

## Adult ICU Admission Policy

### What is the aim for ICU admission policy?

The primary aim for framing ICU admission policy is to facilitate early patient admission when the risk of deterioration in the absence of ICU care is high.

### Who can request for admission of patient in the ICU?

The treating physician of any clinical department can refer any patient under his/her care in the ward/emergency for admission in the ICU.

### Who can admit patient in the ICU?

On receipt of requisition for ICU admission, the ICU Resident on call duty should make thorough clinical assessment of the patient at the bedside within maximum 2(two) hours and record his/her observations on the file as to whether the patient needs ICU admission and bed is available, whether patient needs ICU admission but bed is unavailable or the patient does not need any ICU admission. The same should be communicated to the team of primary physicians and the patients' relatives. When the patient requires ICU admission and bed is available, the ICU Resident should inform about the same to the ICU faculty on call. The faculty of the following departments can admit the patients in their respective ICUs after obtaining consent from HOD or any faculty designated by the HOD for the same. No patient will be admitted directly by any resident.

ICU location	Department
ICU-1(NEB 1 <sup>st</sup> floor), Gen ICU (SSB, Ground floor)	Anaesthesiology
ICU-2 and 3 (NEB 1 <sup>st</sup> floor), HDU (NEB 6 <sup>th</sup> Floor)	Critical Care Medicine
Neurosurgery ICU (NEB 1 <sup>st</sup> floor)	Neurosurgery
Neurology & Neurosurgery ICU (SSB)	Neurology/Neurosurgery
Pulmonary Medicine ICU (SSB)	Pulmonary Medicine
CTVS ICU (SSB)	Cardiovascular & Thoracic Surgery



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CCU (SSB)	Cardiology
Burn ICU (Burn ward)	Burn, Plastic & Maxillofacial Surgery

**What is the patient selection criteria for admission in the individual ICUs?**

ICU location	Patient category
ICU-1(NEB 1 <sup>st</sup> floor), Gen ICU (SSB, Ground floor)	Postoperative, Medical & Surgical emergencies, Obstetrics & Gynaecology emergencies, Multiorgan failure
ICU-2 and 3 (NEB 1 <sup>st</sup> floor), HDU (NEB 6 <sup>th</sup> Floor)	Postoperative, Medical & Surgical emergencies, Obstetrics & Gynaecology emergencies, Multiorgan failure
Neurosurgery ICU (NEB 1 <sup>st</sup> floor)	Postoperative, Trauma & Neurosurgical emergencies
Neurology & Neurosurgery ICU (SSB)	Postoperative, Trauma, Neurology and Neurosurgical emergencies
Pulmonary Medicine ICU (SSB)	Pulmonary emergencies
CTVS ICU (SSB)	Postoperative and Cardiovascular & thoracic emergencies
CCU (SSB)	Postinterventional and Cardiology emergencies
Burn ICU (Burn ward)	Burn emergencies

**Who is responsible for the overall management and care of the ICU patients?**

The patients admitted in the ICU will be under the overall care of respective ICU team with sharing of the responsibilities between the ICU team and the primary physician/surgeon on case to case basis.

**Who will decide the discharge of patient from the ICU on recovery?**

The ICU team when satisfied with recovery/progress of the patient will recommend the shifting of the patient from ICU to the ward. The responsibility to accommodate the patient in the ward will be on the primary physician/surgeon.

**What objective clinical criteria are required to be fulfilled for ICU admission?**

The patients should fulfil *at least one* of the following clinical criteria

- Hemodynamic instability (such as shock or arrhythmias)
- Need for respiratory support, including escalating oxygen requirements
- Respiratory failure necessitating non-invasive or invasive ventilation
- Severe acute or acute-on-chronic illnesses requiring intensive monitoring or organ support,
- Any major intraoperative complications or major surgeries requiring intensive monitoring

**What should be the prioritization basis for ICU admission?**

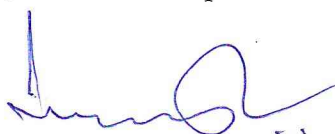
Priority 1	Priority 2	Priority 3	Priority 4
Critically ill, hemodynamically unstable, continuous vasoactive infusions & potentially reversible	Requiring intensive monitoring and/or urgent intervention	Unstable patients with less likelihood of recovery owing to the nature of their disease/illness	Not ordinarily appropriate for ICU admission

**What should be the pre-requisites for ICU discharge?**

- Return of physiological aberrations to near normal or baseline status
- Reasonable resolution and stability of the acute illness necessitating ICU admission
- Treatment futility/End-of-Life care
- When the risks of harm outweigh the risks of benefit

**When should the treatment futility be considered or discussed with patients' relatives?**

The issue of treatment futility should be discussed by both the ICU team and primary physician/surgeon either jointly or separately with the patient's relatives when there is no two mind that the disease/condition for which the patient is admitted is irreversible and that further ICU stay will not accrue any benefit to the patient.





**What criteria should be fulfilled for Brain Dead Declaration, Organ Transplantation & End-of-Life care in ICU?**

The guidelines advocated by the Ministry of Health & Family Welfare, Govt. of India should be fulfilled in all such cases.

**What criteria for monitoring and care should be available to patients awaiting ICU admission in ward/emergency?**

During the crucial time while awaiting an ICU bed, minimum patient monitoring is essential. This includes continuous or intermittent measurements of blood pressure, clinical parameters (such as pulse rate and respiratory rate), heart rate, oxygen saturation (SpO<sub>2</sub>), capillary refill time, urine output, neurological status (measured by GCS or AVPU scale), intermittent temperature monitoring, and blood sugar levels.

**What minimum measures should be taken before emergency shifting of patient to the ICU?**

Before transferring a patient to the ICU, certain minimum stabilization measures must be taken. These include ensuring a secure airway (tracheal intubation if the patient has a GCS  $\leq 8$ ), maintaining adequate oxygenation and ventilation, achieving stable hemodynamic with or without vasoactive drug infusion, ongoing correction of hyperglycaemia/hypoglycaemia, and initiation of definitive therapy for life-threatening conditions.

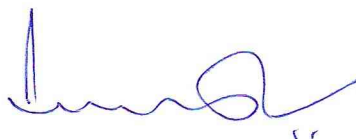
**What care must be taken during shifting of patients to the ICU in-transit?**

No patient must be shifted unescorted by Resident doctor. While transferring critically ill patients to the ICU from ward/emergency, continuous or intermittent monitoring of blood pressure, clinical parameters, continuous heart rate, and continuous SpO<sub>2</sub> should be instituted to ensure a seamless transition and ongoing patient safety. If any patient is on ventilator or inotropic drugs, the exact details should be conveyed to the ICU team during handover.

**When should ICU admission be deferred or avoided?**

The decision to withhold or defer ICU admission should be done in cases of

- Patient's or next-of-kin informed refusal to be admitted in ICU



- Any disease with a treatment limitation plan
- Anyone with a living will or advanced directive against ICU care
- Terminally ill patients with a medical judgement of futility
- Low priority criteria in case of pandemic or disaster situation where there is resource-limitation (e.g. bed, workforce, equipment).

**What should be the key concerns and governing factors for ICU care?**

**A) Prioritizing Medical Need:**

- **Shift from “First-come, First-served”:** The focus on organ failure and need for organ support ensures that the most critically ill patients get access to vital resources like ventilators and dialysis machines. This could potentially reduce mortality rates and improve outcomes for those with the highest chance of survival.

**B) Respecting Patient Autonomy:**

- **Empowering Patients and Families:** The emphasis on informed consent and respecting treatment limitation plans and advance directives empowers patients to have a say in their care, particularly during vulnerable times. This shift aligns with evolving ethical considerations in critical care.
- **Potential Dilemmas:** Navigating situations where patient wishes and medical recommendations differ requires skilful communication and sensitivity from healthcare professionals.

**C) Resource Allocation and Efficiency:**

- **Addressing Scarcity:** By excluding patients with futile care scenarios or low-priority criteria during resource constraints, the aim for optimize utilization of limited ICU beds and equipment should be followed. This could benefit a larger number of patients in critical situations.
- **Equity Concerns:** Ensuring fair and equitable access to ICU care across diverse populations becomes even more important with these guidelines. Potential biases based on socioeconomic status or geographical location must be addressed.

**D) Ethical Considerations:**



- **Transparency and Communication:** Building trust and understanding through clear communication between doctors and patients/families is crucial. Explaining complex medical decisions and the rationale behind ICU admission or denial requires effective communication skills and empathy

**What are the levels of recommendations for admission in the ICU on the basis of diagnosis?**

Level 1	Level 2	Level 3
ICU admission is convincingly justifiable on scientific evidence alone	ICU admission is reasonably justified by scientific evidence and strongly supported by expert opinion	ICU admission is inadequately justifiable on the basis of scientific evidence but widely supported by expert opinion

