Guideline Title: Transfer of Cardiothoracic patients from ICU to Cardiothoracic ward

Approved by: ICU Medical Director A/Professor Michael Parr

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Replaces Existing Guideline: Transfer of Cardiothoracic patients from ICU to Cardiothoracic ward_2012

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1. Background Information:
Patients who have undergone cardiac surgery are at risk of developing bleeding, infection, pain, arrhythmias, respiratory failure, wound complications and fluid and electrolyte disturbances. Cardiothoracic patients require assessment, monitoring and interventions to manage their care in the post operative period. Once the patients are stable they can be transferred to a monitored bed on the cardiothoracic ward. Patients should be transported from ICU to the ward with three lead ECG monitoring on the ZOLL defibrillator. All admissions to and discharges from the ICU/HDU must be at the direction of the attending Intensive Care Specialist.

2. Introduction:
The risk addressed by this policy:

Patient Safety

The Aims / Expected Outcome of this policy:

ICU cardiothoracic patients shall be transferred to the cardiothoracic ward appropriately and safely

Related Standards or Legislation

NSQHS Standard 1 Governance

National Standard 4 Medication Safety

National Standard 9 Recognising & Responding to Clinical Deterioration in Acute Health Care
3. Policy Statement:

- All care provided within Liverpool Hospital will be in accordance with infection prevention/control, manual handling and minimisation and management of aggression guidelines.
- Cardiothoracic patients can be transferred from ICU to the cardiothoracic ward when they meet the set criteria for transfer and have been cleared for transfer by the ICU and Cardiothoracic medical team.
- Competency assessment for patient admission to and discharge from ICU must be attended by the nurse as soon as possible following initial orientation into the ICU.
- The primary teams must be aware of discharge, particularly when this is arranged at short notice. Communication regarding discharge to the primary team will be recorded on the electronic Medical Discharge Summary and Nursing Transfer Form.

4. Principles / Guidelines

Equipment

- Portable monitor and defibrillator. Patient must be monitored on transfer
- Patient belongings
- Old and current medical records

ICU Nursing Transfer Form

- CR 75 ICU Nursing Transfer Form has been designed to be a stand-alone document that should preclude the need to write an additional report in the healthcare record.
- Clinical handover to the receiving nurse should follow the format of the transfer form. This can then be supplemented (as required) using the A-Z approach.
- The ICU Nursing Transfer Form should be placed in the current healthcare record, not archived.
- Where patient review by the receiving doctor is noted on the ICU Medical Discharge entry, this must be communicated to the receiving nurse AND the receiving doctor must be notified.

Procedure:

- The medical discharge summary and the nursing transfer form will be completed for all patients that are discharged from ICU to another ward / area.
- Once a patient is determined cleared for the ward, the ICU NUM1 is to be contacted so they can contact the Demand Management to allocate a ward bed.
- When cleared, monitoring may commence at 4 hourly intervals: temperature (T), respiratory rate (RR), heart rate (HR), blood pressure (BP) and oxygen saturation (SpO2). Blood sugar levels (BSL) as required.
- Once a bed on the ward has been allocated and is ready, patients are to be promptly transferred to the ward.
- Advise patient that they will be transferred to ward
- Advise patients next of kin/ relative of patient transfer to ward
- All medication and I.V fluids are to be signed off on the 24hr flowchart and where required, prescribed on ward charts.
Preparation of patient:
- If patient requires IV cannula one is inserted and cannulation chart recordings are up to date
- Remove any cannulas, drains, ICC as appropriate
- Change dressings on sternal wound, and leg wounds if oozing or dirty
- Ensure IV sites are clean and dressed
- Wrap pacing wires in gauze if not in use
- Record vital signs on flow chart within last hour before transfer
- Record any wound/pressure areas on chart
- Record when bowels last opened and coloxyl with senna prescribed if bowels are not opened
- Ensure bandages to graft sites (vein or artery) are removed Day 1 as per pathway or instruction from the Cardiothoracic team
- Apply anti-embolic stockings to legs
- Assessed by Acute Pain service and adequate pain relief prescribed according to pain score
- If diabetic insulin regime prescribed as per ward regime. Referral should be made to the endocrine team.
- Patients should be transported from ICU to the ward with three lead ECG monitoring on the ZOLL defibrillator.

Clinical Issues:
- Verbal handover ensures that questions can be raised that might not be covered in documentation on the ICU Nursing Transfer Form, ICU flowchart, operative report or health care record. It also provides an opportunity to ask questions, allows both transferring and receiving nurse to ensure that all care has been delivered and to also check when certain cares (e.g. wound dressings) are due.

ICU Discharge Criteria\(^1, 2, 3, 4\)
- Patients who are suitable for discharge from the ICU/HDU will be identified by an Intensive Care Specialist or Senior Registrar.
- The status of all patients admitted to ICU/HDU should be continuously reviewed to identify when patients reach the status where they no longer require ICU care.

The patient may be ready for discharge from ICU when:
Overall status is stable and the need for ICU monitoring and care is no longer necessary.\(^1\)

Criteria for Cardiothoracic patients in particular:
- Haemodynamically stable patients who no longer require inotropes or vasopressors
- No major arrhythmias compromising haemodynamic stability
- Atrial fibrillation is not a contra indication for discharge provided there is adequate rate control and haemodynamically stable
- There is an underlying rhythm if epicardial pacing is being used
- Patients with intercostal catheters who are not bleeding and drain loss is less than 100mls/hr
- Patients receiving non-invasive ventilation (CPAP) with a PEEP of less than 10cmH\(_2\)O
- Patient only receiving routine IV drugs, PCA and maintenance infusion

Contraindications for Discharge from ICU:
- Unstable physiology – hemodynamic or respiratory instability.
- Patients who have epicardial pacing and no underlying rhythm
- Patients who require inotropic or vasopressor support
- Patients with unstable / new onset arrhythmias
- Acute respiratory compromise – requiring NIV support >10cmH\(_2\)O or Fio2>0.4
5. **Performance Measures**

All incidents are documented using the hospital electronic reporting system: IIMS and managed appropriately by the NUM and staff as directed.

6. **References / Links**

1. Admission and Discharge Criteria for ICU. Liverpool ICU Guideline 2013
2. ICU patient waiting for a ward bed. Liverpool ICU guideline 2014

**Author:** ICU CNE (P.Nekic)
**Reviewers:** ICU Staff Specialists, Cardiothoracic Surgeons, cardiothoracic CNC, ICU – CNC, ICU-CNE, NM, NUM, CNS's,
**Endorsed by:** ICU Medical Director – Prof Michael Parr,