Mid Essex Hospital Services NHS Trust

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| **GENERAL INTENSIVE CARE UNIT CLINICAL OPERATIONAL POLICY** | **Policy**<br>**Register No: 10067**<br>**Status: Public** |

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| Developed in response to: | Good practice<br>Service Development |
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| 2.0 | Ellie Makings | 14th November 2014 |
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## 1.0 Purpose

1.1 To define the Critical Care services within Mid Essex Hospital NHS Trust (MEHT).

## 2.0 Aims of the Service

2.1 To provide a high quality, evidence based patient centred Critical Care provision to the population of Mid Essex, approximately 360,000.

2.2 To provide access to a team of Specialist Consultants and Nurses, to facilitate a management plan for critically ill patients with various conditions.

2.3 To provide emergency assessment and resuscitation as required for patients within the hospital setting.

2.4 To improve health outcomes for those suffering with short and long term reversible conditions

## 3.0 Scope of the Service

3.1 MEHT Critical Care provides care for patients requiring Intensive Care Therapy (Level 3) - ICU and High Dependency Therapy (Level 1/2) - HDU. This incorporates advanced organ support for Respiratory, Renal, and Cardiovascular conditions.

3.2 Critical Care provides both elective and emergency Adult level 2 and level 3 beds for Mid-Essex. The patient population includes all specialities at Mid Essex and is inclusive of a provision for regional services such as Ear, Nose and Throat (ENT), Upper Gastrointestinal Surgery and Plastic Surgery. The GICU does not include the St Andrews regional Burns Unit ICU.

3.3 The service is provided 24 hours per day, 7 days a week maintaining the ability to provide uninterrupted Intensive and High Dependency Care.

3.4 Critical Care consists of 1 x 13-bedded Intensive Care area (General Intensive Care Unit E226) comprising 13 Level 2/3 beds. There are 2 side rooms on GICU which are utilised for patients with confirmed/suspected specific infections, end-of-life care and for other appropriate patients.
NB the PICC line insertion service is also located within E226 but is a stand-alone service and occupies one of the unused Intensive Care bedspaces..

Critical Care also consists of GHDU (General High Dependency Unit A211) which can accommodate 8 x Level 2 patients. There are 2 x side rooms also on GHDU which are utilised for patients with confirmed/suspected specific infections, end-of-life care and for other appropriate patients.

GICU and GHDU are geographically different locations, GICU being located in East Wing, and GHDU within South wing PFI. The locations are approximately one minutes walking distance between each other. They are staffed from one single

pool of Critical Care medical, nursing, ancilliary and administration staff. Both units use one single electronic bedside patient database (Metavision) which links both units electronically.

3.5 This service is also responsive to inpatient consultation requests from other clinical teams to facilitate appropriate specialist management in the care of critical conditions to ensure appropriate and realistic outcomes for the patient.

3.6 This service is compliant with:

- NICE – Critical Illness Rehabilitation CG83 (partial compliance)
- NICE – Organ donation CG135
- NICE – Infection Control CG2
- DOH - Saving Lives 2007
- NICE – Head Injury
- NICE – Head & Neck Surgery CSGHN
- NICE – Stroke CG68
- NICE – Pressure Ulcer Management CG29
- NICE - Delirium CG103
- NHS England . D16. Adult Critical Care
- ICNARC
- ICS guidelines for both Medical and Nursing staffing

3.7 All care provided is in accordance with current best practice and data relating to performance is submitted for external audit by ICNARC (Intensive Care National Audit and Research Council) allowing comparison of our performance against national figures.

3.8 The unit has an electronic patient data and record keeping system called Metavision.

3.9 **Inclusion Criteria**

3.9.1 All patients over the age of 16 years requiring Critical Care intervention.

3.9.2 There is no upper age limit to admission.

3.10 **Exclusion Criteria**

3.10.1 The GICU has limited resources to care for paediatric cases requiring Intensive Care. Elective paediatric operations requiring postoperative intensive care should be performed in a regional paediatric ICU centre. Emergency cases may be temporarily cared for on the GICU whilst awaiting retrieval by the regional paediatric ICU team.

3.10.2 Critical Care do not provide services for Elective Neurosurgical and Cardio-thoracic admissions

3.10.3 Critical Care does not provide a service for neo-natal admissions.

## 4.0 Staffing

4.1 Staffing Profile

4.1.1 The service is delivered by a team comprising of

- 11 Critical Care Consultants
- 97 Qualified nurses
- 11 junior doctors who have a multidisciplinary background. These doctors rotate through the unit for training and service provision
- A team of affiliated physiotherapists
- 4 clinical technicians
- 2 ward clerk
- 1 Critical Care ICNARC Data Analyst
- 1 Critical Care Administration manager
- 3 house keeper
- 5 HCSW's

4.1.2 We are currently a staffing establishment of 94.80 WTE.

4.1.3 The nurse: patient ratio varies depending on the level of the patient. One to one nursing is required in Level 3 patients and level 2 patients who may require it. Generally level 2 patients are nursed at a ratio of 1:2. On occasion, with extreme critical illness, this dependency may rise to a ratio of 2:1.

4.1.4 The case mix and hence nurse:patient ratio will determine the unit's flexibility to the number of patients who can be safely cared for.

4.1.5 There are currently 12 funded Consultant posts on the Unit and 11 junior doctors of varying grade.

4.1.6 Senior Sisters and the Clinical Facilitation team assist the Consultants with the monitoring and development of the junior doctors.

4.1.6 **Staffing Table**

Staffing for Critical Care

| **Band** | **AFC Band** | **WTE** |
|---|---|---|
| Lead Nurse | Band 8A | 1.0 |
| Senior Sister | Band 7 | 8.25 |
| Clinical Facilitator | Band 7 | 0.45 |
| Registered Nurse | Band 6 | 29.93 |
| Registered Nurse | Band 5 | 43.22 |

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|---|---|---|
| Health Care Support worker | Band 2/3 | 4.97 |
| Critical Care ICNARC Data Analyst | Band 5 | 1.0 |
| Critical Care Administration manager | Band 5 | 1.0 |
| Housekeepers | Band 2 | 3.0 |
| Ward Administrators | Band 3 | 2.0 |

## 5.0 Training and Education

5.1 All staff within the ICU will comply with the Trust Mandatory Training Programme and NHSLA requirements.

5.2 Clinical Staff will maintain their own requirements for continuous professional development.

5.3 Registered nurses will be able to demonstrate continuous professional development in line with NMC requirements and the need for three-yearly revalidation.

5.4 Medical Staff will be able to demonstrate Continuing Professional Development as required by the GMC and have an annual appraisal and revalidation every 5 years.

5.5 All nurses band 6 and above have either completed the ICU course or equivalent level 3 competencies or National Critical Care competency level 2.

5.6 Band 5 staff are trained up to the level of the Acute Care Course or equivalent in competencies. All band 5 nurse have a trajectory to complete the above course.

5.7 The unit is fully compliant with all training and educational requirements for its staff.

5.8 The unit runs 8 x 1 day in-house mandatory training for all staff which covers all trust requirements.

5.9 The unit provides a Teaching room for staff to utilise educational resources, 2 PCs, filing cabinets to store and maintain their own educational files, books and educational literature. Critical Care has a recently modernized Seminar Room which includes touch-screen 84-inch HD television.

5.10 Weekly teaching is provided for the junior medical staff and any nursing staff who are able to attend

5.11 Critical Care currently delivers the Acute Care Course. This is university-accredited by ARU and can be completed as either part of degree pathway or Masters.

5.12 Critical Care sponsors candidates for ALS, ATLS, EPLS, attendance at BACCN, ISICEM (Brussels) and many other national and local courses.

5.13 Critical Care has a team of x4 Clinical Facilitators who work both rostered and supernumerary shifts across both units

## 6.0 Admissions process

### 6.1 Elective Admissions

6.1.1 All patients with an identified need for level 2/3 bed are reviewed on a case by case basis by the Critical Care consultant.

6.1.2 Requests for an elective bed are reviewed weekly by the Clinical Lead for Critical Care and by the identified Anaesthetic Consultant. This list of patients will be derived from the High Risk Database prior to this triaging process. This finalized list is then disseminated throughout the senior leadership team prior to the following week..

6.1.3 There may occasionally be cases who are identified immediately prior to surgery, and these are referred to the on-call Critical Care Consultant as soon as possible to the day of surgery

6.1.4 Booking of a unit bed does not guarantee an automatic bed place. On the day of surgery the consultant anaesthetist must confirm the availability of the bed prior to sending for the patient.

### 6.2 Emergency admissions

6.2.1 All unplanned admissions need a consultant to consultant referral regardless of time of day or night In exceptional circumstances, referrals will be discussed with the Registrar looking after the patient if a delay in referral would lead to the rapid deterioration of a patient. In this case the consultant responsible for the patient should be contacted as soon as possible after referral. The exceptions to consultant-to-consultant referral are the following cases requiring level 2 care: NIV, DKA and life-threatening arrhythmia. In these cases, Registrar-to-Registrar referral is appropriate.

6.2.2 Between 08.30 and 18.00 hours the Critical Care consultants should be contacted by phoning GICU on extension 4053 or GHDU on extension 4379. Out of these hours, they can be contacted via switchboard.

6.2.3 Occasionally medical staff phone the ICU junior staff for advice regarding a patient's management. Doctors should contact the most senior member of their team for advice who will then contact the ICU consultant if appropriate.

6.2.4 If a doctor requires urgent help with a deteriorating patient on the ward, the Trust observation policy should be followed and a cardiac arrest call put out to obtain immediate help.

6.2.5 All patients discussed with the ICU but not as a referral for admission remain under the care of the primary team and as such remain responsible for reviewing and escalating care should deterioration occur.

6.2.6 We encourage collaborative patient centred care. However the ICU is defined as a closed unit. This means that when patients are admitted into the ICU, they are under the care of the ICU team. It is expected that members of the primary referring

team will liaise daily with the ICU team to discuss the patient's management .However it is up to the ICU team to make final decisions .

## 7.0 Ward rounds and Medical cover

7.1 Critical Care is a consultant-led service. There is a dedicated consultant at all times in charge of Critical Care. They must always be immediately contactable and available.

7.2 Consultant-led ward rounds take place at 08.30, 16.00 and 21.00 hours. These times coincide with the final hour of the junior doctors' shifts so progress and outstanding jobs can be highlighted.

7.3 A robust handover system is necessary to ensure continuity of care in this complex patient group.

7.4 Nursing handover is led by the nurse in charge at 07.45 and 20.30 hours and a one to one handover at the bedside for the nurse responsible for the patient's care

7.5 A consultant to consultant handover is routine when there is a change in the consultant in charge. This may be done in person or verbally.

7.6 There is a morning safety briefing on GICU at 08:30 every morning. This is attended by all senior staff on duty, all senior MDT personnel and the night-time junior doctors from both units. This is also attended by one of the Theatre Matrons. Subjects formally discussed are staffing, allocation, elective admissions, safety issues both prior and possible, potential transfers in and out, stepdowns and bed occupancy status.

7.7 The morning wards round then commence and these are also attended by the nurse in-charge of the respective units

7.8 Each ward round must be documented with a clear plan and objectives for the patient's care.

7.9 A Critical Care junior doctor is expected to attend all trauma calls and cardiac arrest calls in the hospital. During normal working hours (08.30 -18.00) the ICU Junior doctor is not required to attend cardiac arrest calls in the ED. When attending a call, the ITU doctor is required to take the emergency grab bag to the ward to provide extra resuscitation equipment. The GHDU junior doctor is expected to attend trauma calls in ED.

7.10 The grab bags are maintained and equipped by the junior staff according to the checklist. See appendix.

## 8.0 Discharge Process

8.1 The Critical Care consultant will decide which patients no longer require critical care. They are then responsible for liaising with the nurse in charge such that a bed can be secured. This process will usually occur at ward round times.

8.2 Patients should be discharged from ICU to other wards between the hours of 07.00 and 22.00. Out of hours discharge to other wards should be avoided if possible in accordance with best practice and is audited nationally as a quality performance indicator.

8.3 To ensure timely discharge, the unit relies upon good communication with the Clinical Operation Team facilitated by the Matron. The Matron will attend bed meetings to facilitate this and to give a situation update.

8.4 During the evening ward round, the consultant on-call is responsible for liaising with the nurse in charge to enable them to be able to identify patients that are likely to be fit for discharge the following morning assuming set parameters are met. This allows the Clinical Operations team to be informed at the earliest opportunity and ensures the flow of elective surgical patients requiring a bed the following day.

**Medical discharge process**

8.5 A detailed comprehensive medical discharge summary form must accompany the patient to the the ward. The Critical Care consultant is responsible for reviewing the content of the summary.

8.6 A new drug chart and if appropriate a not for resuscitation form must also be completed to transfer with the patient.

8.7 A verbal handover is also required to the receiving team. In the case of a non elective admission ,the Critical Care consultant where possible should aim to verbally discuss the patient with the consultant or senior team member who will be taking on further care of the patient. This should include any discussions regarding ceiling of care or possible need for readmission.

8.8 If the patient subsequently moves to the ward out of hours (after 18 00 hours), then the on call team should be contacted for a verbal handover.

8.9 Documentation of who the patient has been handed over to must occur.

**Nursing discharge process**

8.10 The nurse caring for the patient in the Critical Care is responsible for completing the nursing discharge documentation.

8.11 The patient's closest relative/best contact must be contacted to notify the patient is moving to another ward and identify the ward they are moving to.

8.12 Appropriate Metavision notes must be printed off to be placed in the patient's notes.

8.13 The nurse will then accompany the patient to the ward with a porter and verbally hand over to the receiving nurse on the ward. The nurse will ensure that all belongings, notes , discharge summaries and drug chart accompany the patient.

## 9.0 Pastoral Care and Psychotherapy

9.1 A patient and or their relative may find their stay on the Critical Care to be difficult to cope with. This may be due to receiving bad news or a drastic change in a person's lifestyle. The trust chaplaincy team can be contacted at all times to provide pastoral care to our patients and their relatives.

9.2 Alternatively a referral may be appropriate to the psychotherapy and counselling service. The nurse looking after the patient can make the referral to the service without delay.

## 10.0 Intensive Care follow up Clinic

10.1 Appropriate patients who stay for longer than 72 hours are invited to attend the Critical Care follow up clinic. In accordance with NICE 83 guidance, patients should be seen within 3 months post hospital discharge.

10.2 Any patient who wishes to attend the follow up clinic will be offered an appointment, these may be patients who suffered delirium or patients who have very little memory of their stay with us. Critical Care are currently sponsoring one of our Senior Sisters at Masters level to create ultimately nurse-led follow-up clinics. These are currently consultant-led.
We have also established a nurse-led bereavement follow-up service for appropriate patients. Patient diaries are currently being approved by DRAG.
Critical Care conduct and lead 6-monthly organ donation days between ourselves, Basildon and Southend Critical Care.

## 11.0 Relatives

11.1 It is important that relatives of our patients are regularly updated and informed of their relatives' progress. It is encouraged to speak to relatives in the quiet room and not at the bedside in order to maintain privacy and dignity.

11.2 Relatives should only be spoken to by senior medical and nursing staff to ensure accurate information is relayed. Conversations must always be documented and if possible the nurse caring for the patient should also be present.

11.3 Visiting times for patients are 12:00 to 15:30 and 17:00 to 20.00 hours. These hours change to 12:00 to 20:00 at weekends. A maximum of 2 relatives at a time are allowed to visit. These rules may be relaxed if a patient is very unwell and at the end of their life in which case there is open visiting and more than 2 visitors allowed at a time. This is at the discretion of the nurse in charge.

11.4 Children are allowed to visit relatives in Critical Care if deemed appropriate by the nurse in charge. This is supported by the nurses and the psychotherapy team may be involved if required.

11.5 There is a visitors' waiting room close to Critical Care with tea and coffee making facilities. There are also 2 relatives bedrooms with ensuite bathroom facilities. These are made available to relatives of patients who are physiologically unstable or likely to be at the end of their life. Relatives who live a long distance from the

hospital may also be offered the use of the rooms based on clinical need on a short term basis until alternative accommodation can be found. This is at the discretion of the nurse in charge. This area has again recently undergone enormous refurbishment.

There is no formal waiting area within our Critical Care area. Relatives need to wait to visit in corridors outside both Units. To this end, we have significantly invested in the area outside GICU and are formalizing plans for this to be repeated outside GHDU.

## 12.0 End of Life Care

12.1 End of life care will be carried out in line with the Trust's 06059 Care of the Dying Policy.
It may be possible for patients who die on Critical Care to become an organ or tissue donor..Any such patients should be discussed with the Specialist Nurse in Organ Donation (SNOD). Please see 14021 Organ & Tissue Donation Policy.

12.2 Patients relatives should be given the opportunity to view their loved one with tubes removed such as breathing tubes once they have passed away. This may not be possible if the patient needs to be referred to the coroner.

12.3 Nursing staff will ensure relatives receive a copy of the Trust bereavement booklet which outlines the process they will need to follow.

12.4 If a patient dies on Critical Care out of normal working hours, the notes will stay on Critical Care so that they can be completed by the ward clerk before they are taken to the bereavement office for scrutiny by the Medical Examiner.

## 13.0 Clinical Governance

1.31 All care is delivered in accordance with current best practice and data relating to performance is submitted for external audit by ICNARC (Intensive Care National Audit and Research Council) allowing comparison of our performance against national figures.

13.2 Departmental audit meetings are held every 3 months . Every junior doctor is expected to carry out an audit during their ICU placement.

13.3 Regular Morbidity and mortality meetings are held every 3 months.

13.4 **Meetings**

13.4.1 Weekly MDT meetings occur to discuss the progress and plans for long stay patients including ceiling of care and no return to ICU post discharge if appropriate.

13.4.2 Monthly senior leadership team meetings are held to discuss operational processes, as well as regular updates on mandatory training, budgets and patient safety issues, the minutes of which are distributed via monthly Critical Care newsletter.

13.4.3 Monthly Band 7 meetings – the minutes of which are distributed via monthly Critical Care newsletter.

13.4.4 Monthly Staff meetings – the minutes of which are distributed via monthly Critical Care newsletter.

## 14.0 Facilities

14.1 Unit and hospital facilities include:

- Male and female staff change and toilet facilities
- Staff Rest Rooms
- Kitchens
- Lockers – lockable filing cabinets for staff personal belongings
- Staff refreshments – restaurant, League of Friends, WRVS coffee shops, Hospital shop, Costa, WH Smith, M and S.
- Occupational Health
- Self Referral to Physiotherapy
- Regular social events for all staff

## 15.0 Equipment Requirements

15.1 For Critical Care to work efficiently and effectively and maintain high standards of patient care, modern electrically powered patient beds with pressure relieving mattresses are provided

15.2 Well maintained and serviced monitoring equipment and ventilators are co ordinated by the Clinical Technician team.

15.3 A dedicated computer at every bed area for Metavision.

15.4 Haemofiltration machines and specialist monitoring ie cardiac output pulmonary artery catheter, Oesophageal doppler and LiDCo, blood gas machine.

15.5 The unit also requires transfer equipment, i.e. monitors and ventilators and a supply of portable O2 cylinders.

15.6 Each of the 13 bed areas in GICU are equipped with:

- Drager beam for electrical, air and oxygen supplies, and vacuum.
- Cardiac monitor with allied Slave monitor
- Ventilator
- Infusion pumps and syringe drivers
- Digital thermometer
- Bedside trolley to store all essential items for patient care and requirements
- Electrical bed with pressure relieving mattress
- Computer and trolley
- Portable oxygen cylinder and emergency Ambu bag

Each of the 8 bed areas in GHDU are equipped with:

- Drager beam for electrical, air and oxygen supplies, and vacuum.

- Cardiac monitor with allied Slave monitor
- Infusion pumps and syringe drivers
- Digital thermometer
- Bedside trolley to store all essential items for patient care and requirements
- Electrical bed with pressure relieving mattress
- Computer and trolley
- Portable oxygen cylinder and emergency Ambu bag
- NB 4 x bed spaces in GHDU are equipped with NIV provision

15.7 There is 1 further unfunded bed area that is currently used by the PICC line service.

16. Infection Prevention

16.1 The service will be delivered in accordance with and compliance to the Trust's Infection Prevention Policies.

16.2 The unit has regular updates from the Microbiology consultant who attends weekly MDT and infection control team regarding any positive microbiology results and changes in therapy required as a result. Critical Care has 4 x side rooms in total should a patient requirement barrier nursing measures.

16.3 Monthly infection control and environmental audits are carried out to comply with Trust policy.

## 17.0 Key Relationships

17.1 Key Operational Requirements

- Fully equipped Critical Care area
- Access to Clinical OperationsTeam to facilitate patient transfers from Critical Care.
- Dedicated office space
- Access to ICT
- Emergency Bed Service
- Hard and Soft FM services.
- Knowledgeable and skilled nursing staff
- Administrative support
- Critical Care specialist Consultants leading the Unit medical team.
- Hygiene facilities for Level 1/2 patients
- Staff rest and handover area
- Relative consultation area /Seminar room for unit Teaching
- Kitchen facilities

17.2 **Key Relationships with Other Departments**

17.2.1 As a secondary support service within the Acute Trust, good working relationships with all medical teams referring patients for level 2 and 3 care is essential. This is best achieved by early discussion of problems at Consultant level to determine appropriate and timely admissions.

17.2.2 Other Key Relationships as listed below.

- Clinical Operations Team
- Pharmacy
- Pathology
- Neurophysiology
- Pharmacy
- Portering Services
- Medical Records
- Imaging, MRI/CT/X-ray- Radiology services
- Medical Emergency Ward
- Accident and Emergency
- Pain Clinic Service
- Occupational Therapy
- Physiotherapy
- Tissue Viability CNS
- Psychotherapy
- Department of Clinical Technology
- Ambulance Control
- Stoma Care Service CNS
- Transplant Coordinator
- Theatre Department/Recovery
- St. Andrews Regional Burns ICU
- Specialist Referral Hospitals
- Pastoral Service
- Facilities Management, hard and soft FM
- Police
- Anglia Ruskin University and allied training facilities
- Warner Library

## 18.0 Key Requirements for Facilities Management (F.M.)

18.1 The unit has a dedicated cleaning service for ongoing cleaning and rapid but effective bed space decontamination for the efficient use of beds. There is a service level agreement in place.

18.2 For lower level patients there is an appropriate catering service.

18.3 Our complex equipment is maintained by a team of dedicated Clinical Technicians; they also act to maintain specialist stock levels and assist with introduction of new

equipment and facilitate staff training and competency documentation. The technicians are also available in assistance with the transfer of critically ill patients

18.4 For hospital maintained equipment we require good support from EBME and likewise estates teams for the fabric of Critical Care.

18.5 The portering team provides an essential service to the unit. There is also a pod system for transfer of items around the hospital.

18.6 The unit has a dedicated Critical Care pharmacist who helps maintain drug stock levels and facilitates access to non-stock items.

18.7 Bathroom and toilet facilities to meet the hygiene needs for lower level patients.

18.8 A daily stock system is required to maintain safe and effective levels of stock to accommodate the needs of all patients. And allow for immediate response to major incidents

## 19.0 Environmental requirements

19.1 The patients within Critical Care can require very close observation and examination at all times and so good natural lighting is the ideal. We have windows, but additional adjustable lighting is required for the unit and each bed space.

19.2 Natural lighting is very important to maintain patient's normal diurnal rhythms to reduce undue stress.

19.3 The unit cannot have open windows and to maintain safe heating levels is air conditioned throughout.

19.4 Walls are neutral in colour and allow a wipe down surface.

## 20.0 Security Requirements

### 20.1 Data Security

- The service will be delivered in accordance with and compliance to the Trust's IT Policies.
- Data sharing agreements will be drawn up to cover all data sharing outside the Trust in accordance with the Trust data sharing policy.
- Hospital information/patient data will only be downloaded onto devices provided by the Trust which are encrypted.
- Databases will be registered on the Trust database of databases.
- A data mapping form will be completed for all routine data flows leaving the Trust.

- Patient identifiable information will only be sent out of the Trust from an nhs.net account or other secure route (never from an nhs.uk account). All senior nursing staff and ward administrators have nhs.net accounts.

20.2 **Security for Patients**

- The service will be delivered in accordance with and compliance to the Trust's Patient Safety Policies.

- Both units have security TV & telephone entry systems preventing unwanted access. Each patient (s) is (are) cared for by a nominated nurse for each shift who will maintain a safe environment.

- Critical Care is only accessible by swipe card or manned TV entry system. There are security porters that we can request in event of incidents. The clean utility is also swipe access only. The clean utility is only accessible to Critical Care members of staff or those who have been provided with access.

20.3 **Security for Staff**

- The service will be delivered in accordance with and compliance to the Trust's Lone Worker and Security / Risk Management Policies.

20.4 **Medical Records Security**

- All patients medical records will be managed confidentially at all times and stored securely in locked office or outpatient facility whilst not in use.

- All movement of patient records will be accurately tracked in accordance with the Trust's Case note Tracking Policy.

- All new documentation will be secured into the folder prior to it leaving the department.

## 21.0 Manual Handling

21.1 The service will be delivered in accordance with and compliance to the Trust's Manual Handing Policies. This is covered by the in-house mandatory training.

## 22.0 Fire safety

22.1 The service will be compliant with the Trust's Fire Safety Policy, Fire Evacuation Policy and other local fire plans and procedures. This is covered by the in house mandatory training.

22.2 The detail of these items will then be developed as part of the separate Fire Safety Work Programme, as led by the Trust's Fire Officer.

## 23.0 ICT Requirements

23.1 ICT Requirements for the Unit include:

- We have a quantity of PC's with office based software, available to all staff.
- Lorenzo
- INFOFLEX
- PAX
- Pathology
- Telephone access throughout the unit
- Pager service for all Clinical Staff
- Metavision
- TOMCAT
- Healthroster

23.2 Metavision is our patient data and record keeping system, this is locally maintained by a group of in house Consultants and nurses, but the unit requires IT support for hardware issues and network problems. Metavision has a dedicated server which is maintained by our IT department.

23.3 It is vital that new doctors and nurses receive adequate training to use the Metavision system on the first day of their placement to allow safe documentation and drug prescribing. This will be incorporated in their local induction.

## 24.0 Equality and Diversity

24.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

24.2 Every patient will be treated with dignity and privacy. Curtains will be secured around a bedside with a 'no entry' sign clip to ensure privacy is maintained.

24.3 The unit runs the trust E&D training as part of its in house mandatory update for all staff.

Please see Appendix 4, Equality Impact assessment Form (EIA) Form

**25.0** Contingency

25.1 The unit is an active participant in major incident and accident planning. The role is clearly defined within that plan. In the event of local problems i.e. fire we have a plan for patient management that will be assessed and addressed between the nurse in charge for the shift and the consultant.

25.2 The unit must be able to deal with a sudden increase in the need for Critical Care beds, such as in the event of a severe influenza outbreak. Please see the surge plan for further details.

25.3 We have established links with the IT department to address the reliance on

computers and a system of prioritisation has been attached to the unit when calls / faults are logged with the helpdesk. In the event of IT failure, we have packs available to manually collect patient data and observations, and we have regularly updated patients prescription forms to follow in this event. This back up system of paperwork was recently tested during the IT attack in April 2017.

25.4 The contingency for reduced staffing due to sickness is to ensure Critical Care is appropriately staffed, maintaining patient safety. We would look at swapping staff shifts in the first instance for cover, failing that we would contact staff for Bank shifts. Confirmation with General Managers is required if we need to staff the GICU during busy periods, so that the allotted staff numbers can be extended.

25.5 If a junior doctor is not able to attend due to sickness, an alternative junior will be sort to cover the shift. If no one can be identified, the consultant on call will act down and be resident for the night for an agreed fee and another consultant will act as the consultant on call.

25.6 If a Critical Care consultant is sick and unable to work, the night on call will be covered by a colleague if available. If a day session is uncovered, a Critical Care consultant present in the hospital in another area eg theatres, they may need to be pulled out to cover Critical Care.

## 26.0 Repatriations

26.1 Patients may require specialist treatment at other hospitals. When these patients are clinically stable and require ongoing critical care, they may be repatriated back to Mid Essex. This may also happen to the Mid Essex population if they are taken ill on holiday in the UK or abroad.

26.2 The unit will aim to comply with the East of England Critical Care Network Repatriation policy which states that the patient should be repatriated within 48 hours post referral. Please see repatriation policy for further details**.**

## 27.0 Pharmacy Services

27.1 For full details of the pharmacy services please refer to the Pharmacy Clinical Operational Policy, which includes workflows to be followed by non-pharmacy hospital staff. The Medicines Management Policy also includes the embedded SOP for Critical Care.

## 28.0 Auditing this Policy

28.1 This policy will be audited as part of a 2 year cycle by a lead clinician with input from the general manager (critical care) and senior nursing leads, more frequent update will be instituted in response to significant restructuring or request from the Trust Board.

## 29.0 Responsibilities

29.1 The units on a day to day basis are managed between the Critical Care consultants and the shift nurses in charge.

29.2 In the unusual event these two parties cannot resolve the problem; we have a clear line of escalation to our Clinical Lead, Clinical director and Associate Director of Nursing.

## 30.0 References


http://guidance.nice.org.uk/CG83
http://guidance.nice.org.uk/CG2
http://guidance.nice.org.uk/CG135
http://guidance.nice.org.uk/CG56
http://guidance.nice.org.uk/CG103
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documentshttp://guidance.nice.org.uk/CG68
http://guidance.nice.org.uk/CG29
http://guidance.nice.org.uk/CSGHN
/digitalasset/dh_080059.pdf
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113471.p
www.england.nhs.uk/commissioning/spec-services/npc-crg/d16

**Appendix 1**

## EMERGENCY BAG CONTENTS

**Arrest Drugs: Main Bag**

Adrenaline mini-jet x3
Atropine mini-jet x1
Calcium Chloride mini-jet x1
Epipen x1
Glucose mini-jet x1

**Hypnotics Reversals: SingleRed Bag**

Diazepam 10mgs/2ml x2
Flumazenil 500mcgs/5ml x2
Midazolam 10mgs/5ml x2
Naloxone 400mcgs/1ml x4

**Respiratory Drugs: Single Red Bag**

Aminophylline 250mg/10ml x1
Chlorphenamine 10mg/1ml x1
Dexamethasone 8mg/2ml x1
Hydrocortisone 100mg x1
Salbutamol 5mg/5ml x1

**Cardiovascular Drugs: Single Red Bag**

Adenosine 6mg/2ml x4
Amiodarone 150mg/3ml x4
Atropine x1
Calcium Chloride 5mmols/10ml x1
Digoxin 2mls x1
Frusemide 50mgs/5ml x2
Esmolol 10mg/ml x1
Glycopyrrolate 600mcg/3ml x1
Magnesium Sulphate 5g/10ml x1

**Red Pouch Drugs: INOTROPES - Middle bag -**

Adrenaline 1:1000 x4
Dobutamine x2
Ephedrine 30mg/1ml x4
Saline x2
Labetolol20ml x1
Noradrenaline 1:1000 4mg/4ml x6
Metaraminol x2

**Blue Pouch Drugs: ANAESTHETIC**

Atracurium 50m/5ml x1
Etomidate 20mg/10ml x2
Propofol 1% 200mg/20ml x2
Suxamethonium 100mg/2m x2
Thiopentone 500mg x1
Vecuronium 10mg/5ml x2

## AIRWAY EQUIPMENT: Main Bag

Acquagel x2
Large batteries x2
Catheter Mount x1
Guedel Airways size 1-4
HME filter x1
Nasopharyngeal airways size 6 & 7
Reservoir Bag x1
Bougie15g x1
Endotracheal tubes sizes 3-9
Mapelson C Waters Circuit x1

Laryngoscope Handle x1
Laryngoscope mac 3 blade x1
Laryngoscope mac 4 blade x1
Magills Forceps x1
Non-rebreathe mask x1
Ambu-bag Complete x1 - ***outside bag***
Facemask size 5 x1
Scissors x1 - ***front pouch***
Tie x1 - ***front pouch***
Capnograph device

## LINES & GENERAL EQUIPMENT:

Arterial Lines selection
IV cannula 14-22G
Guide Wire x2
Stitch Cutter x1
Spare Guide Wire x1
Blood Giving Sets x2
Various syringes, needles **RED Bag with drugs**

Arterial extension line
2-0 ethilonsuture x2
Lignocaine 5ml 2% x1
Femoral arterial line x2
Multi-lumen Central Line x1 - ***front pouch***

Trauma line x1
3-way taps x3

**Appendix 2**

**Equality Impact Assessment Form (EIA) Form**

**Clinical Operational Policy for Inpatient and Outpatient Procedures**

| **Equality or human rights concern** ***(see guidance notes below)*** | **Does this item have any differential impact on the equality groups listed? Brief description of impact.** | **How is this impact being addressed?** |
|---|---|---|
| **Gender** | The ICU does not have single sex areas. Consideration is given to try to nurse patients of the same sex in the same area if possible. The ICU is exempt from single sex ward policy. | |
| **Race and Ethnicity** | Language may be seen as a barrier for some patients. | Interpreters are made available when required either face to face or via language line.<br>All staff attend in-house training courses on equality and diversity. |
| **Disability** | There may be patients, carers or staff who have a disability who use, visit or work within the above service area. | The clinical areas are easily accessible by wheelchair and lifts.<br>The nurse stations are accessible on the ward.<br>There is type talk available.<br>Sign language interpreters can be booked if required.<br>Staff carry out moving and handling for all inpatients and day cases and perform risk assessments when necessary. |

| | | |
|---|---|---|
| **Religion, Faith and Belief.** | Unique to each individual and dependent on patient, carer or staff needs and/or requirements. | There is access to the chaplaincy team who are available to offer advice and support for staff, patients and relatives and/or carers.<br>Written information is available in the clinical areas provided by the chaplaincy team and a Faith centre is available within the hospital which is accessible to patients, relatives, carers and staff.<br>It is possible to access multi-faith leaders when required. |
| **Sexual Orientation** | All people who use, visit or work within the service are treated the same regardless of their sexual orientation. | All staff attend in-house training courses on equality and diversity.<br>Any issues or complaints are fully investigated and responded to within 28 days where appropriate. |
| **Age (Safeguarding Children)** | Adult ICU does not admit patients under the age of 16 routinely. All staff on the ICU have received Safeguarding children training. | Any children visiting a relative on the ICU will be accompanied by an adult, a member of staff and a member of the psychotherapy team if necessary. |
| **Transgender People** | All people who use, visit or work within the service are treated the same regardless of their sexual orientation. | All staff attend in-house training courses on equality and diversity.<br>Any issues or complaints are fully investigated and responded to within 28 days where appropriate. |

| | | |
|---|---|---|
| **Social Class** | A number of patients may have difficulty assessing the service due to financial or transport problems. | Offer information on public transport to patients, relatives, carers and escorts travelling to Broomfield Hospital.<br>Patients may be legible for hospital transport if there is a clinical need.<br>All Staff are made aware that when communicating information either by verbal means or in writing to adapt the information to the needs and level of understanding to the individual. (It is important to remember patients, relatives and carers may not understand clinical terminology). |
| **Carers** | A number of patients may have difficulty in visiting the hospital. | Offer information on public transport.<br>Encourage staff to be flexible with visiting hours for these members of the public.<br>Encourage staff to talk to their carers on the telephone if the carer or relative is unable to visit.<br>Ensure relatives and carers are involved in the discharge planning process alongside the patient and working in partnership discuss expected discharge dates and care package. |

**Date of Assessment: 28th June 2018**

**Name of Assessor (s) Paul Arnold**
**Rebecca Martin**