE

General Principles:

The decision to undertake inter-hospital transfer of a critically ill patient must be made by appropriate senior decision makers in both referring and receiving hospitals, who take joint responsibility for the transfer. Appropriate senior nursing staff should be involved at both sites.

4.1 Level 3 patients

Level 3 patients will be managed by 'Treat and Transfer' to RLI or another appropriate critical care unit in line with the patients clinical need.

4.2 Level 1 and 2 patients

Level 2 patients will be managed and cared for within ICU at FGH as per usual practice.

4.21 Referral for critical care support should be made in accordance with the Critical Care Admission, Discharge and Operational Policy (ICU/POL/001). The underlying philosophy of the unit is of shared care between referring and intensive care consultants, but the final decision to admit a patient to ICU lies with the intensive care consultant.

4.22 The patient should be referred to the ICU resident doctor by a consultant or appropriate member of the team caring for the patient. The decision to admit to ICU should be discussed by the reviewing doctor with the intensive care consultant. In daytime hours, this will be the ICU consultant at FGH. Out-of-hours, this will be the ICU consultant at RLI, who can be contacted via Switchboard.

For patients at Level 3

4.23 If a decision is made to admit the patient to ICU, the patient should be transferred to the ICU at FGH for immediate stabilisation, including intubation and ventilation if required.

4.24 The on-call ICU consultant at RLI should be contacted via Switchboard as soon as possible to discuss appropriateness of admission to ICU and timescale for transfer. Early engagement with the recipient team should be the default in order to ensure ongoing care is optimal.

4.3 Transfer to RLI ICU should be organised and carried out in accordance with the Trust guideline Intra and Inter-hospital Critical Care Transfers (Adult Patients) (ICU/GUID/010)

4.31 In preparation for safe transfer, resuscitation and stabilisation measures must be taken to ensure the patient's condition is as stable as possible. This needs to be balanced against the need for transfer for ongoing appropriate critical care.

4.32 The use of a checklist (Appendix 1) ensures that appropriate transfer equipment and procedures are in place. The FERNO trolley will be used and should be checked daily. Any

anticipated medications that may be required during the transfer should be drawn up and readily available. Appropriate monitoring should be in place, including end tidal carbon dioxide monitoring.

4.33 The patient should be accompanied by two suitably trained, experienced and competent attendants. One should be a medical practitioner – usually a resident anaesthetist of specialty doctor/ST3 grade or above with the necessary competence and skills as advised by the Intensive Care Society. The other may be an appropriately trained nurse or Advanced Critical Care Practitioner (ACCP).

4.34 Transfer may be by the Critical Care Network transfer ambulance, or the North West Ambulance Service (NWAS). The Critical Care Network ambulance is available during daytime hours, (11:00 – 22:00) and can be utilised when transfers are not time-critical. Outside of these hours, or in the case of a time-critical transfer, NWAS should be contacted to arrange transfer in line with current practice in patients requiring tertiary neurosurgery, cardiology and vascular interventions.

4.35 It may be necessary to discuss with the triaging NWAS practitioner to ensure timely response from NWAS. This should be a clinician to clinician discussion via the Clinical Incident Hub.

4.36 Immediately prior to transfer, a call should be made to RLI ITU to inform them of imminent departure from FGH. An update should be provided on the current clinical condition of the patient, along with the medications the patient is receiving, so the admitting unit can prepare for the patient's arrival.

4.37 Patients transferred into the stabilisation Bay are not a critical care admission. They should not be entered onto DoS or into CCMDS.

4.4 Specialty Specific Considerations

4.41 Patients admitted through ED who are accepted for level 1 or 2 care should be transferred from ED to ICU at FGH as per usual practice. In the event of any transport delay, Level 3 patients may be transferred to the Stabilisation Bay so ED Resus Flow is not impeded

4.42 Medical Inpatients/CCCU should be escalated to critical care as usual, where resuscitation and stabilisation will be carried out by the resident anaesthetic/ICU doctor and the critical care nursing team/ACCPs/CCOT. Level 3 patients will subsequently be transferred to RLI when adequately stable.

4.43 Surgical patients:

No surgical interventions should be delayed as a result of a potential need for post- operative Level 3 care. Early discussion by the FGH anaesthetic/ITU team with the RLI ITU consultant on-call should facilitate a process to minimise this risk and should be done proactively as soon as the

patient is anaesthetised and condition stabilized, or if feasible, prior to surgery if potential need is flagged.

4.44 Patients identified as needing level 3 care post-surgery should be discussed with the RLI Consultant as a priority to prevent delays in transfer. Ideally patients should be transferred straight from theatre recovery, where there will be a clear requirement for ongoing intubation/ventilation. However if there is a delay in the transport arriving, the patient may be transferred to the stabilisation Bay whilst awaiting transfer.

4.45 The treating surgeon will remain the named clinician for that patient throughout the hospital inpatient stay across the Trust; the ICU consultant at RLI will oversee daily reviews and decisions, involving the local on-call surgeon at RLI on daily ward rounds, and ad hoc as required. If there are treatment decisions such as the need to return to theatre, these will be made in conjunction with the FGH surgeon, but care delivered on the RLI site (by the RLI on-call surgeon or FGH surgeon if able to attend).

4.46 Following ICU admission, repatriation to FGH will occur once the patient is deemed stable Level 2, and transfer back to FGH ICU will be arranged (see below).

4.47 Paediatrics: Any child requiring critical care will be stabilised and managed by the resident and on-call anaesthetic and paediatric teams until the North West Transfer Service (NWTS) are able to collect and transfer the child. This is as per current practice and will occur in the safest and most appropriate place.

4.48 Major Trauma Patients: Any major trauma patient will be received and resuscitated by the Trauma Team in ED and onward transfers arranged via NWAS. This is as per current practice.

4.49 Maternity Patients: Maternity patients will be cared for in line with the operational policies for the management of maternity patients; this is undergoing urgent revision and will be shared appropriately.

4.5 Repatriations

4.51 If the Clinical Site Manager or FGH ICU are notified of patients who require repatriation from another critical care unit, the level of care required needs to be identified. If those patients are receiving Level 3 care, please direct the repatriating unit to speak with RLI ICU consultant. The usual process for repatriation will then be followed. Once patients are stepped down to Level 2 care, RLI will then repatriate these patients back to FGH.

4.52 Repatriation of patients transferred to RLI from FGH will occur as soon as clinically appropriate to ensure maximum use of bed capacity and allow patients to be nearer their home. Patients can be transferred back to FGH ICU when they no longer require Level 3 care and are deemed to be at low risk of further deterioration.

4.53 If an ICU patient is assessed as requiring palliative care, consideration will be given to transfer back to FGH to be nearer family if this can be safely facilitated.

Appendix 1

Inter-hospital critical care transfer checklist

NHS
North West Critical Care Networks

TRANSFERRING HOSPITAL/UNIT: Checklist for Critical Care Transfers

1. Preparation

Patient fit for transfer	
Transfer trained medical and qualified nursing or ODP staff available	
Bed confirmed at destination	
Named accepting specialty consultant and critical care consultant identified	
Case notes and investigations photocopied or printed	
Patient and/or relatives informed	
Patient valuables secured	
Ambulance service contacted, appropriate personnel and vehicle for transfer trolley en-route	
Destination hospital and department location confirmed	

2. Patient Checks

Airway		**Disability**	
Safe and secure		Seizures controlled	
ETT / Tracheostomy position confirmed		ICP managed	
NGT in position		Sedation +/- Paralysis	
Breathing		**Exposure / Metabolic**	
Ventilation established		Temperature maintained	
Arterial blood gas checked		Urinary catheter checked	
Capnography in use		Glucose > 4 mmol/l	
Bilateral breath sounds		Potassium < 6, Ionised calcium > 1mmol/l	
Chest drains secure			
HMEF		**Monitoring**	
		ECG, BP, Sa02, ETC02	
Circulation		Indwelling lines, tubes, secure/accessible	
CVS stable		**Trauma**	
Hb adequate		C-Spine stable/ protected	
Minimum two routes of IV access		Pneumothoraces drained	
A-Line + CVC working and zeroed		Thoracic /Abdominal bleeding controlled	
Blood for transfer checked		Long bone/pelvic fractures stabilised	

2. Immediate Pre-Departure Time Out *Read aloud with all transfer team members present, including paramedics*

Introductions of staff completed	
Patient stable on transfer trolley and monitoring in place	
Emergency airway equipment available	
Oxygen & batteries adequate (use ambulance oxygen and electrics)	
Intra-venous access established and checked	
Infusions running and secure	
Spare sedatives / vasopressors / inotropes / fluids available as required	
Blankets / heat-loss measures in place	
Pressure points protected	
Mobile telephone available	
Transferring & receiving unit phone numbers available	
Receiving unit informed of departure	
Directions to destination department at receiving hospital known	

NB.
Please ensure the Network Transfer Form is fully completed for all level 2 and 3 patient transfers

Transfer Checklist August 2019

5. ATTACHMENTS		
Number	**Title**	**Separate attachment**
	Monitoring	N
	Values and Behaviours Framework	N
	Equality & Diversity Impact Assessment Tool	N

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
The latest version of the documents listed below can all be found via the Trust Procedural Document Library intranet homepage.	
Unique Identifier	**Title and web links from the document library**

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
Every effort been made to review/consider the latest evidence to support this document?	*Yes / Not applicable *Please delete as required
If 'Yes', full references are shown below:	
Number	**References**
	NICE Guidance
	Royal College Guidelines
	Regional Guidelines

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**

9. CONSULTATION WITH STAFF AND PATIENTS		
Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name/Meeting	**Job Title**	**Date Consulted**

10. DISTRIBUTION & COMMUNICATION PLAN	
Dissemination lead:	Enter the lead of the development group
Previous document already being used?	Yes / No (Please delete as appropriate)
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	

To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Please detail how staff will be informed of document contents and changes. Include in the UHMB Weekly News. New documents uploaded to the Document Library.

11. TRAINING

Is training required to be given due to the introduction of this procedural document? ***Yes / No** (Please delete as required)

If 'Yes', training is shown below:

Action by	Action required	To be completed (date)

12. AMENDMENT HISTORY

Version No.	Date of Issue	Section/Page Changed	Description of Change	Review Date

These should be the last 3 appendices in the document

Appendix ??: Monitoring

Section to be monitored	Methodology (incl. data source)	Frequency	Reviewed by	Group / Committee to be escalated to (if applicable)

Click here for a guide to completing this section of the procedural document template

Appendix ??: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a positive workplace culture. By following our own policies and with our **ambitious** drive we can cultivate an **open, honest and transparent culture** that is truly **respectful and inclusive** and where we are **compassionate** towards each other.

Appendix ??: Equality & Diversity Impact Assessment Tool

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Equality Impact Assessment Form

Department/Function		
Lead Assessor		
What is being assessed?		
Date of assessment		
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Patient Experience and Involvement Group?	YES / NO
	Staff Side Colleague?	YES / NO
	Service Users?	YES / NO
	Staff Inclusion Network(s)?	YES / NO
	Personal Fair Diverse Champions?	YES / NO
	Other (including external organisations):	

1) **What is the impact on the following equality groups?**

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Positive / Negative / Neutral	
Disability (Including physical and mental impairments)	Positive / Negative / Neutral	
Sex	Positive / Negative / Neutral	

Gender reassignment	Positive / Negative / Neutral	
Religion or Belief	Positive / Negative / Neutral	
Sexual orientation	Positive / Negative / Neutral	
Age	Positive / Negative / Neutral	
Marriage and Civil Partnership	Positive / Negative / Neutral	
Pregnancy and maternity	Positive / Negative / Neutral	
Other (e.g. carers, veterans, people from a low socioeconomic background, people with diverse gender identities, human rights)	Positive / Negative / Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review once approved/noted by Trust Procedural Document Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.