



DEDER GENERAL HOSPITAL

ICU ADMISSION, TREATMENT, AND DISCHARGE PROTOCOLS

PREPARED BY: HSQU

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PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL: ICU NURSING CARE PACKAGE PROTOCO

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THIS PROTOCOL IS EFFECTIVE

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1. Purpose:

To provide criteria and guidelines for the appropriate admission, treatment, and discharge of patients of the Intensive Care Unit (ICU), ensuring effective resource utilization and optimal patient outcomes.

2. Introduction

ICU (Intensive Care Unit) admission, treatment, and discharge protocols are critical for managing patients with severe or life-threatening illnesses. The protocols vary depending on the medical condition, hospital policies, and local regulations, but general guidelines are widely followed to ensure patient safety and care quality.

3. ICU Admission Protocol

3.4. Criteria for ICU Admission:

ICU admission is generally indicated for patients with severe, life-threatening illnesses or conditions that require:

- ☞ Continuous monitoring of vital signs.
- ☞ Advanced medical interventions (e.g., mechanical ventilation, invasive monitoring).
- ☞ Intensive nursing care.
- ☞ A multidisciplinary team approach for critical care.

3.2. Categories for ICU Admission:

A. Respiratory Failure

Indications:

- ☞ Patients requiring mechanical ventilation.
- ☞ Acute respiratory distress syndrome (ARDS).
- ☞ Respiratory failure unresponsive to standard treatments.
- ☞ Severe exacerbation of chronic respiratory diseases (e.g., COPD, asthma) requiring non-invasive or invasive ventilatory support.
- ☞ Hypoxemia requiring high-flow oxygen or non-invasive ventilation.

B. Cardiovascular Instability

Indications:

- ☞ Hemodynamic instability (e.g., shock) requiring vasopressors or inotropes.
- ☞ Life-threatening arrhythmias or myocardial infarction requiring close monitoring and intervention.
- ☞ Cardiac arrest or post-cardiac arrest requiring intensive monitoring (e.g., therapeutic hypothermia).
- ☞ Acute heart failure requiring mechanical circulatory support or invasive monitoring.

C. Neurological Emergencies

Indications:

- ☞ Patients with reduced consciousness (e.g., Glasgow Coma Scale < 8) requiring airway protection.
- ☞ Acute stroke or intracranial hemorrhage requiring continuous monitoring and possible interventions (e.g., intracranial pressure monitoring, neurosurgery).
- ☞ Status epilepticus or uncontrolled seizures despite treatment.
- ☞ Severe traumatic brain injury or spinal cord injury.

4. Renal Failure

Indications:

- ☞ Acute kidney injury requiring continuous renal replacement therapy (CRRT) or dialysis.
- ☞ Electrolyte imbalances (e.g., hyperkalemia) requiring intensive monitoring and treatment.

5. Severe Sepsis/Septic Shock

Indications:

- ☞ Patients with severe sepsis or septic shock requiring vasopressors, invasive monitoring, and/or mechanical ventilation.
- ☞ Multisystem organ failure requiring intensive supportive care.

D. Post-operative Care

Indications:

- ☞ Patients requiring close post-operative monitoring due to the risk of complications (e.g., high-risk surgeries, massive blood loss, or major organ surgeries).
- ☞ Patients requiring prolonged mechanical ventilation or hemodynamic support post-surgery.
- ☞ Immediate post-operative care for patients with compromised respiratory or cardiovascular function.

E. Trauma

Indications:

- ☞ Polytrauma with multiple injuries requiring close monitoring of vital signs and organ function.
- ☞ Patients with a high risk of deterioration following trauma (e.g., chest trauma, abdominal trauma, or severe burns).

F. Toxicological Emergencies

Indications:

- ☞ Patients with life-threatening poisonings or drug overdoses requiring continuous monitoring and advanced interventions (e.g., intubation, antidotes, or hemodialysis).

G. Other Indications

Indications:

- ☞ Any patient requiring continuous monitoring and life-support measures not available on regular wards (e.g., patients with metabolic disorders, immunocompromised patients with severe infections).
- ☞ Patients requiring intensive nursing care due to complex treatments (e.g., continuous infusion of medications, invasive devices).

3.3.ICU Admission Procedure:

☞ Initial Assessment:

Emergency Room (ER) or Ward Assessment:

- Patients presenting to the ER or deteriorating in a general ward should be assessed by the primary team for ICU suitability based on the criteria listed above.
- Critical Care consultation should be requested for patients who meet the criteria.

☞ Triage by Severity:

- Priority for ICU admission should be given to patients with reversible conditions and those expected to benefit from intensive care.
- Triage criteria include the severity of illness, prognosis, and likelihood of benefiting from ICU care.

☞ Admission Decision:

- **Consultation:**
 - The primary physician should consult with the ICU team (critical care physician or intensivist) to determine whether ICU admission is necessary.
 - The decision should be based on clinical criteria, patient prognosis, and available resources.

☞ Decision Documentation:

- The decision to admit the patient to the ICU must be clearly documented in the patient's medical records, including the rationale for ICU care.
- The admitting diagnosis and anticipated treatment plan should also be documented.

☞ Transfer to ICU:

- **Patient Stabilization:**
 - Before transfer, ensure the patient is stable enough for transport (e.g., initiate life-saving interventions like airway management, vasopressors, etc.).

- The patient should be closely monitored during transfer with the appropriate equipment (e.g., portable monitors, oxygen, emergency medications).

➤ **Handoff Communication:**

- A thorough handoff should be conducted between the transferring team and the ICU team using standardized communication tools (e.g., SBAR: Situation, Background, Assessment, Recommendation).
- The patient's history, current condition, and treatment plan should be clearly communicated.

☞ **ICU Admission Documentation:**

- Upon arrival in the ICU, document the patient's vital signs, initial assessment, and the interventions performed during transfer.
- ICU staff should perform a complete reassessment of the patient, including necessary diagnostics, to formulate an ICU care plan.

3.4. Additional ICU Admission Considerations:

A. Ethical Considerations:

- ICU care should only be provided to patients who are likely to benefit from it. For patients with poor prognosis (e.g., terminal illness, advanced age with multiple comorbidities), ICU admission may not be appropriate.
- Decisions should be made collaboratively with the patient, family, and the healthcare team, considering the patient's advance directives or wishes.

3.5. Monitoring and Quality Control:

A. Daily Rounds:

- ICU patients should be assessed by the critical care team daily, with adjustments made to their treatment plans as necessary.
- Admission criteria should be reviewed periodically to ensure patients continue to meet ICU requirements.

B. ICU Admission Review:

- ICU admissions should be periodically reviewed as part of the hospital's quality improvement program. This includes evaluating outcomes, mortality rates, and appropriate resource utilization.

C. Communication with Family:

- Family members of ICU patients should be kept informed about the patient's status, prognosis, and treatment plan. This ensures transparency and facilitates decision-making in cases of critical illness.

3.6. Exclusions for ICU Admission:

Patients who may not benefit from ICU care or have a limited prognosis may include:

- Terminally ill patients not expected to recover.
- Patients with advanced dementia or other severe irreversible conditions where ICU care would not improve the quality or length of life.
- Patients with clear advance directives that specify “do not resuscitate” (DNR) or requests for comfort care only.

4. ICU Treatment Protocol

The **ICU Treatment Protocol** provides a standardized approach to managing critically ill patients in the Intensive Care Unit. The goal is to deliver optimal, evidence-based care to improve outcomes, minimize complications, and ensure appropriate resource utilization. This protocol covers key areas of ICU treatment, including initial assessment, ongoing monitoring, life-support interventions, and specific management of common ICU conditions

4.1. Initial ICU Admission and Assessment

A. Patient Handoff and Initial Assessment:

- **Handoff Communication:** Ensure a thorough handoff from the transferring team using structured communication tools (e.g., SBAR: Situation, Background, Assessment, Recommendation).

- **Immediate Assessment:**

- Perform a comprehensive physical examination.
- Review vital signs, lab results, imaging, and clinical notes.
- Initiate monitoring (continuous ECG, blood pressure, oxygen saturation, and, if needed, invasive hemodynamic monitoring).

- **Diagnostic Testing:**

- Obtain baseline blood tests (CBC, electrolytes, arterial blood gases, renal and liver function tests, lactate).
- Obtain chest X-ray, ECG, and other relevant imaging studies as needed.

- **Documentation:**

- Document the patient's condition, history, medications, allergies, and plan of care in detail.

4.2.Vital Signs and Monitoring

Parameters to be monitored continuously

Parameter	Frequency of monitoring	Limitations
RR, HR and SpO₂	Measure continuously using a non- invasive monitor Normal value is 98–100% (at sea level) goal in adults is more than 90%.	Requires a pulsatile signal – challenging with motion or poor perfusion, Does not measure ventilation (pCO ₂), False readings can be seen with abnormal Hb or CO poisoning, Remember to remove nail polish if present!
BP (SBP, DBP, MAP)	Measure every 5–15 minutes during initial resuscitation of patients with shock. Once stabilized, can reduce to every 30–60 minutes. Consider invasive continuous monitor if refractory shock to fluids or need frequent arterial sample	Technically difficult to obtain in shock states Use appropriate cuff size Invasive blood pressure monitoring ,Benefits Directly measures arterial pressure, More accurate ,More reproducible, Continuous









Mental status	Monitor hourly	
(GCS or four scale)	If patient is receiving sedation, analgesia or mechanical ventilation, monitor sedation and pain with standardized scales every hour (RASS, etc.)	
Temperature	Measure at least every 3 hours	
Urine output	Measure hourly	
Physical examination	Focused examination of cardiovascular and respiratory system should be assessed every 30–60 minutes during the resuscitation phases of shock. Once patient is stabilized, can reduce to every 2–4 hours.	
Laboratory tests	As often as needed when managing shock and metabolic abnormalities (i.e. CBC, creatinine, electrolytes, glucose, and lactate). Avoid routine laboratory testing.	
Arterial blood gas analysis	Measure on arrival in patient with Severe hypoxaemia Risk of hypercapnea (e.g. COPD, depressed mental status)	Invasive arterial puncture Heparinized syringe Can consider use of end-tidal CO2 in conjunction with SpO2 and RR to make assessment, understanding the limitations
Ventilator parameters (if patient on mechanical ventilation)	Every 2-4 hours. This includes: mode, expiratory tidal volume, respiratory rate (patient and machine), PEEP, FiO2, I: E ratio, flow rate, compliance, plateau airway pressure, peak pressure, set inspiratory pressure (if using	
Ultrasound	If possible on daily bases and as indicated in ventilated patients.	
Capnography in normal lungs, PETCO2 is about 3–5	During intubation and as needed	Limits: inaccurate if there is no discernable plateau: e.g. airflow obstruction. Underestimates PaCO2 when there is decreased lung perfusion: Pulmonary emboli Hypotension, High PEEP, Severe ARDS, Emphysema

4.3. Nutrition and Glycemic Control

A. Nutritional Support:

Principle of care

-  Critically ill patients are in catabolic stress state
-  Early nutrition favorably modulates immune response. **Feeding should be started as early as possible or within 48 hours.**
-  If hemodynamic instability, start after shock resuscitation
-  Nutritional assessment should be done with indirect calorimetry
-  Monitoring of nutrition must be done on daily bases and nutritional plan modified accordingly
-  Plan for parenteral nutrition if enteral nutrition cannot be achieved in 7 days.

Feeding procedure

A. Feeding amount

- Use actual body weight unless the patient is obese
- Calories should contain 70% carbohydrate, 30% fat and proteins
- Start with 20kcal/kg, increase to 25 to 30kcal/kg within 5 days
- Protein requirement: 1.2-2.0g/kg actual body weight/day and 2g/kg for sever burn. In acute kidney injury: give 1.0-1.5 g/kg/day if not in dialysis, 1.5-2.0 g/kg/day if on hemodialysis (HD) and 2.0-2.5 g/kg/day if patient on CRRT.
- In trauma patients: give 1.5-2.0 g/kg/day and traumatic brain injury: 1.5-2.5 g/kg/day.

B. How to start enteral feeding

- It can be administered by continuous, intermittent or bolus methods.
- The head of the bed has to be elevated at 30-45 degree to prevent aspiration Absence of bowel sounds is not necessarily contraindication for enteral feeding. Look for abdominal distention, bloating, pain, increased residuals, diarrhea and dilated loops of bowel on films.

If the patient cannot take orally 50% of required amount within 72 hr, or 100 % within 7 days start tube feeding

- ♣ Naso duodenal and naso jejunal tubes (transpyloric tubes): Is used when nasogastric causes frequent aspiration or if gastric emptying time is prolonged
- ♣ Percutaneous gastrostomy, duodenostomy or jejunostomy tubes: these routes may be indicated in patients with esophageal stricture or following esophageal reconstruction

Contraindication to enteral feedings

- ♣ Resuscitated shocks, bowel obstruction, severe and protracted ileus, major UGIB, intractable vomiting or diarrhea, gastrointestinal ischemia

Locally Available Formula foods for enteral use in ICU

Formula diet is recommended whenever possible

- ♣ **Mumbai formula** is formulated with the following recipe:

☞ **3 boiled eggs + 3 bananas + 3 tablespoons=50g sugar + 9 tablespoons=1.5dl full fat powder milk OR 1.50dl full fat milk, Add filtered water to make totally 1liter.**

☞ Mix with blender and can be refrigerated **up to 24 hours.**

☞ The energy content of **Mumbai formula** per **1000ml is 1000 kcal.**

☞ Has caloric density of approximately **1kcal/ml**, protein content of about **40g/1000ml** and have **essential vitamins, minerals** and **micronutrients.**

- ♣ **Plumpy'Nut:** a ready to use therapeutic food with packaging of **sachet =92 g.**

Energy/nutrient/100g is 500 kcal; 12.5g protein and 32.9g fat.

C. Parenteral Nutrition

- ♣ GI tract is not functional /cannot be accessed /Inadequate GI feeding:
- ♣ Consider TPN on day 3-7, if enteral nutrition is not possible or adequate
- ♣ Made up aseptically
- ♣ Start low and build up
- ♣ Usually given with central line in ICU – keep a clean port if PN may be needed.

- ☞ Short term PN – can have PIC (need a different formula) or PICC
- ☞ Long-term TPN – tunneled subclavian catheter (Hickman) or subcutaneous port is usually inserted – OBSERVE STRICT ASEPSIS if handling these lines.

Manage complications of feeding

a High gastric residual diet (residual volume is more than 500ml or 50% of the feed)

- Decreasing the feed temporarily
 - Making it continuous rather than bolus
 - Addition of metoclopramide 10 mg IV or erythromycin and correct electrolyte
- Consider trans pyloric feeds

b Diarrhea during enteral feeding

Cause could be: hyper osmolar formula, lactose intolerance, malabsorption, infectious causes or drug induced. **Management** of diarrhea during enteral feeding:

- Electrolyte and rehydration therapy:
 - Avoid cessation of feeding
 - Consider reducing rate and strength of feed
 - Consider antibiotic associated colitis
 - If intractable stop feeding till diarrhea stops

c Dumping syndrome:

- Inpatients with concentrated feedings
- Nausea, shaking, diaphoresis and diarrhea.

d Aspiration:

- Prevention, motility agents, PEG, motility agents

B. Glycemic Control:

- **Blood Glucose Monitoring:** Target blood glucose levels between 140–180 mg/dL. Avoid hypoglycemia.
- **Insulin Therapy:** Administer IV insulin infusion or subcutaneous insulin to maintain target glucose levels.

4.4. MAINTENANCE FLUID

Table 1: Fluid requirement calculation

Maintenance (sensible & insensible losses, fever)	4:2:1 principle. Eg for a 50kg patient the 1 st 10kg x 4 = 40ml/hr; 2 nd 10kg x 2 = 20ml/hr; 3 rd and above 30kg x 1 = 30ml/hr. total 90ml/hr x 24hrs = 2160ml/24hrs plus insensible loss (300-500ml/24hrs) = 2460-2660ml/24hrs plus For each degree of fever above 37, 2-2.5 ml/kg/day	0-10kg = 100ml/kg/24hrs 11-20kg = 1000ml + 50ml/kg for every kg above 10kg >20kg - 1500ml + 20ml/kg for every kg above 20kg/24hrs
Fluid deficit	Maintenance/hr x NPO time	
Ongoing loss	For 1ml blood loss 3ml crystalloid, for other losses 1:1	
3 rd space loss	Depends on the size of the wound or surgical site and ranges from 4-8ml/kg/24hrs	

- Maintenance volume: consider both sensible and insensible losses, Fluid deficit
 - shock, NPO time, Ongoing loss – bleeding, drainages, any GI loss, 3rd space loss fluid extravasation on the wound side

4.5.DVT and Pressure Ulcer Prophylaxis

A. Deep Vein Thrombosis (DVT) Prophylaxis:

VTE is one of the most common complications for an intensive care inpatient. Primary thromboprophylaxis reduces the morbidity and mortality associated with deep vein thrombosis (DVT) and pulmonary embolism (PE). For those patients not receiving an adequate VTE prophylaxis, the incidence of DVT is 10–28% , and the incidence of PE is 7–27%. The risk increases depending on the age, the weight, and a previous history of thromboembolic disease. The incidence could increase up to 85% if including the asymptomatic ones.

VTE Prevention

Thromboembolic risk prevention could be made with medications, through a mechanical way, or, more often, with a combination of those. The pharmacological and physical therapies represent a continuum of care led according to patient's characteristics, past and current medical history, surgical and traumatological condition, bleeding risk, and contraindications to both ways of proceeding.

Pharmacological Prophylaxis

Pharmacological VTE prophylaxis could be made with:

- low dose **ultra-fractionated heparin (UFH)**,
- low-molecular-weight **heparin (LMWH)**,
- **fondaparinux** (selective inhibitor of factor Xa), and
- **oral vitamin K antagonist**, chosen according to patient's risk.

Monitoring has to be carried out with **particular attention** as it needs to detect **signs and symptoms**:

- of VTE (*pain, redness, swollen legs, alterations of the breath and saturation, or the skin color*) and
- of bleeding (*external, visible internal, or not visible internal bleeding, anemia, and signs of hemorrhagic shock*)

B. Pressure Ulcer Prevention:

- Reposition patients regularly and use pressure-relieving devices (e.g., special mattresses or cushions).
- Perform skin assessments regularly.

5. ICU Discharge Protocol

The **ICU Discharge Protocol** ensures that patients who no longer require intensive care are safely transferred to an appropriate lower level of care, such as a general medical ward or intermediate care unit. This process requires thorough assessment, communication, and planning to guarantee patient stability and continuity of care. Below is a structured ICU discharge protocol:

5.1.Criteria for ICU Discharge

A patient is considered for discharge from the ICU when they meet the following criteria:

A. Clinical Stability:

- **Hemodynamic Stability:** Patient maintains stable blood pressure and heart rate without the need for continuous vasopressors or inotropes.
- **Respiratory Stability:**
 - Adequate oxygenation ($\text{SpO}_2 > 92\%$) on room air or low-flow oxygen (e.g., nasal cannula $< 4 \text{ L/min}$).
 - Patient has been successfully weaned off mechanical ventilation and non-invasive ventilatory support.
- **Neurological Stability:** Improved or stable neurological status with no immediate need for invasive monitoring.
- **Renal Stability:**
 - Adequate urine output ($> 0.5 \text{ mL/kg/hr}$) and stable renal function.
 - No ongoing need for continuous renal replacement therapy (CRRT) or dialysis in the ICU setting.
- **No Immediate Life-Support Needs:** The patient no longer requires continuous, advanced life support (e.g., invasive monitoring, critical infusions).

B. Resolution of Acute Issues:

- The acute illness or condition that necessitated ICU care has resolved or significantly improved, and no intensive interventions are needed.

C. Adequate Mental and Functional Status:



- Patient is conscious, oriented (or improving toward a normal mental status), and able to follow commands.
- Functional improvements allow them to participate in necessary rehabilitative therapies (e.g., physical therapy).

D. Appropriate for Lower Level of Care:

- The patient's condition can be safely managed in a general ward or step-down unit with intermittent monitoring and less intensive nursing care.

5.2. Discharge Decision Process

A. Daily Multidisciplinary Rounds:

- The ICU team (intensivists, nurses, respiratory therapists, dietitians, and physical therapists) should review the patient's condition daily to assess readiness for discharge.
- Criteria for discharge should be explicitly discussed during rounds.

B. Consulting Primary Team:

- The patient's primary or admitting team should be consulted regarding the discharge decision.
- Any unresolved issues or planned investigations or interventions should be coordinated between the ICU team and the primary team.

C. Patient and Family Communication:

- Discuss the discharge plan with the patient and their family.
- Explain the reasons for ICU discharge, the patient's progress, and what to expect in the new care environment.
- Address any concerns or questions they may have regarding the transition

5.3. Discharge Preparation

A. Ensure Clinical Stability:

- Confirm that the patient has remained clinically stable for a reasonable period, typically 24-48 hours, before transfer.
- Reassess and document the patient's vital signs, lab results, and any changes in condition before discharge.

B. Medical and Nursing Handoff:

- Perform a structured handoff to the receiving team using a standardized communication tool (e.g., **SBAR**).
 - **Situation:** Describe the patient's current condition and recent clinical course.
 - **Background:** Provide a brief history of the patient's admission to the ICU and key interventions.
 - **Assessment:** Detail the current clinical assessment, including vital signs, respiratory status, and laboratory results.
 - **Recommendation:** Outline the plan for ongoing care and any pending diagnostic tests or treatments.
- Ensure that the receiving medical and nursing teams understand the patient's current medications, any ongoing treatments, and specific care requirements.

C. Medication Review:

- Review the patient's medications to ensure they are appropriate for transfer. Adjust dosages or discontinue ICU-specific medications (e.g., sedatives, vasopressors).
- Provide a detailed list of medications and any changes for the receiving team.

D. Patient Transfer Documents:

- Prepare a comprehensive discharge summary for the receiving team, including:
 - Reason for ICU admission and treatment received.
 - Current diagnosis and clinical progress.
 - List of medications and treatments.
 - Specific care needs (e.g., wound care, oxygen therapy).
 - Pending investigations or interventions.

5.4. ICU Discharge Procedure

A. Stabilize the Patient for Transfer:

- Ensure the patient is stable during the transfer and that necessary medical equipment (e.g., oxygen, monitors) is available if needed.

B. Handoff to Receiving Unit:

- Transfer the patient to the designated ward or step-down unit with continuous monitoring if needed.
- Conduct a verbal handoff to the receiving medical and nursing teams.

5. Post-Discharge Monitoring

A. Follow-Up and Reassessment:

- After transfer, the receiving team should closely monitor the patient during the first few hours to ensure stability.
- The ICU team may provide guidance or assistance in the immediate post-transfer period if any concerns arise.

B. Escalation Plan:

- Establish a clear plan for re-escalation to ICU care if the patient deteriorates.
- The patient should be placed in a unit where they can be monitored for potential clinical decline, and early warning scores (EWS) or rapid response teams should be available if necessary.

6. Documentation

A. Discharge Summary:

- A detailed discharge summary should be prepared by the ICU team. This summary should include:
 - Patient's demographics and ICU admission details.
 - A concise summary of the ICU stay (e.g., treatments, interventions, complications).
 - Current clinical condition and the rationale for discharge.
 - Ongoing care needs, including medications, lab monitoring, and follow-up tests.

B. Progress Notes:

- Document the patient's progress leading up to the discharge decision, including their current clinical status.
- Record the patient's response to treatment and any remaining issues that will be followed in the receiving unit.

7. Special Considerations

A. End-of-Life or Palliative Care Transfers:

- If the patient is being transferred for palliative care or end-of-life care, ensure that the plan is communicated clearly to the receiving team and the patient's family.
- Ensure that Do Not Resuscitate (DNR) orders or other advance directives are documented and understood by the receiving team.

B. High-Risk Transfers:

- For patients at higher risk of deterioration post-ICU, consider a step-down unit or intermediate care setting where more intensive monitoring can be continued.
- Ensure that a plan is in place for frequent reassessment by the primary care team.

5.5. Discharge to Home or Long-Term Care

In some cases, patients may be discharged directly from the ICU to home or a long-term care facility:

A. Discharge to Home:

- Ensure that the patient is medically stable, can perform basic activities of daily living (ADLs), and has appropriate support systems at home.
- Arrange for home healthcare services if necessary, including physical therapy, nursing care, or respiratory support.

B. Discharge to Long-Term Care Facility:

- Coordinate with the receiving facility to ensure they are equipped to meet the patient's needs.
- Provide the facility with a comprehensive discharge summary and medication list.

6. REFERENCES

1. Ministry of Health Ethiopia: Critical care Pocket Guide, 2022.
2. An academy of American Cardiovascular and Pulmonary Physical therapy: ADULT VITAL SIGN INTERPRETATION IN ACUTE CARE GUIDE 2021.
3. Nursing in Critical Care Setting: An Overview from Basic to Sensitive Outcomes, Springer, 2018.