Title: Farwaniya Hospital Internal Medicine and Intensive Care Unit Interdepartmental Policy	
Policy Owner:	**Policy Code**: A-IMICU-005
Section location: Intensive Care Units and Medical Wards	**Effective Date**: 15-01-2023
Applies to: Inpatient Clinical Services	**Revision Date: 01-01-2025**
Approvals	**Signature Date:**
Approved by: Head of Internal Medicine Department	
Approved by: Head of Intensive Care Unit	
Approved by: Chief Medical Officer	
Notes	

1.0 **Purpose:** To regulate the relationship between Internal Medicine and Intensive Care department.

2.0 **Consultation policy**

2.1 To follow Ministry of Health (MOH) "consultation policy" released in October 2022 https://www.moh.gov.kw/en/Technical/Pages/Policies.aspx

2.2 Consultation request form: all consultations that are sent from the Medical Department to the Intensive Care Unit should be filled properly by the medical registrar or above rank using the special ICU consultation form that's available in HIS.

2.3 Some important points mentioned in the MOH consultation policy with few modifications:

2.3.1 The welfare of the patient should be central to the consulted service-patient relationship (beneficence) and the management, transfer of care or takeover of the patients should be guided by this ethical principle.

2.3.2 The referring practitioner should provide a clear question/reason of consult, a summary of the history, results of the physical examination, laboratory findings, and any other information that may facilitate the consulted service evaluation and recommendations including referring practitioner's contact information.

2.3.3 For urgent and emergent consultations, the consulted service should first be informed verbally, then a written official consultation should be issued.

2.3.4 Complex clinical situations may call for multiple consultations. Unless authority has been transferred elsewhere, the responsibility for the patient's care should rest with the referring/treating practitioner until the patient is transferred to the intensive care unit. The referring attending physician has overall responsibility for the patient's treatment and should remain in charge of communication with the patient and

coordinate the overall care on the basis of information derived from the consulted service. This will ensure a coordinated effort that remains in the patient's best interest.

2.3.5 Consults cannot be refused once issued without patient assessment with great attention to filling the consultation form properly.

2.3.6 In-hospital response time

2.3.6.1 STAT/Emergency consult, 3-5 mins

2.3.6.2 Urgent consult,15-30 mins

2.3.6.3 Routine consult, within 24 hours (non-emergent procedure e.g., pre-operative assessment, etc.)

2.3.7 Services may set criteria and indications of consults (through their respective council) BUT it remains left to the responsible treating physician to consult that service(s) if deemed necessary/fit by him/her.

3.0 Guideline for Intensive Care Unit consultation for evaluation and possible admission to ICU

3.1 Neurology

3.1.1 Acute confusional state/altered mental status, for airway protection (metabolic, toxic, infective, convulsive)

3.1.2 Acute ischemic stroke with any of the following:

3.1.2.1 Post thrombolysis – in the ICU under the care of neurology/medical unit

3.1.2.2 Post thrombolysis patients who are candidate for out of hospital vascular intervention only if requires transportation assessment (check thrombolysis/thrombectomy flow chart)

3.1.2.3 Massive infarction (clinically and/or radiologically)

3.1.2.4 Hemorrhagic transformation with consequent neurological deterioration

3.1.2.5 Uncontrolled BP, SBP>220 mmhg and/or DBP>120 mmhg requiring intravenous (I.V.) anti-hypertensive medication

3.1.3 Acute hemorrhagic stroke (Intracranial hemorrhage/Subarachnoid hemorrhage) requiring I.V. anti-hypertensive or monitoring

3.1.4 Status epilepticus

3.1.5 CNS or neuromuscular disorders with potential compromise of the respiratory muscles (e.g., Guillain-Barre Syndrome, Myasthenia Gravis, muscular dystrophies, etc.)

3.1.6 Encephalitis/cerebritis that is evident by imaging with GCS equal or less than 10, and requiring pulse steroid, aggressive immunosuppressive therapy and/or exchange transfusion

3.1.7 Potential organ donor (brain death or potential brain death)

3.2 **Cardiovascular**

3.2.1 Hypertensive emergency requiring intravenous anti- hypertensive medication and continuous monitoring

3.2.2 Post cardiac arrest due to non-cardiac cause and good prognosis patient. If poor prognosis, refer to the MOH Operational and Management Policy and Guide for Adults with Terminal Illness

3.3 **Pulmonology**

3.3.1 Acute respiratory failure requiring advanced respiratory support or impending intubation.

3.3.2 Massive pulmonary embolism evident by any of the following:

3.3.2.1 Hemodynamic instability or requiring respiratory support.

3.3.2.2 Right ventricular strain evident by echo.

3.3.3 Massive hemoptysis with any of the following:

3.3.3.1 Hemodynamic instability or requiring respiratory support.

3.3.3.2 Requiring urgent intervention (bronchoscopy, interventional radiology or surgical)

3.3.3.3 Significant blood loss (use the attached calculator link)

3.3.3.3.1 Loss of more than one blood volume within 24 hours (around 70 mL/kg, >5 liters in a 70 kg adult)

3.3.3.3.2 50% of total blood volume lost in less than 3 hours

3.3.3.3.3 Bleeding more than 150 mL/minute

3.4 **Gastrointestinal and Hepatology**

3.4.1 Upper gastrointestinal bleeding with any of the following:

3.4.1.1 Hemodynamic instability or requiring respiratory support

3.4.1.2 Chest pain

3.4.1.3 Ongoing active bleeding

3.4.1.4 Patient on anti-coagulation and/or antiplatelets for recent acute thrombo-embolic events (e.g., ACS, stroke, DVT/PE, etc.)

3.4.1.5 Fresh bleeding per rectum due to a known upper gastrointestinal etiology with hemodynamic instability

3.4.2 Fulminant hepatitis/acute hepatic failure

3.4.3 Infectious, immune (e.g., Inflammatory Bowel Disease), drug induced colitis with hemodynamic instability

3.4.4 Advanced encephalopathy due to liver cell failure

3.4.5 Severe acute pancreatitis evident by clinical criteria and/or intra-abdominal pressure more than 20 mmhg

3.5 **Endocrinology and Diabetes**

3.5.1 Diabetes ketoacidosis (DKA) with any of the following:

3.5.1.1 Hemodynamic instability or requiring respiratory support

3.5.1.2 Altered mental status

3.5.1.3 Severe metabolic acidosis (pH equal or less than 7) that is not responding to the proper initial management

3.5.1.4 Significant electrolyte disturbances that are not responding to the proper initial management and requiring frequent intravenous correction

3.5.2 Hyperglycemic Hyperosmolar State (HHS) with any of the following:

3.5.2.1 Hemodynamic instability or requiring respiratory support

3.5.2.2 Altered mental status

3.5.2.3 Significant electrolyte disturbances that are not responding to the proper initial management and requiring frequent intravenous correction

3.5.3 Thyroid storm / myxedema coma

3.5.4 Adrenal crisis

3.5.5 Symptomatic pituitary hemorrhage/apoplexy

3.6 **Nephrology**

3.6.1 Acute severe metabolic acidosis

3.6.2 Unstable patients requiring dialysis under close monitoring

3.6.3 Severe electrolyte abnormalities with any of the following:

3.6.3.1 Altered mental status

3.6.3.2 Hemodynamic instability

3.6.3.3 Seizures

3.6.3.4 Life threatening arrhythmias

3.6.3.5 Progressive muscular weakness (e.g., hypokalemic paralysis)

3.6.3.6 Refractory despite repeated correction

3.7 **Hematology**

3.7.1 Severe anemia causing hemodynamic instability

3.7.2 Severe hemolytic anemias (e.g., TTP, sickle cell crisis) requiring invasive supportive care (e.g., exchange transfusion)

3.8 **Infectious Diseases (ID)**

3.8.1 Hemodynamic instability or requiring respiratory support

3.8.2 Septic shock requiring vasopressors

3.8.3 Sepsis with multiorgan failure

3.9 **Substance overdose/withdrawal and toxins**

3.9.1 Substance ingestion with any of the following:

3.9.1.1 Hemodynamic instability or requiring respiratory support

3.9.1.2 Altered mental status with potential inadequate airway protection

3.9.1.3 Potential cardiovascular and/or CNS toxicity

3.9.1.4 Seizures

3.9.1.5 Requiring hemodialysis (e.g., methanol, ethylene glycol intoxication, etc.)

3.9.2 Ethanol withdrawal syndrome with:

3.9.2.1 CIWA-Ar score >20

3.9.2.2 Hemodynamic or respiratory instability

3.9.2.3 Withdrawal seizure

3.9.2.4 Requiring continuous intra venous infusion of benzodiazepine
3.9.2.5 Requiring hemodialysis (e.g., severe acidosis, rhabdomyolysis)
3.9.3 Inhalational injury
3.9.3.1 Carbon mono oxide poisoning
3.9.3.2 Organophosphorus poisoning

3.10 **Environmental Hazards**

3.10.1 Heat stroke
3.10.2 Severe hypothermia/hyperthermia
3.10.3 Near drowning
3.10.4 Electrical shock with significant organ dysfunction
3.10.5 Insects/animal bite with organ dysfunction (e.g., bees, snake, scorpion)
3.10.6 Anaphylaxis and anaphylactic shock

3.11 **Miscellaneous**

3.11.1 Psychiatric patient that is requiring high dose sedation (for monitoring and airway protection)

4.0 Stroke Thrombolysis and Thrombectomy

4.1 Stable patients who receive thrombolysis treatment will be admitted under the medical team in a monitored bed (currently the monitored bed is in the ICU 2).
4.2 In case the patient has decreased level of consciousness GCS 12 or less, or significant hemodynamic instability, ICU will be informed for evaluation and takeover.
4.3 Stable patients who will undergo thrombectomy intervention outside the hospital, the medical team will accompany the patient to the destination.
4.4 Unstable patients who will undergo thrombectomy intervention outside the hospital, the ICU doctor will accompany the patient to the destination.
4.5 Stable patients after the thrombectomy intervention and after 24 to 48 hours stay in Ibn Sina ICU/HDU will be shifted medical ward.
4.6 Unstable patients (including no bed availability in Ibn Sina ICU/HDU) after the thrombectomy intervention must stay in ICU/HDU for 24 to 48 hours for observation before shifting the patient to medical ward.

5.0 Patients on Mechanical Ventilation (M.V.) in the Wards

5.1 All ventilated patients (including tracheostomized on M.V.) outside the ICU are assessed daily by the ICU team with a daily plan for each patient. In case any of these patients need an active ICU management, they will be shifted to ICU.
5.2 If the tracheostomized patient is weaned off the M.V. and kept on T-piece, the ICU team will no longer follow the patient.

6.0 Procedures in the Wards not Transferrable to OT (by Anesthesia)

6.1 Difficult peripheral line insertion after multiple trials by ward senior nurses and senior medical physician
6.2 Central line insertion for monitoring and/or inotropic support

6.3 Difficult lumbar puncture cases (agitated patients, abnormal spine anatomy, and/or failed by the medical/neurology team)

7.0 Formalities and Reports

7.1 Intensive care unit is a closed unit with full responsibilities regarding writing medical reports, mortality reports and medical board committees.

7.2 All ICU discharged patients should have a discharge note that includes a detailed summary of all active issues and a management plan, including the following:

- 7.2.1 Procedures performed during the ICU stay
- 7.2.2 Medication plan
- 7.2.3 Nutritional plan
- 7.2.4 Daily follow-up plan for the patient on I.V. sedation

8.0 Transfer policy

8.1 Transferring patients that are labeled critical or in need for (or may potentially require) respiratory and/or hemodynamic support for imaging or procedure (inside or outside the hospital) are subject to the MOH transfer policy, kindly visit the following link https://www.moh.gov.kw/TechnicalDepartmentPolicies/policy4.pdf

- 8.1.1 It is the responsibility of the **transferring service/department** responsible for the patient's care **to consult the anesthesia/ICU physician** (or any physician with critical care and advanced airway competency) to accompany the respective patient deemed -by the guide set forth in this policy- to require such advanced level of expertise, to ensure the safe transfer of their respective patients **to** the **receiving service/specialty/department/ward** and or back.
- 8.1.2 It is the responsibility of the **transferring service/department** responsible for the patient's care to decide, according to the patient's medical status, the need of accompany by the treating physician and/or anesthesia/ICU physician only. This decision should be documented in the file by the senior registrar (or an above rank) of the treating unit transferring the patient.
- 8.1.3 It is the responsibility of the ***anesthesia/ICU physician*** (or any physician with critical care and advanced airway competency) who is consulted or delegated to accompany a patient deemed -by the guide set forth in this policy- to need advanced airway and critical care support, to ensure that the required medical equipment and support is available at hand, functional and ready for the transfer.
- 8.1.4 Transfers of admitted patients to other hospital should be:
  - 8.1.4.1 Ward to ward
  - 8.1.4.2 CCU/ICU to CCU/ICU, unless agreed upon to transfer otherwise (e.g., CCU to ward)

8.2 The medical treating unit senior registrar (or above rank) and the medical on-call senior registrar must be informed in case their patient will be shifted to the medical ward from the ICU.

9.0 Monitoring procedures

9.1 Any breach for the above policy can be reported using the hospital incident report online system.

References

- **ICU Policy 2019 – Adan Hospital**
- **Kuwait MOH unified policies (consultation policy, transfer policy, diagnosis-based admission policy etc.).**
- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee