



Prince Sultan Military Medical City

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وزارة الدفاع
MINISTRY OF DEFENSE

Departmental Policy	Dept.: Intensive Care Services	Policy No: 1-2-9451-01-012 Version No: 05		
Title: General Intensive Care Unit 1 & 2 (GICU1 & GICU2) Admission and Discharge		JCI Code: ACC		
Supersedes: 1-2-9451-01-012 Version No: 04; 30 September 2020	Issue Date:	Effective Date:	Revision Date:	Page 1 of
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1. INTRODUCTION

- 1.1. The Intensive Care Unit (ICU) serves as a place for monitoring and care of patients with potentially severe physiological instability requiring technical and/or artificial life support.
- 1.2. As with any other treatment, the decision to admit a patient to the Intensive Care Unit should be based on the concept of potential benefit. Patients who are too well to benefit or those with no hope of recovering to an acceptable quality of life usually should not be admitted (see Priority 4). It is also important to respect patient's autonomy and patient should not be admitted to Intensive Care Unit if they have a clearly stated or written, desire not to receive intensive care management.

2. PURPOSE

The main aim is to assure the appropriate utilization of resources of the Intensive Care Unit (ICU) and staff. It is well known that proper utilization of these resources is vital to assure that care is given to those patients with severe unstable physiology, requiring technical and / or artificial life support. The Director of Intensive Care Services has the authority and responsibility over this policy and its implementation.

3. APPLICABILITY

All Medical and Nursing Staff

4. POLICY

- 4.1. Patients are admitted to critical care areas for advanced life support and monitoring, during active treatment of an underlying clinical condition. These conditions should be identifiable, acute and potentially reversible.
- 4.2. Even when there is an acute reversible component, the patient's chronic health status (impairment of organ systems or physiological reserve) may significantly affect the patient's ability to survive and benefit from an intensive care episode. This requires careful assessment, but should not be prejudiced by age or ethnicity.



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- 4.3. A patient has stated or written preference for or against intensive care must be taken into account. The role of relatives in the case of an incapacitated patient is to represent their understanding of what the patient would wish.
- 4.4. The final decision to admit or refuse admission of patients to the critical care unit is the responsibility of duty critical care consultant. Any disputes should initially be discussed between the duty critical care consultant and referring consultant. If further resolution is required, this should involve the respective clinical directors.
- 4.5. The final decision to admit or refuse admission will be based on the combination of following criteria:
 - 4.5.1. Priority of Care
 - 4.5.2. Diagnostic Criteria
 - 4.5.3. Objective Parameters Model (Vital Signs, Laboratory values, Radiography/Ultrasonography/Tomography, Electrocardiogram, and Physical Findings)
- 4.6. All decisions to admit patients to a critical care area must involve the duty critical care consultant.
- 4.7. Protocols for the various aspects of medical and nursing care will be available in critical care ward areas. All staff including visiting staff should be aware of these protocols.
- 4.8. A critical care consultant will review all new admissions to critical care within 12 hours of admission. However, it should be recognized that many patients would benefit from earlier review. The date and time of first consultant review must be clearly documented in the patients note.
- 4.9. All critical care patients will be reviewed at least twice per day by a critical care consultant and other ICS physicians at least twice per day.
- 4.10. All critical care patients will undergo a full daily review by the critical care staff. This should include a full clinical examination and a review of the chart, notes and investigations. The review and all significant interventions, verbal reports of results and other clinical events should be documented in the patient's records.



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- 4.11. Visiting staff reviewing patients should also record their findings and recommendations in the notes/RABET (CERNER Electronic Patient Chart). Final decisions on day-to-day management rests with the Critical Care Consultants.
- 4.12. Management of critical care patients in critical care units will be the responsibility of the critical care medical staff, headed by the duty consultant. For clarity of accountability, in areas of debate, the final decision will rest with the Critical Care Consultant
- 4.13. Primary/ Referring teams will be encouraged to review patients on a daily basis or more frequently if desired. Recommendations of referring teams will be given consideration.
- 4.14. To ensure consistency as a closed unit only critical care staff will make entries on the drug and fluid administration charts
- 4.15. Staff will be trained about the criteria during the departmental orientation.
- 4.16. Critical Care Teams will seek the opinion of any specialist in the best interest of the patient.
- 4.17. The critical care medical staff will communicate significant changes in a patient's condition to the referring team.
- 4.18. Relatives of a critical care patient should be kept fully informed of his/her condition and any formal interviews should be recorded, together with their views as well as the explanations offered by staff. Discussion with relatives by referring teams should only occur once they have familiarized themselves with the content of previous discussions and should be well documented. All discussion must take place in the presence of a member of the critical care nursing staff. Joint family conference with different referring team with critical care staff can be arranged.
- 4.19. Patients in whom critical care therapy is only prolonging the process of death should receive compassionate care.
- 4.20. Each Critical Care Unit must ensure they adhere to hospital consent policies and that appropriate consent to treatment forms are completed.



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5. DEFINITION OF TERMS

5.1. **HEMODYNAMIC INSTABILITY**

Alteration in patient's blood pressure, heart rate, heart function from patient's baseline where changes in perfusion cause signs and symptoms of end organ hypoperfusion.

5.2. **ADMISSION PRIORITIZATION**

This system defines those that will benefit most from the ICU (**Priority 1**) to those that will not benefit at all (**Priority 4**) from ICU admission. Based on these priorities, the ICS Team will decide to provide appropriate management to the patient either in ICU or in Wards.

5.2.1. **Priority 1.**

Critically ill, unstable patient in need of intensive care treatment and monitoring that cannot be provided outside of ICU. Usually, these treatments include ventilator support, continuous vasoactive drug infusions, etc. Priority 1 patients generally have no limits placed on the extent of the therapy they receive. Examples may include post-operative, or acute respiratory failure patients requiring mechanical ventilator support and shock or hemodynamically unstable patients receiving invasive monitoring and/or vasoactive drugs.

5.2.2. **Priority 2.**

These patients require intensive monitoring and potentially may need immediate intervention. No therapeutic limits are generally stipulated for these patients. Examples include patients with chronic co-morbid conditions who develop acute severe medical or surgical illness.

5.2.3. **Priority 3.**

These unstable patients are critically ill but have a reduced likelihood of recovery because of underlying disease or nature of their acute illness. Priority 3 patients may receive intensive treatment to relieve acute illness; however, limits on therapeutic efforts may be set, (such as no intubation or cardiopulmonary resuscitation). Examples include patients with metastatic malignancy complicated by infection, cardiac tamponade or airway obstruction.



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5.2.4. Priority 4.

- 5.2.4.1. These are patients who are generally not appropriate for ICU admission. Admission of these patients should be on an individual basis, under unusual circumstances and at the discretion of the Director of Intensive Care Services or his designee. These patients can be placed into the following categories.
- 5.2.4.2. Little or no anticipated benefit from ICU care based on low risk or active intervention that could safely be administered in a non-ICU setting (too well to benefit from ICU care). Examples include patients with peripheral vascular surgery, hemodynamically stable, diabetic ketoacidosis, mild congestive heart failure, conscious drug overdose, etc.
- 5.2.4.3. Patients with terminal and irreversible illness facing imminent death (too sick to benefit from the ICU care). For example, severe irreversible brain damage, irreversible multi-organ system failure, metastatic cancer unresponsive to chemotherapy and/or radiation therapy (unless the patient is on a specific treatment protocol), patients with decision making capacity who decline intensive care and/or invasive monitoring and who receive comfort care only, brain dead non-organ donors, patients in a persistent vegetative state, patients who are permanently unconscious, etc.

5.3. ADMISSION BY DIAGNOSTIC CATEGORY.

5.3.1. Diagnostic Model.

This model uses specific conditions or diseases to determine appropriateness of ICU admission.

5.3.1.1. Cardiac System.

- 5.3.1.1.1. Acute myocardial infarction with complications.
- 5.3.1.1.2. Cardiogenic shock.



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- 5.3.1.1.3. Complex arrhythmias requiring close monitoring and intervention.
- 5.3.1.1.4. Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support.
- 5.3.1.1.5. Hypertensive emergencies.
- 5.3.1.1.6. Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain.
- 5.3.1.1.7. Post cardiac arrest.
- 5.3.1.1.8. Cardiac tamponade or pericardial constriction with hemodynamic instability
- 5.3.1.1.9. Dissecting aortic aneurysms.
- 5.3.1.1.10. Complete heart block with hemodynamic instability. These patients should be admitted in Prince Sultan Cardiac Centre (PSCC).

5.3.1.2. **Pulmonary System.**

- 5.3.1.2.1. Acute respiratory failure requiring ventilatory support.
- 5.3.1.2.2. Pulmonary embolism with hemodynamic instability.
- 5.3.1.2.3. Patients in Respiratory Intensive Care Unit (RICU) who are demonstrating respiratory deterioration.
- 5.3.1.2.4. Need for nursing / respiratory care not available in lesser care areas such as wards or RICU.
- 5.3.1.2.5. Massive hemoptysis.
- 5.3.1.2.6. Respiratory failure with imminent intubation.

5.3.1.3. **Neurological Disorder.**

- 5.3.1.3.1. Acute stroke with altered mental status and hemodynamic instability.
- 5.3.1.3.2. Coma: metabolic, toxic, or anoxic.
- 5.3.1.3.3. Intracranial hemorrhage with potential for herniation.



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- 5.3.1.3.4. Acute subarachnoid hemorrhage.
- 5.3.1.3.5. Meningitis with altered mental status or respiratory compromise
- 5.3.1.3.6. Central nervous system or neuromuscular disorders with deteriorating neurologic or pulmonary-function.
- 5.3.1.3.7. Status Epilepticus.
- 5.3.1.3.8. Brain dead or potentially brain dead patients who are being aggressively managed while determining organ donation status.
- 5.3.1.3.9. Cerebral Vasospasm.
- 5.3.1.3.10. Severe head injured patients.
- 5.3.1.4. **Drug Ingestion and Drug Overdose.**
 - 5.3.1.4.1. Hemodynamically unstable drug ingestion.
 - 5.3.1.4.2. Drug ingestion significantly altered mental status with inadequate airway protection.
 - 5.3.1.4.3. Seizure following drug ingestion.
- 5.3.1.5. **Gastrointestinal Disorders.**
 - 5.3.1.5.1. Life threatening gastrointestinal bleeding including hypotension, angina, continued bleeding, or with comorbid conditions.
 - 5.3.1.5.2. Fulminant hepatic failure.
 - 5.3.1.5.3. Severe pancreatitis.
 - 5.3.1.5.4. Esophageal perforation with or without mediastinitis.
- 5.3.1.6. **Endocrine.**
 - 5.3.1.6.1. Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis.



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- 5.3.1.6.2. Thyroid storm or myxedema coma with hemodynamic instability.
- 5.3.1.6.3. Hyperosmolar state with coma and/or hemodynamic instability.
- 5.3.1.6.4. Other endocrine problems such as adrenal crisis with hemodynamic instability.
- 5.3.1.6.5. Severe hypercalcemia with altered mental status, requiring hemodynamic monitoring.
- 5.3.1.6.6. Hypo or hyponatremia with seizures, altered mental status.
- 5.3.1.6.7. Hypo or hypomagnesemia with seizures, altered mental status.
- 5.3.1.6.8. Hypo or hyperkalemia with dysrhythmias or muscular weakness.
- 5.3.1.6.9. Hypophosphatemia with muscular weakness.
- 5.3.1.7. **Surgical.**
 - 5.3.1.7.1. ASA 2 (American Society of Anesthesiologist) and above post-operative patients requiring hemodynamic monitoring / ventilatory support or extensive nursing care.
 - 5.3.1.7.2. Patients with partial or full sternotomies
- 5.3.1.8. **Miscellaneous.**
 - 5.3.1.8.1. Septic shock with hemodynamic instability.
 - 5.3.1.8.2. Hemodynamic monitoring.
 - 5.3.1.8.3. Clinical conditions requiring ICU level nursing care.
 - 5.3.1.8.4. Environmental injuries. (lightning, near drowning, hypo/hyperthermia)
 - 5.3.1.8.5. New/experimental therapies with potential for complications.



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5.4. OBJECTIVE PARAMETERS MODEL.

The following objective criteria for admission to Adult ICU are the guidelines. They do not replace the clinical judgement of the physicians. The criteria listed, while arrived at by consensus, are by necessity arbitrary. Data demonstrating improved outcome using specific criteria levels are not available.

5.4.1. Vital Signs.

- 5.4.1.1. Pulse <40 or >150 beats/minute.
- 5.4.1.2. Systolic arterial pressure <80 mmHg or 20 mmHg below the patient's usual pressure.
- 5.4.1.3. Mean arterial pressure <60 mmHg.
- 5.4.1.4. Systolic arterial pressure > 200 mmHg.
- 5.4.1.5. Diastolic arterial pressure >120 mmHg.
- 5.4.1.6. Respiratory Rate <10 or >35 breaths/minute.

5.4.2. Laboratory Values. (Newly discovered)

- 5.4.2.1. Hemoglobin equal to or less than 7 (unless chronic) and/or greater than 2 gm decrease in 24 hours.
- 5.4.2.2. Serum sodium <120 mEq/L or >170 mEq/L
- 5.4.2.3. Serum potassium <2.0 mEq/L or >7.0 mEq/L
- 5.4.2.4. PaO₂ <50 mmHg.
- 5.4.2.5. pH <7.1 or >7.7
- 5.4.2.6. Serum glucose > 44 mmol/l (800 mg/dl).
- 5.4.2.7. Serum calcium > 3.75 mmol/l (15 mg/dl).
- 5.4.2.8. Toxic level of drug or other chemical substance in a hemodynamically or neurologically compromised patient.

5.4.3. Radiography/Ultrasonography/Tomography. (Newly discovered)

- 5.4.3.1. Cerebral vascular hemorrhage, contusion or subarachnoid hemorrhage with altered mental status or focal neurological signs.



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5.4.3.2. Ruptured viscera, bladder, liver, esophageal varices or uterus with hemodynamic instability.

5.4.3.3. Dissecting aortic aneurysm.

5.4.4. **Electrocardiogram.**

5.4.4.1. Myocardial infarction with complex arrhythmias, hemodynamic instability or congestive heart failure.

5.4.4.2. Sustained ventricular tachycardia or ventricular fibrillation.

5.4.4.3. Complete heart block with hemodynamic instability. These patients should be admitted in Prince Sultan Cardiac Centre (PSCC).

5.4.5. **Physical Findings. (acute onset)**

5.4.5.1. Unequal pupils in an unconscious patient.

5.4.5.2. Burns covering >25% BSA.

5.4.5.3. Anuria.

5.4.5.4. Airway obstruction.

5.4.5.5. Coma (GCS \leq 8).

5.4.5.6. Continuous seizures.

5.4.5.7. Cyanosis.

5.4.5.8. Cardiac tamponade.

5.5. Fast Track ICU.

A five (5) bedded unit located in Ward 1:1, Building 5

6. **PROCEDURE**

6.1. **REFERRAL PROCEDURE**

6.1.1. The nurse-in-charge and the intensive care consultant shall agree upon operating states/ bed status for critical care.

6.1.2. Admission will take place based on the following circumstances:

6.1.2.1. **EMERGENCY ADMISSION FROM THE WARDS**



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- 6.1.2.1.1 Patients from the Emergency Department or the wards who are considered by the Primary Physician to require intensive care management will be seen by Rapid Response Team Intensivist in the Emergency Department or in the ward.
- 6.1.2.1.2 They will be evaluated to determine the need for admission to the Intensive Care Unit. No patient will gain automatic admission to ICU without being assessed.
- 6.1.2.1.3 Where possible, the “Code” status of all patients assessed should be documented by the Primary Physician.
- 6.1.2.1.4 Early referral to the ICU team is encouraged to allow for better assessment and earlier institution of therapy.
- 6.1.2.1.5 Decision to Admit will be based on the following criteria:
- 6.1.2.1.5.1 Patient has a reversible acute condition and is appropriate for advanced intervention.
- 6.1.2.1.5.2 Patient needs Priority 1 care, or is likely to need such care in the near future, and would be at risk if he or she remains in a general ward area (Priority 2).
- 6.1.2.1.6 Substantive decision not to admit will be based on the following criteria:
- 6.1.2.1.6.1 Patient is suffering his or her final illness – the clinical deterioration and organ failure for which he or she has been referred is not amenable to treatment of an underlying acute problem; or any such acute problem has already progressed beyond reasonable hope of recovery (Priority 3& 4).



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- 6.1.2.1.6.2 Patient's co-morbidity and poor physiological reserve. Make the prospect of significant and sustained recovery minimal.
- 6.1.2.1.6.3 Patient refuses admission, either by previous stated wish or on discussion with critical care and referring team.
- 6.1.2.1.6.4 Decision shall be discussed between referring team and critical care team.
- 6.1.2.1.6.5 The Intensive Care Senior Administrative Consultant is the final gatekeeper for critical care admission. No referring staff may order or force an admission which has been refused by the critical care team after discussion at consultant level. In cases of extreme dissent the respective clinical directors will resolve the issue.
- 6.1.2.1.6.6 Critical care staff shall render assistance and advice on palliative or other supportive care of refused patients.
- 6.1.2.1.6.7 Final responsibility for on going management shall rest with the referring team.
- 6.1.2.1.6.8 The patient's resuscitation status should be reviewed under the hospital's "Do Not Resuscitate" policy as a logical and integrated part of critical care discussion.



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6.1.2.2. POST OPERATIVE ADMISSIONS

6.1.2.2.1. ELECTIVE SURGERY

Certain patients having major elective procedures benefit from admission to the Surgical ICU and Fast Track post operatively.

6.1.2.2.1.1. The referral to Critical Care for postoperative care should be based on the assessment of the patient's care requirements by the Anesthesiologist and/or Surgeon and not based on the procedure to be carried out.

6.1.2.2.1.2. For planned (elective) admissions, the referring consultant's team should liaise directly with the medical staff on the Critical Care Unit as early as possible with a minimum of 24H prior to the procedure and they should complete the information in the Bed Booking Logbook. Bookings should be made before the end of the night shift (before 7AM).

6.1.2.2.1.3. These patients should have a bed booked in the ICU pre-operatively and reconfirmed prior to the surgery. Bookings will be accepted for specific patients only.

6.1.2.2.1.4. Their post-operative management plan should be discussed with a member of the ICU physicians upon admission and on a daily basis.

6.1.2.2.1.5. The ICU team must make every effort to prevent cancellation of such surgical cases.



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6.1.2.2.1.6. Patient bed in the ward must be blocked for at least three days.

6.1.2.2.1.7. In the event that elective surgery is cancelled, Primary team should inform the ICU team for cancellation of the booking. However, if the procedure is postponed, the Primary team should another rebooking of the same patient at least 24H prior to the time of the surgery.

6.1.2.2.1.8. After 3 days if the patient still requires ICU care, the blocked bed in the originating ward will be released for other patient's admission.

6.1.2.2.1.9. If any case that a patient for surgery has MDRO infections, patient will be booked to GICU/SICU individual room for isolation purposes, he/she will not be placed in a shared room in GICU or in Fast Track / HDU area.

6.1.2.2.2. **EMERGENCY SURGERY**

6.1.2.2.2.1. High-risk patients undergoing emergency life threatening surgery and who require invasive hemodynamic monitoring and/or ventilatory support post operatively must be admitted to ICU.

6.1.2.2.2.2. If no bed is available, elective surgery may be delayed / postponed for this patient.

6.1.2.2.2.3. A bed must be blocked in the ward for this patient for at least three days.



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6.1.2.3. ADMISSION FROM OTHER HOSPITAL

6.1.2.3.1. Eligible patients from other hospital who may benefit from Intensive Care management in Prince Sultan Military Medical City Riyadh may be admitted to the ICU via Emergency department (ED) and following consultation with the physician from the receiving service, i.e., Internal Medicine, Surgery, or other specialty and the Intensivist on-duty and Hospital Admission Officers. If there is any doubt about suitability for ICU care, the primary physician and the ICU team in the Emergency Department should assess them and a decision must be made.

6.1.2.3.2. Transfer must be completed within 48 hours of acceptance. If there is a delay, transfer must be reorganized and the status of the patient re-assessed and updated prior to re-acceptance.

6.1.2.3.3. **Mechanically Ventilated Patients.**

Ventilated patients, who are hemodynamically unstable, may be admitted directly to ICU only after consultation with the ICU team, but the details about the patient and care given must be available on admission to the ICU, so that appropriate investigations and therapy can be commenced without delay. Some such patients may benefit from a rapid assessment in the ED prior to transfer to the ICU.

6.1.2.3.4. **Non-Ventilated Patients.**

6.1.2.3.4.1. Patients from other hospitals who are not being ventilated or who are hemodynamically stable will be accepted in consultation with the Primary physician.



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6.1.2.3.4.2. These patients should be assessed in the Emergency Department and admitted to either the ICU or ward depending on their condition. A bed must be available in both ICU and ward prior to transfer.

6.2. COURSE OF ACTION WHEN UNIT CLOSED TO REFERRALS

6.2.1. The intensivist will undertake a balanced clinical risk assessment of the short-term strategies available to deal with further referrals for care, pending a definitive critical care bed.

6.2.2. Triage.

Patients will be admitted or discharged strictly on their potential to benefit from ICU care. Unfortunately, on occasions the number of patients exceeds the available beds. Method of prioritizing or triaging patients may follow the guidelines given for prioritization for admission.

6.2.3. These decisions will be influenced by medical and nursing staff issues, and the availability of physical resources. The manager of the site should also be made aware of the critical care bed state, and they should then consider whether the hospital should close to emergency intake of further patients

6.2.4. Overflow.

When the ICU is full and a bed is needed, the ICS Consultant or Senior Administrative Consultant should liaise with the other critical care areas to determine their bed status and the possibility of "borrowing a bed". Priorities should be based on patient need and if necessary, may involve any of the other critical care areas in the hospital. The authorization of overflow procedure will be at the ICS Director's discretion or his designee.

6.3. DISCHARGE CRITERIA

6.3.1. The status of patients admitted to an ICU should be revised continuously to identify patients who may no longer need ICU care.



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MINISTRY OF DEFENSE

Departmental Policy	Dept.: Intensive Care Services	Policy No: 1-2-9451-01-012 Version No: 05		
Title: General Intensive Care Unit 1 & 2 (GICU1 & GICU2) Admission and Discharge		JCI Code: ACC		
Supersedes: 1-2-9451-01-012 Version No: 04; 30 September 2020	Issue Date:	Effective Date: 25 OCT 2023	Revision Date: 24 OCT 2023	Page 17 of 19

6.3.2. When a patients' physiologic status has stabilized and the need for ICU monitoring and care is no longer necessary. The parameters are:

- 6.3.2.1. HR > 50 and < 120 bpm.
- 6.3.2.2. SBP >90 mmHg and < 160 mmHg
- 6.3.2.3. SpO₂ > 90%
- 6.3.2.4. Oxygen Requirement ≤ 40%
- 6.3.2.5. GCS > 8
- 6.3.2.6. Off Ventilator

6.3.3. These are guidelines which does not replace the clinical judgment of the physician.

6.3.4. When a patient's physiological status has deteriorated and active interventions are no longer planned, discharge to a lower level of care is appropriate.

6.3.5. Discharge criteria from ICU should be similar to the admitting criteria for the next level of care.

6.4. **DISCHARGE PROCEDURE**

6.4.1. After the decision to transfer a patient from a critical care area to the general ward has been made, he or she should be transferred as early as possible during the day according to the hospital Transfer policy. Delayed transfer of care over 4 hours should be documented as an incident report.

6.4.2. The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:

6.4.2.1. There is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan.

6.4.2.2. That the receiving ward, with support from critical care if required, can deliver the agreed plan. The formal structured handover of care should be based on Hand-off /Hand over communication I-SBAR communication tool policy:



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- 6.4.3. After discharge from the critical care area if the patients need to be followed up on a daily basis until it deemed necessary by the Critical Care Follow-up to address any ongoing physical, nutritional, psychological and emotional needs.
- 6.4.4. When patients are transferred to the general ward from a critical care area, they should be offered information about their condition and encouraged to actively participate in decisions that relate to their recovery. The information should be tailored to individual circumstances. If they agree, their family and carers should be involved.
- 6.4.5. Staff working with acutely ill patients on general wards should be provided with education and training to recognise and understand the physical, psychological and emotional needs of patients who have been transferred from critical care areas.

7. REFERENCES

- 7.1. Joint Commission International (2021). Section II: Patient Centered Standards. Access to Care and Continuity of Care. JCIA Standards for hospitals (7th Ed.pp39-40) Illinois, USA. Joint Commission International
- 7.2. Saudi Central Board for Accreditation of Healthcare Institutions (2016). CBAHI National Hospital Standards. Third Edition



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8. CONTRIBUTING DEPARTMENT

Intensive Care Services

Adelle

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