ADMISSION AND DISCHARGE POLICY
PRINCE OF WALES HOSPITAL INTENSIVE CARE UNIT

1. **Admission Policy**:

   a) The ICU admits adult patients and paediatric patients from 12 years old and above.
   b) Admission is arranged by consultation with the on-call ICU consultant or their nominated deputies via direct telephone call to the ICU (3026/3027) or via ICU senior pager no 2170. Consultations are accepted 24h a day.
   c) Patients admitted directly from the Accident and Emergency department or by transfer from another hospital will always be recorded as under the care of the duty medical or surgical team or other special unit (e.g. Paediatrics, Orthopaedics, O&G) as appropriate.
   d) Admission of patients from another hospital must be arranged with the ICU Medical staff BEFORE transfer of the patient.
   e) Resuscitation or admission must not be delayed where the presenting condition is imminently life-threatening, (eg profound shock or hypoxia), unless clear advanced directives are available.
   f) Patients are admitted under the parent team or unit while in the ICU and remain under the long term care of the parent team consultant under whom they are admitted.
   g) Admission disputes must be referred to the on-call ICU consultant.
   h) Admission will be arranged by the ICU consultant or their nominated deputies provided that a bed is available. If admission is delayed or impossible due to bed unavailability the ICU staff will discuss and if appropriate, assist in the process of alternative specialized care.
   i) Until the patient enters the ICU his/her medical care remains the responsibility of the referring physician.

2. **Admission Criteria:**

   a) ICU provides services that include both intensive monitoring and intensive treatment for patients with actual or potential vital system failures, which appear reversible with the provision of ICU support. During times of high utilization and scarce beds, patients requiring **intensive treatment (Priority 1)** have priority over **monitoring (Priority 2)** and **terminally or critically ill patients with a poor prognosis for recovery (Priority 3)*****. Eligibility for ICU admission and discharge is also based upon reversibility of the clinical problem as well as the likely benefits of ICU treatment and expectation of recovery.
   b) It is the responsibility of the patient's attending physician to request ICU admission and to promptly accept back patients meeting discharge criteria.
   c) It is the responsibility of the ICU consultant or their nominated deputies to decide if a patient meets eligibility requirements for ICU. In case of conflict regarding admission or discharge criteria, the ICU consultant will decide which patient should be given priority.

d) Some patients are admitted to the ICU only under unusual circumstances, at the discretion of the ICU consultant, and they should be discharged if necessary to make room for priority 1, 2 or 3 patients. Examples of patients who do not meet routine admission criteria are:
   1. Competent patients who refuse life-support therapy.
   2. Patients with nontraumatic coma causing a permanent vegetative state.

*** **Priority 1 Patients**: Critically ill, unstable patients in need of intensive treatment such as ventilatory support or continuous vasoactive drug infusion. Examples of such admissions may include, but are not limited to post oesophagectomy patients, status asthmaticus patients, or patients in septic shock. Priority 1 patients have no limits placed on therapy.

Priority 2 Patients: Patients who, at the time of admission, may not be critically ill but whose condition requires the technologic monitoring services of the ICU. These patients would benefit from intensive monitoring (e.g. peripheral or pulmonary arterial lines) and are at risk for needing immediate intensive treatment. Examples of such admissions may include, but are not limited to, patients with underlying heart, lung, or renal disease who have a severe medical illness or have undergone major surgery. Priority 2 patients have no limits placed on therapy.

Priority 3 Patients: Critically ill, unstable patients whose previous state of health, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from ICU treatment. Priority 3 patients may receive intensive therapy to relieve acute complications, but therapeutic efforts might stop short of other measures such as endotracheal intubation or cardiopulmonary resuscitation.

3 **Discharge Policy:**

a) All discharges must be approved by the on call ICU consultant.
b) Patients are discharged when the reason for admission has resolved.
c) At discharge from ICU the patient will be immediately accepted by the parent team.
d) Primary care teams must be informed of all patient discharges and any potential or continuing problems.
e) Notify the Acute Pain Team if patients under their care are discharged.
f) If appropriate, limitation/non-escalation of treatment must be clearly documented and discussed with the parent team prior to discharge.
g) A discharge summary must be completed in the case notes prior to discharge.

Mass Casualties for ICU

Refer to the department guidelines for procedures regarding mass casualties. The ICU consultant will be available on site to help sort out the extra-staffing and ICU bed availability.