Critical Care Discharge SOP

The ICCA clinical information system generates a structured discharge letter and note summary which provide a comprehensive summary of the patient's critical care admission.

Critical Care Discharge Summary: A structured letter including details around admission, events and interventions on critical care, and discharge. This includes entries for nursing, medical and AHP groups.

Critical Care Notes: Contains critical care ward round, visiting specialty ward rounds, and family discussion for the duration of admission.

These documents are automatically created from fields in the ICCA record. Whilst this greatly simplifies the process of discharge documentation, it does require the discharging clinician to ensure that the relevant fields in ICCA have been completed prior to discharge. This SOP outlines the recommended steps to ensure that the discharge paperwork

The following processes should be triggered when a patient is identified as being ready for discharge from critical care. These steps must be completed in full to ensure critical information is available to ward teams.

Medical Team

1. Ensure time considered ready for discharge is entered in the Daily Ward Round document on ICCA.
2. Review the **Critical Care Timeline** document in ICCA and ensure that the following fields are up to date:
    a. Outstanding Actions
    b. General Timeline (1&2)
    c. Microbiology Timeline (1&2)
    d. Interventions on Critical Care (checkbox)
    e. Critical Care Related Issues(checkbox)
3. Review the **Medical Discharge** document in ICCA and ensure that the following fields are up to date:
    a. List of diagnoses in Critical care
    b. Current Issues
    c. Narrative Summary of Critical Care Stay (this is the field in which to write a short summary of stay for patients with complexity. It may not be required for patients with short critical care stays if all necessary information can be captured in other fields).
    d. Changes Made to Baseline Medications
    e. Treatment escalation plan and readmission to critical care section (NB this does not negate the need to ensure the TEP is updated on Trak)
    f. Discharge checklist
    g. Name of discharging ACCP/doctor and discharging consultant
4. Review the **Medical Discharge Document** (under discharge section in ICCA) and ensure the following fields are up to date:

    a. Narrative Summary of Critical Care Stay (this is the field in which to document a summary of the patient's stay).
5. Review the **Medications** chart in ICCA:
    a. Ensure the prescription is up to date and drugs discontinued as appropriate. Any drugs that remain active will be included in the discharge summary document sent to ward.
6. Prescribe discharge drugs on **HEPMA** as per current processes. Ensure all ancillary paper charts (e.g. PCA, heparin infusion, insulin infusion etc) are completed, up to date and accurate
7. Ensure that the **Allergies** and **Treatment Escalation Plan** are updated in Trak.
8. Write an **Inpatient Discharge Letter** in the correspondence section of Trakcare as current practice (this process will be automated at some point but currently the letter should be written as before).

Nursing Team

1. Review the **Nursing Admission** form and ensure that all fields that are relevant post discharge are complete and current.
2. Review the most recent **Daily PCCP** document and ensure the 'goal' sections are complete and current as relevant.
3. Review the **Nursing Discharge** document
    a. Complete discharge timeline and demographics as relevant.
    b. Complete Discharge Details when information is available.
    c. Complete the Patient Centred Care Plan Discharge (in the discharge summary letter these fields will be combined with the PCCP goals from the daily PCCP form).
    d. Complete the:
        i. Discharge Plan
        ii. Ongoing Issues/Concerns
        iii. Discharge Consideration
        iv. Checklist
        v. Handover
4. Ensure that **Trak Risk Assessments** are up to date.
5. Ensure **Next of Kin** details are up to date in **Trak.**

Pharmacy Team

1. Review **Drug Chart** and ensure drugs have been discontinued as appropriate
2. Ensure **Medicines Reconciliation** is complete
3. In the **Medical Discharge** document, complete Pharmacy Handover field as required.

Physiotherapy Team

1. Review the most recent Physiotherapy Review and review the fields that will pull through into the Discharge Summary:
    a. Subjective Assessment
    b. Objective Assessment

    c. Analysis
    d. Plan
2. For more complex patients, for whom a more detailed handover is required, please document handover in Trak clinical notes.

Dietetic Team

1. Review most recent Dietician Review and review the fields that will pull through into the Discharge Summary
    a. Dietetic Plan
2. For more complex patients, for whom a more detailed handover is required, please document handover in Trak clinical notes.

Speech and Language Therapy Team

1. Review the most recent SLT review and review the fields that will pull through into the Discharge Summary
    a. Observations
    b. Diet Recommendations
    c. Fluid Recommendations
    d. Additional Advice
    e. Communication advice
    f. Plan
2. For more complex patients, for whom a more detailed handover is required, please document handover in Trak clinical notes.