STATE OF KUWAIT
MINISTRY OF HEALTH

Title: MOH ICU Admission and Discharge Policy.	
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1. Introduction:

1.1. Patients admitted to hospitals vary in the disease severity they suffer and the level of care they require. The level of care designated to them is subjected to their disease acuity, hemodynamic status, organ dysfunction, pre-morbid condition, functional/physical performance, acute and long-term prognosis, reversibility of the pathology and/or its consequences.

1.2. A hospital's Critical care beds (and services) are designated based on the healthcare facility's capabilities and standards, regional patients' population and demographics and their common pathologies. An Intensive Care Unit (ICU) is an organized system for the provision of care to critically ill patients that provides intensive and specialized medical and nursing care and enhanced capacity for monitoring and multiple modalities of physiologic organ support to sustain life during a period of life-threatening organ dysfunction. The beds to population ratios for the ICU may range between 5-35 : 100,000 or 5-15 % of the hospital bed capacity.

1.3. Although this organized system is usually based in a defined geographic area of a hospital, its activities and services may extend beyond the walls of the physical space to include the emergency department (ED), Cardiac Care Units (CCU), Post Anesthesia Recovery Units (PACU) and hospital wards. As such policies defining the standards, rules, responsibilities, and general scope of services the ICU provides are paramount to ensure optimal appropriate care is provided to all patients in need accordingly.

2. Purposes: This policy:

2.1. Establishes unified definitions of the levels of acute care across MOH hospitals.

2.2. Establishes unified general standards for admitting and discharging patients to and from the intensive care units (ICUs) in MOH hospitals.

2.3. Defines the responsibilities of the involved respective healthcare providers with regards to the ICU admissions and discharges of patients.

2.4. Defines the responsibilities of the involved health care providers regarding patients admitted to the different levels of care within a health care facility.

3. Policy Statements:

3.1. The Intensive Care Units in the MOH provide supportive management for patients in need of critical care.

3.2. Specialized Intensive Care Units in the MOH provide supportive management for their respective patients' populations in need of critical care (Neuro ICU, Pediatric ICU, etc.).

3.3. The Intensive Care Units in the MOH (pediatric and adult) also provide supportive management for pediatric patients in need of critical care in accordance with decree 137/2024.

3.4. The scope of critical care support for the pediatric population by the adult ICU is subject to the health care facility's available pediatric medical resources and capabilities (e.g., PICU, back hospital PICU, specialists and or governing policies).

3.5. As ICU beds constitute (5:15 %) of total bed capacity, requests for admission to the ICU should be properly and appropriately triaged to the receipt of the services.

3.6. The services provided by the ICU should be reserved for conditions deemed to have a reasonable prospect of significant recovery, with good prognostic outcome and an acceptable quality of life (i.e. ICU admission should be provided for patients who are likely to benefit from the complex care delivered in ICU).

3.7. The decision to admit patients to and discharge from the ICU is subject to the discretion and clinical judgment of the attending ICU Physician.

3.8. Health care facilities may differ in the admission criteria and process depending on the scope of services provided, facility resources, patient clinical status and model of critical care provided.

3.9. It should be acknowledged that guidelines cannot be exhaustive nor be able to address all potential clinical circumstances. They are provided as a guide to assist in the interpretation of levels of critical care. Clinical expertise and judgment are required in all circumstances to ensure the best care is provided in the most appropriate facility and setting.

4. Definitions:

4.1 Attending: Any Physician of the rank of Specialist and above.

4.2 Most Responsible Physician (MRP): The designated most responsible physician. Generally, it refers to the physician or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point of time.

4.2.1 Admitting MRP: is the designated most responsible physician under whose care the patient was originally admitted (as documented in medical records e.g. Dr. X, Department of Internal Medicine)

4.3 Pediatrics: **According** to the Child Protection Law number 21/2015, a child is defined as any individual of the age of 18 and below. Currently, and for administrative and resource-related reasons, pending future amendments, the pediatric population in Kuwait accepted for treatment in pediatric wards is circulated by the MOH as children aged <14 years or a neurologically impaired individual who weighs less than 35 kg AND is less than 18 years of age, according to decree 137/2024.

4.4 Intensivist: A physician specialized, licensed or credentialed in critical care in accordance with an official acknowledgment of the MOH governing leadership.

4.5 Physician with an Intensive Care Competency:

4.5.1 A Senior registrar or above rank from the Anesthesia and ICU Department with >40% ICU service and ICU On-calls in the past 12-24 months and deemed to possess the competency to lead the Intensive Care Unit, ICU outreach/rapid response/consults team or the ward critical care support team.

4.5.2 An attending physician (General Internal Medicine, Cardiology, Respirology, Nephrology, Infectious diseases, General Surgery, etc.), specialist and above with critical care and ACLS competency and/or expertise.

4.6 Covering ICU Attending: A physician of the rank of attending, fulfilling requirements of the above articles 4.4 or 4.5, and designated to cover the ICU (leading consultation, rounds, admission, and discharge) at a specific time (day, week, or month).

4.7 Intensive Care Nurse: A nurse experienced and or credentialed in patient care in the Intensive Care Unit or any other monitored setting (CCU) and practicing critical care nursing in the past 12 months.

4.8 Nurse with Intensive Care competency: A nurse ***not*** experienced and/or credentialed in patient care in the Intensive Care Unit or any other monitored setting (CCU) ***but*** practicing or trained in critical care nursing in the past 1-6 months (Usually ward or operating room nurses trained before the event or during the event to assume the necessary critical care nurse roles in the ward or areas of need).

4.9 ICU Outreach/Rapid response/Consults team: A team of ICU-based physicians (registrar or senior registrar and above rank physicians with either Anesthesia and/or Critical Care training) who are delegated with the task of managing patients with critical illness and/or on mechanical ventilators in the wards. They are either consulted or delegated to assess, manage, and follow up with critically ill patients and those on mechanical ventilators in the ward. They provide support and oversight to the ward critical care support team and relay updates on critically ill patients, free mechanical ventilators and resources to the intensivist in the ICU to regulate flow and resource allocation.

4.10 Respiratory Therapist: A certified/credentialed technician experienced in non-invasive and invasive mechanical ventilators and responsible for adjustments, follow-up, weaning, and or discontinuation of ventilatory support to patients as deemed fit by the leading Intensivist, ICU outreach leader or attending (specialist and above rank) of ward critical care support team. He/she is also responsible for the audit of available functional and dysfunctional devices and maintenance of the invasive and non-invasive mechanical ventilators.

4.11 PICU: Pediatric Intensive Care Unit.

4.12 Open ICU: An ICU operational model where any physician can admit patients to the ICU. The admitting physician is the most responsible physician (MRP) for that patient. The care for the patient's health status is continued during the ICU stay by this physician. The Intensive care team is consulted at the discretion of the responsible physician. The primary physician has the responsibility concerning treatment decisions. The primary physician has other responsibilities outside the ICU.

4.13 Closed ICU: An ICU operational model where all patients are cared for by a team of intensivists, nurses and a multidisciplinary team in collaboration with a primary service (and other services as seen necessary). These physicians are trained in critical care medicine. Only intensivists have admitting/discharge privileges to the ICU.

4.14 Monitored setting: A patient care setting within a health care facility where a level of acute care is provided with a frequency of monitoring of vital signs and clinical status that is more frequent than regular level 0 care.

4.15 Critical Care Outreach team: A team of ICU-based physicians (registrar or senior registrar and above rank) with a senior ICU nurse if available, who are delegated with the task under the supervision of ICU attending for assessment and management of patients with critical illness or on mechanical ventilators outside the ICU (e.g. wards).

4.16 Prognosis: An opinion based on medical experience of the likely course of a medical condition.

4.17 Functional outcome: Functional outcome distinguishes itself from the clinical outcome, focusing instead on an individual's physical, cognitive, mental, socioeconomic and health-related quality of life recovery.

4.18 PACU: Post-Anesthesia Care Unit.

4.19 HDU: High Dependency Unit.

4.20 HCF: Health Care Facility.

4.21 HCP: Health Care Provider; Generally, refers to any individual including but not limited to physicians, nurses and physiotherapists, who in the course of their professional activities, may directly or indirectly recommend, administer and/or determine the medical and/or related services for the patient.

4.22 Index facility: the current facility in which the service and patient are present.

4.23 Index site: the current site/location within the facility in which the service and patient are present.

4.24 BLS: Basic Life Support.

4.25 PALS: Pediatric Advanced Life Support.

4.26 ACLS: Advanced Cardiac Life Support.

4.27 ATLS: Advanced Trauma Life Support.

4.28 ECLS: Extra Corporeal Life Support.

4.29 BP: Blood Pressure.

4.30 HR: Heart Rate.

4.31 RR: Respiratory Rate.

4.32 Temp.: Temperature.

4.33 sO2: Oxygen Saturation.

4.34 ECG: Electrocardiogram.

4.35 DKA: Diabetic Ketoacidosis.

5. Equipment / Forms Required:

5.1 Monitors for BP, heart rate (HR), ECG rhythm, RR, temp. and oxygen saturation.

5.2 Scales for weight and height.

5.3 Beds specified for surgical procedures.

5.4 Electronic reporting system including computers, printers, computer desks, chairs, specialized reporting software and data storage server.

5.5 Life-Saving Crash Cart.

5.6 Intravenous (IV) stand, Infusion pumps, Syringe pumps, oxygen supply lines, air supply lines and vacuum lines.

6. Procedures:

6.1 <u>Levels of Clinical Care</u>:

6.1.1 The levels of acuity are divided into 4 levels corresponding to the level of critical care available to be provided.

6.1.1.1 Level 0 Care:

6.1.1.1.1 Patients at this level of acuity of illness are hemodynamically stable with stable organ function, not requiring specialized or more frequent monitoring and are fit for regular care in the ward. (Example: Pneumonia with acceptable saturation and hemodynamically stable, Post elective surgery care and Post DKA with normal pH).

6.1.1.1.1.1 Location: regular ward.

6.1.1.1.1.2 Requirements:

6.1.1.1.1.2.1 Nurses trained as per MOH leadership set standard requirements for ward care. (e.g. BLS or PALS).

6.1.1.1.1.2.2 Physicians; as per ward/department specialty for the respective patient population, presenting diseases and MOH credential/license requirements.

6.1.1.1.1.2.3 Nurse to patient ratio 0.8:1 (service).

6.1.1.1.1.2.4 Nurse to patient ratio 1:2-1:5 (per shift).

6.1.1.1.1.2.5 Physicians to bed ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars).

6.1.1.1.1.2.6 Total bed per ward 10-60.

6.1.1.1.1.3 Degree of monitoring; as per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians).

6.1.1.2 Level 1 Care:

6.1.1.2.1 Patients cared for in this level setting are characterized by acuity of illness requiring targeted monitoring in a designated resourced ward (Example; COPD exacerbation or pulmonary edema with hemodynamic stability in need of non-invasive ventilation (NIV) a suitable facility may include a designated resourced NIV ward within, for example, a respiratory service, Coronary Care Unit or other Acute Care Unit, as determined by the clinical context and expert clinical judgment. (Institutionalized patients with tracheostomy in need of therapies to be delivered via tracheostomy).

6.1.1.2.1.1 Location: Monitored area in a regular ward or a designated resourced ward (They do not require management in a Critical Care Unit. Where concern arises related to acute clinical deterioration, the advice of the critical care team is sought).

6.1.1.2.1.2 Requirements:

6.1.1.2.1.2.1 Nurses trained as per MOH leadership set standard requirements for the ward care. (e.g. BLS or PALS).

6.1.1.2.1.2.2 Physicians; as per ward/department specialty for the respective patient population and presenting diseases and MOH credential/license requirements.

6.1.1.2.1.2.3 Nurse to patient ratio 0.8:1 (service).

6.1.1.2.1.2.4 Nurse to patient ratio 1:2-1:4 (per shift).

6.1.1.2.1.2.5 Physicians to bed ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars).

6.1.1.2.1.3 Degree of Monitoring; as per facility and specialty standard practice (closer monitoring of vital signs every 1 to 4 hours unless specified otherwise by facility policy and standard or treating physicians).

6.1.1.3 <u>Level 2 Care</u>:

6.1.1.3.1 Patients cared for in this level setting are characterized by an acuity of illness requiring more frequent monitoring or suffer from a single organ failure *(Where concern arises related to acute clinical deterioration, the advice of the critical care team is sought)* **(Examples;** Complex NIV as a part of a process of weaning to Level 1 care or where higher levels of NIV are required and progression to invasive mechanical ventilation a clinical concern.

6.1.1.3.2 Intermittent renal replacement therapy is normally managed in a dialysis facility but may require critical care in the context of other organ failures, particularly shock. Neurological therapy requires protection of the airway, invasive neurological monitoring and continuous ongoing sedation infusions for seizure management or targeted temperature management. Dermatological injury involving major skin loss, major soft tissue injury or extensive burns.

6.1.1.3.3 Hepatic Support. Hemodynamically unstable patients requiring invasive cardiovascular monitoring, frequent fluid challenge therapy, management of hypovolemia, vasoactive drug infusion therapy, antiarrhythmic infusions etc., as determined by the clinical context and clinical judgment).

6.1.1.3.4 Location: Suitably resourced observation ward or PACU vs HDU or step-down unit (based on clinical judgment to determine the best environment for the care of the patient). Where the only requirement as defined for level 2 is one of increased frequency of monitoring, this may be provided in the same environment as for Level 1 patients. (e.g. a suitably resourced observation ward, HDU or PACU).

6.1.1.3.5 Requirements:

6.1.1.3.5.1 Nurses trained as per MOH leadership set standard requirements for ward care. (e.g. BLS or PALS).

6.1.1.3.5.2 Nurse to patient ratio 1:2 per shift (at certain circumstances may be up to 1:4 for adjacent patients in the same allocated space e.g. cubicle).

6.1.1.3.5.3 Nurse to Patient ratio per service/ward 2.5:1.

6.1.1.3.5.4 Physician to patient ratio 1:5 up to 1:10 in accordance with ratios in decree 146/80.

6.1.1.3.5.5 Attending physician-to-patient ratio 1:15 to 1:20.

6.1.1.3.5.6 Total bed set up per ward 5-15.

6.1.1.3.6 Degree of Monitoring: As per regular ICU standards (every hour in the hour) with direct monitoring and documentation of vitals 2-4 hourly unless specified otherwise by facility policy and standard or treating physicians.

6.1.1.4 Level 3 Care:

6.1.1.4.1 Patients cared for in this level setting are characterized by an acuity of illness requiring management of two organ failures or more with Invasive monitoring, support and/or mechanical ventilatory treatment.

6.1.1.4.2 A minimum of 5-10% hospital beds is to be designated for such level of care.

6.1.1.4.3 A minimum of 70-75% annual occupancy is expected for such beds.

6.1.1.4.4 Location: Intensive care unit or similar equipped and staffed settings.

6.1.1.4.5 Requirements:

6.1.1.4.5.1 Critical Care trained or experienced nurses as per MOH leadership set standards and requirements.

6.1.1.4.5.2 Physicians with critical care Training, competencies, or credentials/licenses as defined above.

6.1.1.4.5.3 Nurse to patient ratio 1:1 to 1:2 per shift (2.5:1 to 3:1 per service).

6.1.1.4.5.4 Physician to patient ratio 1:3 to 1:5.

6.1.1.4.5.5 Covering attending physician to bed ratio 1:15 to 1:20.

6.1.1.4.5.6 Total bed set up per ward: 5-20.

6.1.1.4.6 Degree of Monitoring: As per regular ICU standards (every hour in the hour) with direct monitoring and documentation.

6.1.1.5 Level 4 Care:

6.1.1.5.1 Patients cared for in this level setting are characterized by an acuity of illness requiring management of two organ failures or more with Invasive monitoring, Invasive specialized support and management provided by a national or regional specialty service (e.g. Extra Corporeal Life Support (ECLS), Neuro Critical Care, Cardiothoracic ICU and burn unit ICU).

6.1.1.5.2 Location: Intensive care unit or similar equipped and staffed settings.

6.1.1.5.3 Requirements:

6.1.1.5.3.1 Nurse to patient ratio 1:1 to 1:2 per shift (2.5:1 to 3:1 per service).

6.1.1.5.3.2 Physician to patient ratio 1:3 to 1:5.

6.1.1.5.3.3 Covering attending physician-to-bed ratio 1:15 to 1:20.

6.1.1.5.3.4 Total bed set up per ward: 5- 20.

6.1.1.5.3.5 Minimum 8-10 beds per hospital.

6.1.1.5.3.6 70-75% annual occupancy.

6.1.1.5.4 Degree of Monitoring; as per regular ICU standards (every hour in the hour) with direct monitoring and documentation.

6.2 Prioritization of Admission to the ICU:

6.2.1 As ICU beds constitute (5:15 %) of total bed capacity, requests for admission to the ICU should be properly and appropriately triaged to the receipt of the services, such prioritization approach is based on numerous patient-related factors including disease acuity, hemodynamic status, organ dysfunction, functional status, prognosis, the reversibility of the pathology and/or its consequences.

6.2.1.1 The Priority levels are defined as follows:

6.2.1.1.1 Priority 1: Applies to patients who are critically ill, unstable in need of intensive treatment and monitoring (acute ventilator support, continuous vasoactive drug infusions, airway protection, extracorporeal life support) that cannot be provided outside of the ICU or any level 3 care (provided *the likelihood of clinical benefit and outcome reversibility*).

6.2.1.1.2 Priority 2: Applies to patients requiring intensive monitoring and potential immediate intervention.

6.2.1.1.3 Priority 3: Applies to unstable patients who are critically ill but have a reduced likelihood of recovery because of underlying disease, poor functional status, severe end-stage debilitating comorbidities or non-reversible nature of their acute illness (*at times such patients may be admitted to level 3 care settings to manage acute clinical issues with limits on therapeutic efforts defined and set*).

6.2.1.1.4 Priority 4: This applies to patients who are generally not appropriate for ICU admission or any level 3 care settings. This includes hemodynamically stable patients with no indication for intensive monitoring or patients with irreversible conditions with no additional benefit from ICU or any level 3 setting care) *(admission of these patients should be on an individual basis, under unusual circumstances and at the discretion of the ICU covering attending).*

6.3 Methods of Prioritization and Triage:

6.3.1 Prioritization by priority and level of care.

6.3.1.1 All Patients' will be assessed and triaged according to the priority level applying to their clinical status and disease process and the appropriate level of care setting required. *With priority 1 to 3 in an ascending order (e.g. Priority 1 then 2 then 3, requiring level 2 or level 3 care in a descending order (level 3, then level 2).*

6.3.1.2 Upon receipt of consultation for admission to the ICU, the evaluation and assessment of the respective patient is to be performed by the ICU-assigned physician.

6.3.1.3 The decision regarding the patient's candidacy for admission to the ICU and or the suggested appropriate level of care to be provided, is to be established by the attending ICU physician (or designee with ICU admitting privileges).

6.3.1.4 Attendings with admitting privileges to the ICU include:

6.3.1.4.1 The attending ICU physician covering as the MRP in the intensive care unit at the time of the consultation in a closed ICU operational model.

6.3.1.4.2 The attending MRP of the respective patient (in the ER or ward) in a facility with an open ICU operational model.

6.3.1.5 Patients are prioritized for admission or discharge to the ICU strictly on their potential to benefit from care in the ICU.

6.3.1.6 In an open ICU model, the triaging of consults and gatekeeping of ICU bed designation is the responsibility of the attending anesthetist of the ICU at the time.

6.3.1.7 In an open ICU model, disputes arising between services regarding admission to the ICU and allocation of resources should be raised to the chairman level of the respective departments. Failure to resolve such disputes at the level of department chairs should be raised to the health care facility chief medical officer for resolution and final decision on the admission/discharge and resource allocation.

6.3.1.8 Patients are not to be refused critical care due to a lack of ICU beds or critical care resources. If an ICU bed is not available, yet the patient is a candidate for admission, level 3 standard care should be provided by the MRP in the index setting (ER, PACU, or ward) with support from the ICU outreach team and/ or anesthesia team when deemed possible until one of the following outcomes are attained:

6.3.1.8.1 The patient is stable and no longer requires ICU admission or level 3 care.

6.3.1.8.2 An ICU bed is available for the patient in the index health care facility or another health care facility.

6.3.1.8.3 If an ICU bed is not available in the index HCF and it is decided to transfer the patient to a backup hospital, the following should be ensured:

6.3.1.8.3.1 Notification and acceptance of transfer by the recipient ICU team.

6.3.1.8.3.2 Notification and acceptance of transfer by the recipient treating/admitting specialty.

6.3.1.8.3.3 Adherence of the transferring and recipient teams to the MOH Intra-hospital /Inter-hospital Transfer Policy A-ADM-6.1.

6.4 Sources and Processes of Consultation:

6.4.1 Sources of consultation or referral:

6.4.1.1 A Consultation / Referral is issued by one of the following Sources:

6.4.1.1.1 Wards.

6.4.1.1.2 Emergency Room.

6.4.1.1.3 Recovery Room.

6.4.1.1.4 PACU.

6.4.1.1.5 CCU.

6.4.1.1.6 HDU.

6.4.1.1.7 Level 3 care settings from the index or other healthcare facilities.

6.4.2 Processes of Consultation:

6.4.2.1 The decision to consult the ICU team for a patient is to be issued by the most senior MRP of the treating team (or designee).

6.4.2.2 Communication of a consult to the ICU team is to be both verbal and documented by a designated member of the treating team (preferably of the rank of registrar and above).

6.4.2.3 Communication of a senior-issued consult to the ICU team may be delegated to residents in training with supervision from their supervising senior members of the treating team.

6.4.2.4 Consultations should be in accordance with the MOH medical consultation policy standards A-ADM-001.

6.4.2.5 Referrals and consultations for ICU admission post-elective or emergency surgical procedures should be in accordance with the MOH surgical suite policy A-ADM-09.

6.4.2.6 Referrals for ICU admissions from other healthcare facilities (MOH or otherwise) are to be in accordance with the MOH Intra-hospital / Inter-hospital Transfer Policy A-ADM-05.

6.5 ICU Assessment:

6.5.1 Upon receipt of consultation for ICU admission for a patient, an ICU-designated physician is to assess the patient in an appropriate & timely manner in accordance with the MOH medical consultation policy A-ADM-001.

6.5.2 The ICU-designated physician is to inform the responsible ICU attending about the consultation and the respective patient's clinical status.

6.5.2.1 The ICU attending is to establish one of the following decisions:

6.5.2.1.1 Admission to the ICU.

6.5.2.1.2 For follow-up with a recommended plan (applies to those who are stable or are improving).

6.5.2.1.3 Not for ICU admission.

6.5.2.1.4 Not candidate for ICU admission (e.g. priority 4, palliative, end-stage chronic illness, persistent vegetative state, etc.).

6.5.3 For patients who are deemed stable or improving in clinical status but are for follow-up with a recommended plan & reassessment by the ICU team, it is the treating/admitting team (or on-call designee) in the index site (i.e. ward, ER, PACU, etc.) on whom is the responsibility of the first line of care, observation, and response pending the ICU team reassessment. Any deterioration in patients' condition is to be monitored, managed, and relayed accordingly by the MRP to the ICU team.

6.5.4 When deemed possible, the ICU leadership is to delegate assessment, management, and reassessment of the respective patients to designated team members (e.g. critical care outreach team) over a predefined time and according to the facility policy.

6.5.5 Once a decision for admission is undertaken, the patients and/or their legal guardians will be informed accordingly. Voluntary acceptance of the admission will be taken as proof of consent.

6.5.6 The decision of no admission to the ICU due to lack of candidacy and benefit is to be relayed to patients and/or their legal guardians, by the MRP and ICU team and documented by both the ICU consulted team and the treating MRP.

6.6 Admission process to the ICU:

6.6.1 All patients should be transferred accompanied by a health care provider from their index area to the ICU with continuous monitoring (HR, BP, RR, Temp. and sO2).

6.6.2 During transfer to the ICU, the patient should be accompanied by an ICU-designated physician unless deemed otherwise, and in accordance with the MOH Intra-hospital/Inter-hospital Transfer Policy A-ADM-05.

6.6.3 Upon admission of the patient, the designated admitting ICU physician is expected to complete the following:

6.6.3.1 Completion of the admission orders and notes including, allergies & treatment plan in the patient's file.

6.6.3.2 Completion of the Medication reconciliation.

6.6.3.3 Informing the patient and/or legal guardian or next of kin, of the treatment plan.

6.6.4 In an open ICU model, the MRP or treating team designee, is expected to comply and assume the duties in the above article 6.6.3 with the responsibility of the covering ICU physician/anesthetist limited to the in-house and hourly supportive care and intervention including but not limited to:

6.6.4.1 Central line insertion.

6.6.4.2 Arterial line insertion.

6.6.4.3 Invasive and non-invasive ventilatory support.

6.6.4.4 Vasoactive and Inotropic Support.

6.6.5 In an open ICU model, the MRP or a senior treating team designee is responsible for:

6.6.5.1 Daily rounds on their ICU patients.

6.6.5.2 Initiation & reassessment of treatment plans in coordination with the ICU team.

6.6.5.3 Consult of services when deemed necessary and follow up on the consult team's impressions/recommendations.

6.6.5.4 Organization of investigations or interventions and acquiring the necessary informed consent from the patient or legal guardians.

6.6.5.5 Ensuring, when possible, regular patient, family, or legal guardian meetings disclosing updates on clinical status, treatment plans, interventions necessary or expected outcomes.

6.6.5.6 Issuing medical reports and death certificates for their respective patients.

6.6.6 In a closed ICU model, the attending ICU physician/intensivist is to assume responsibility for the duties mentioned in the above article 6.6.5 and designate duties accordingly to their respective teams.

6.7 Patient and family orientation to the service:

6.7.1 Upon admission to the ICU, the patient and or legal guardians (or next of kin), will be provided with the following information:

6.7.1.1 Orientation to the Service (infection control, the role of ICU, etc.).

6.7.1.2 Visitation protocol.

6.7.1.3 Patient and family rights and responsibilities (including the right of the patient to participate in decisions about care and treatment).

6.7.1.4 The patient and or legal guardians (or next of kin) will be informed about the patient's transfer/discharge from the ICU prior to their discharge.

6.8 The Discharge from the ICU:

6.8.1 The clinical condition of ICU patients is dynamic and should be monitored with the treatment plan revised regularly to identify those patients for whom discharge to a lower level of care is appropriate.

6.8.2 The decision to discharge a patient from the ICU is based on one of the following endpoints/criteria of care:

6.8.2.1 The patient's physiologic status has been normalized or stabilized to pre-admission non-critical baseline and deemed no longer in need of intensive care, close monitoring and/or intervention.

6.8.2.2 The patient's physiological status has plateaued to relative stability (stably unstable, e.g. on ventilator support, tracheostomy) with expected future deterioration, institutional dependence, poor functional outcome and or poor prognosis and to which active interventions are no longer beneficial or planned.

6.8.2.3 The patient requires transfer to another facility for care (MOH, local private or abroad).

6.8.2.4 The ICU resources required to be freed (e.g. from chronically ventilated and or vegetative patients) to accommodate other acute critically ill patients.

6.8.2.5 The ICU resources are required to be freed to accommodate other critically ill patients in accordance with the MOH critical care unit bed crisis management policy A-ADM-07.

6.8.3 Direction of Discharge:

6.8.3.1 Patients are discharged from the ICU to one of the following settings:

6.8.3.1.1 Ward.

6.8.3.1.2 Another level 3 or 2 care setting.

6.8.3.1.3 Another healthcare facility.

6.8.3.1.4 Hospital morgue.

6.8.4 The decision to discharge must be taken by the on-call ICU attending (with the admitting MRP and family made aware).

6.8.4.1 The admitting MRP must accept the discharge of the patient from the ICU when deemed appropriate by the ICU team (refer to article 6.5).

6.8.4.2 It is the responsibility of the admitting MRP wishing to transfer care of the patient to another specialty, to consult the respective recipient specialty/service for transfer of primary clinical responsibility, in accordance with the MOH medical consultation policy A-ADM-001, prior to the decision and time of the discharge of the patient from ICU.

6.8.4.3 Failure or delays in confirmation or finalization of the transfer of primary clinical responsibility between services prior to discharge from ICU will result in the transfer of the discharged patient to the ward and care of the admitting MRP.

6.9 ICU Discharge Process:

6.9.1 When the decision to discharge is confirmed, arrangements are to be made in a timely manner with the primary team and ward recipient nursing staff receiving the patient's care.

6.9.2 A detailed discharge summary (with the clinical course during ICU stay, investigations, medication reconciliation and recommendations) is to be issued by the ICU-designated physician in a closed model ICU, and by the treating MRP team in an open model ICU.

6.9.3 Handover to the receiving team should be communicated prior to transfer (verbal / written).

6.9.4 The patient and/or his/her legal guardians/ next of kin should be informed about the discharge expected time and direction.

6.9.5 ICU discharges should not be delayed. In case of bed crises, the assigned Matron should be informed to facilitate bed arrangements in the assigned ward or other wards within the facility.

6.9.6 When deemed possible, the ICU leadership is to delegate assessment, management and reassessment of the respective patients to designated team members (e.g. critical care outreach team) over a predefined time and according to the facility policy.

7. References:

7.1 Nates JL, Nunnally M, Kleinpell R, et al. ICU Admission, Discharge, and Triage Guidelines: A Framework to Enhance Clinical Operations, Development of Institutional Policies, and Further Research. *Crit Care Med.* 2016; 44(8):1553-1602. doi:10.1097/CCM.0000000000001856.

7.2 Guidelines for intensive care unit admission, discharge, and triage. Task Force of the American College of Critical Care Medicine, Society of Critical Care Medicine. *Crit Care Med.* 1999; 27(3):633-638.

7.3 Caldeira VM, Silva Júnior JM, Oliveira AM, et al. Criteria for patient admission to an intensive care unit and related mortality rates. *Rev Assoc Med Bras (1992).* 2010; 56(5):528-534. doi:10.1590/s0104-42302010000500012.

7.4 MOH decree 146/80.

7.5 MOH decree 137/2024.

7.6 Child Protection Law number 21/2015.