CRITICAL CARE IMMEDIATE DISCHARGE LETTER (CCIDL) NEW CHANGES

DISCHARGE DOCUMENTATION

Changes have been made to the IDLs from ICU to meet the needs of the Receiving ward, GP, Recovery team and patient (lay summary).

\icuidlelec and \icuidlemerg are now the same to make the transition easier and also prepares us for the future move towards our new clinical information system that will encompass a lot of these changes.

Below is some troubleshooting and suggestions to aid in completing the new IDLs.

LETTER FORMAT

Discharge to: (ward location)

Date of discharge:

Date of ICU admission/ICU stay duration: (can use WW to get total number of days on this admission, or from Pt Enq in EPR to find admission date)

Admission:

- Presentation and symptoms: (e.g. Found collapsed. Known IVDU)
- Referring Source: (e.g. ED/ Hospital transfer for PCI)

Primary diagnosis/diagnoses: (e.g. Long Lie / aspiration / AKI)

Critical Care complications: (e.g. VAP/ delirium/Critical illness polyneuropathy)

Significant Past Medical History:

Interventions: (e.g. vasopressors, prone ventilation, multiple antibiotics, CVVHD)

Clinical Progress - Time line of key events: (include relevant investigations, bullet point accepted)

Date of Intubation(s):

Date/type tracheostomy:

Date of Extubation(s)/decannulation:

Duration of mechanical ventilation: (WW should help to provide this)

Physiotherapy status with goals: See trak entry

Nutritional status with goals: see trak entry

Allergies:

Medication:

- Continuing
- Withheld
- Stopped
- New

Key points for review:

- Ongoing issues
- Medication
- Investigations / specialty referral

TEP completed:

Delirium status:

- In ICU: Y/N (if has been CAM-ICU +ve at any point during their stay)
- On transfer to ward: Y/N

Discharge NEWS:

EXAMPLE

THIS IS A CORE CRITICAL CARE DISCHARGE DOCUMENT INTENDED FOR THE RECEIVING WARD AREA

DISCHARGE WARD: Ward 107

DATE OF DISCHARGE: 01/05/23

DATE OF ICU ADMISSION/LENGTH OF STAY: 22/04/23 10 days

ADMISSION:

- REFERRING SOURCE: ED
- PRESENTATIONS AND SYMPTOMS: RUQ Pain, shocked

PRIMARY DIAGNOSIS:

1. Cholangitis

2. Choledocholithiasis

CRITICAL CARE COMPLICATIONS:

Delirium, agitations

SIGNIFICANT PAST MEDICAL HISTORY:

1. Known Gallstones
2. Alcohol excess
3. Obesity
4. Type 2 DM

INTERVENTSIONS IN CRITICAL CARE:

1. Invasive BP support, Noradrenaline

2. Antimicrobials

3. Percutaneous I/R gallbladder drainage

4. ERCP

CLINICAL PROGRESS / TIMELINE OF EVENTS:

DATE OF INTUBATION : N/A

DURATION OF MECHANICAL VENTILATION: 0

PHYSIOTHERAPY STATUS : SEE TRAK ENTRY

NUTRITIONAL TEAM STATUS: SEE TRAK ENTRY

ALLERGY: NKDA

MEDICATIONS:

- CONTIUNED – Thiamine, Bisoprolol
- WITHHELD – Metformin, Gliclazide
- STOPPED – Dapagliflozin, Co-codamol
- NEW – Actrapid, Tazocin, Paracetamol, Olanzapine

KEY POINTS FOR REVIEW:

- CONTIUNED ISSUES –
  Resolving delirium, managed well with Olanzapine
  Requires Cholecystectomy in future
  Drain management to be decided by surgical team

- MEDICATIONS
  Complete course of 7 days Tazocin
  Review ongoing need for Olanzapine as delirium settles
  Will need diabetic medication review as will not re-start SGLT-2

- INVESTIGATIONS / SPECIALTY REVIEWS
  Diabetic team review
  Surgical team planning

TEP COMPLETED:

Would be for re-referral to critical care and escalation to level 3 (ventilation, multi-organ support) if required.

DELIRIUM STATUS:

- IN ICU: Y
- AT DISCHARGE: Y

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NAME:

POSITION:

CONTACT:

PAGE: