



Complete Summary

GUIDELINE TITLE

Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Jul. 106 p. (Clinical guideline; no. 50). [63 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Acute illness in adult patients in hospitals

GUIDELINE CATEGORY

Evaluation
Management
Risk Assessment

CLINICAL SPECIALTY

Critical Care
Emergency Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Hospitals
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations to guide healthcare professionals in the appropriate care of acutely ill patients in hospital

TARGET POPULATION

Adult patients who become acutely ill in the hospital

Note: This guideline does not address care that should be provided to children, dying patients receiving palliative care or patients in critical care areas who are directly under the care of critical care consultants. It does not address the decision to discharge a patient from a critical care area.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Recording of physiological observations at initial assessment and as part of routine monitoring
 - Heart rate
 - Respiratory rate
 - Systolic blood pressure
 - Level of consciousness
 - Oxygen saturation
 - Temperature
2. Identification of patients whose clinical condition is deteriorating or is at risk of deterioration
3. Use of multiple-parameter or aggregate weighted scoring systems for track and trigger systems
4. Monitoring of additional parameters (e.g., urine output, biochemical analysis, pain assessment), as necessary
5. Critical care outreach services for patients whose clinical condition is deteriorating
 - Ensuring adequate education and training for hospital staff
 - Optimization of trigger thresholds for sensitivity and specificity
6. Use of a graded response strategy for patients at risk of deterioration (low-, medium, and high-score groups)
7. Transfer of patients from critical care to general wards
8. Care on the general ward following transfer

MAJOR OUTCOMES CONSIDERED

- Hospital mortality (survival to discharge), including number of unexpected deaths
- Adverse events (for example, cardiac and respiratory arrest and organ failure)
- Length of stay on acute wards and in Critical Care Areas
- Number of avoidable Critical Care admissions
- Number of readmissions into Critical Care Areas
- Functional status, health-related quality of life, and satisfaction with care

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
 Hand-searches of Published Literature (Secondary Sources)
 Searches of Electronic Databases
 Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Developing Key Clinical Questions

The third step in the development of the guidance was to refine the scope into a series of key clinical questions. These questions formed the starting point for the subsequent evidence reviews and facilitated the development of recommendations by the Guideline Development Group.

The key clinical questions were developed by the Guideline Development Group with assistance from the Short Clinical Guidelines Technical Team. As necessary, the questions were refined into specific research questions by the project teams to aid literature searching, appraisal, and synthesis. The full list of key clinical questions is shown in appendix 5.2 of the original guideline document.

The Guideline Development Group and Short Clinical Guidelines Technical Team agreed appropriate review parameters (inclusion and exclusion criteria) for each question or topic area. A full table of the included and excluded studies is shown in appendix 5.5 of the original guideline document.

Literature Search

The evidence reviews used to develop the guideline recommendations were underpinned by systematic literature searches following the methods described in "The guidelines manual 2006" (See the "Availability of Companion Documents" field). The purpose of systematically searching the literature is to attempt to comprehensively identify the published evidence to answer the key clinical questions developed by the Guideline Development Group and Short Clinical Guidelines Technical Team.

Substudies of the work commissioned by the National Institute for Health Research Service Delivery and Organisation (SDO) from Intensive care National Audit and Research Centre (ICNARC) (see section 3.3.10 of the original guideline document) were used as the basis of two of the evidence reviews. The search

strategies underpinning these systematic reviews were obtained from the authors and re-run across a number of databases to identify studies indexed from 2004 onwards.

The search strategies for the evidence reviews on discharge from critical care areas were developed by the Short Clinical Guidelines Technical Team, in consultation with the Guideline Development Group. Structured clinical questions were developed using the PICO (population, intervention, comparison, outcome) model and were translated in to search strategies using subject heading and free text terms. The strategies were run across a number of databases, with no date restrictions imposed on the searches.

To identify economic evaluations the National Health Service (NHS) Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED) were searched, and search filters to identify economic evaluations were appended to the strategies previously developed (see the original guideline document) to interrogate a range of bibliographic databases. There were no date restrictions imposed on the searches.

In addition to the systematic literature searches, the Guideline Development Group was asked to alert the Short Clinical Guidelines Technical Team to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The searches were undertaken between October 2006 and February 2007. Full details of the systematic search, including the sources searched and the MEDLINE strategies for each evidence review are presented in appendix 5.3 of the original guideline document.

NUMBER OF SOURCE DOCUMENTS

Identification and evaluation of risk scoring tools: 46

Response strategies for patients identified as having a deteriorating clinical condition: 20

Transfer of patients from critical care areas: 6

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence for Intervention Studies

Level of Evidence	Type of Evidence
1++	High-quality meta-analyses, systematic reviews of RCTs, or RCTs with

Level of Evidence	Type of Evidence
	a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias ^a
2++	High-quality systematic reviews of case-control or cohort studies High-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal ^a
3	Non-analytic studies (for example, case reports, case series)
4	Expert opinion, formal consensus

^a Studies with a level of evidence '-' should not be used as a basis for making a recommendation

Hierarchy for Evidence of Accuracy of Diagnostic Tests

Levels of Evidence	Type of Evidence
<u>Ia</u>	Systematic review (with homogeneity) ^a of level-1 studies ^b
<u>Ib</u>	Level-1 studies ^b
<u>II</u>	Level-2 studies ^c Systematic reviews of level-2 studies
<u>III</u>	Level-3 studies ^d Systematic reviews of level-3 studies
<u>IV</u>	Consensus, expert committee reports or opinions and/or clinical experience without explicit critical appraisal; or based on physiology, bench research or 'first principles'

^a Homogeneity means there are no or minor variations in the directions and degrees of results between individual studies that are included in the systematic review.

^b Level-1 studies are studies:

- That use a blind comparison of the test with a validated reference standard (gold standard)
- In a sample of patients that reflects the population to whom the test would apply.

^c Level-2 studies are studies that have **only one** of the following:

- Narrow population (the sample does not reflect the population to whom the test would apply)
- Use a poor reference standard (defined as that where the 'test' is included in the 'reference', or where the 'testing' affects the 'reference')
- The comparison between the test and reference standard is not blind
- Case-control studies

^d Level-3 studies are studies that have **at least two or three** of the features listed for level-2 studies.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Reviewing the Evidence

The aim of the literature review was to systematically identify and synthesise relevant evidence in order to answer the questions developed from the guideline scope. The guideline recommendations were evidence based where possible; if evidence was not available, informal consensus of opinion within the Guideline Development Group was used. The need for future research was also specified. The review process consisted of four main tasks: selection of relevant studies; assessment of study quality; synthesis of the results; and grading of the evidence. The Technical Analyst had primary responsibility for reviewing the evidence but was supported by the Project Lead, Information Scientist and Health Economist.

After the scope was finalised, searches based on individual key clinical questions were undertaken. The searches were first sifted by the Short Clinical Guidelines Technical Team using title and abstract to exclude papers that did not address the specified key clinical question. After selection based on title and abstract, the full texts of the papers were obtained and reviewed by the Short Clinical Guidelines Technical Team in order to determine which studies should be included in the literature review. Studies suggested or submitted by the Guideline Development Group and expert advisers were also reviewed for relevance to the key clinical questions and included if they met the inclusion criteria.

The papers chosen for inclusion were then critically appraised by the Short Clinical Guidelines Technical Team for their methodological rigour against a number of criteria that determine the validity of the results. These criteria differed according to study type and were based on the checklists included in 'The guidelines manual' (2006) (see the "Availability of Companion Documents" field). The checklists that were used in this particular guidance included checklist C for randomised control trials, checklist B for cohort studies, checklist F for diagnostic studies, and checklist F for qualitative studies. 'The data collection checklist' by the Effective Practice and Organisation of Care Group on controlled before-and-after studies was also used where relevant.

The data were extracted to standard evidence table templates. The findings were summarised by the Short Clinical Guidelines Technical Team into both a series of evidence statements and an accompanying narrative summary.

Grading the Evidence

Intervention Studies

Studies that meet the minimum quality criteria were ascribed a level of evidence to help the guideline developers and the eventual users of the guideline understand the type of evidence on which the recommendations have been based.

The Short Clinical Guidelines Technical Team used the system shown above in the "Rating Scheme for the Strength of the Evidence" field. It was the responsibility of the Guideline Development Group to endorse the final levels given to the evidence.

Diagnostic Studies

The system described above covers studies of treatment effectiveness. However, it is less appropriate for studies reporting diagnostic tests of accuracy. In the absence of a validated ranking system for this type of test, NICE has developed a hierarchy for evidence of accuracy of diagnostic tests that takes into account the various factors likely to affect the validity of these studies (shown in the "Rating Scheme for the Strength of the Evidence" field).

This evidence grading system was applied to the evidence review of track and trigger systems set out in section 2.1 of the original guideline document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Forming and Running the Short Clinical Guideline Development Group

The short clinical guideline for acutely ill patients in hospital was developed by a unique Guideline Development Group consisting of 14 members, two co-opted experts who attended two of the Guideline Development Group meetings, and the Short Clinical Guidelines Technical Team. The Guideline Development Group had a chair and healthcare professional members and patient/carer members who were recruited through open advertisement. A clinical adviser, who had specific content expertise, was also appointed. Development took 4 months and the Guideline Development Group met on three occasions, every 6 weeks.

Developing Recommendations

For each question, recommendations were derived from the evidence summaries and statements presented to the Guideline Development Group.

Evidence to Recommendations

The evidence tables and narrative summaries for the key clinical questions being discussed were sent to the Guideline Development Group 1 week before the Guideline Development Group meeting.

All Guideline Development Group members were expected to have read the evidence tables and narrative summaries before attending each meeting. The review of the evidence had three components. First, the Guideline Development Group discussed the evidence tables and narrative summaries and corrected any factual errors or incorrect interpretation of the evidence. Second, evidence statements drafted by the Short Clinical Guidelines Technical Team were presented to the Guideline Development Group, who agreed the correct wording of these. Third, from a discussion of the evidence statements and the experience of Guideline Development Group members, recommendations were drafted. The Short Clinical Guidelines Technical Team explicitly stated that the Guideline Development Group should consider the following criteria (considered judgement) when developing the guideline recommendations from the evidence presented:

- Internal validity
- Consistency
- Generalisability (external validity)
- Clinical impact
- Cost effectiveness
- Ease of implementation
- Patients' perspective
- Overall synthesis of evidence

The Guideline Development Group was able to agree recommendations through informal consensus. The process by which the evidence statements informed the recommendations is summarised in an "evidence to recommendations" section in the relevant evidence review of the original guideline document. Each recommendation was linked to an evidence statement if possible. If there was a lack of evidence of effectiveness, but the Guideline Development Group was of the view that a recommendation was important based on the Guideline Development Group members' own experience, this was noted in the "evidence to recommendations" section of the original guideline document.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

To assess the cost-effectiveness of strategies associated with the identification and response to acute illness, a systematic review of the economic literature relating to acutely ill patients was conducted. In addition, the Guideline Development Group and expert advisers were questioned over any potentially relevant unpublished data. The search of the published literature yielded no relevant economic studies, save for one book chapter that simply cited some cost estimates of outreach services. However, relevant ongoing and unpublished data were identified (Intensive Care National Audit and Research Centre [ICNARC] substudy 7: See section 3.3.10 of the original guideline document for further details) and made available to the Guideline Development Group and the Short

Clinical Guidelines Technical Team at the National Institute of Health and Clinical Excellence (NICE).

Despite limitations of the unpublished research (for example, its focus on outreach activity after intensive care unit [ICU] discharge), further economic modelling by the NICE health economist was considered unnecessary. The key features of this research are presented within the relevant clinical chapter of the original guideline document.

Health economics statements are made in the original guideline document in sections in which the use of National Health Service (NHS) resources is considered.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Every effort has been made to maximize the relevance of recommendations to the intended audience through the use of a guideline development group with relevant professional and patient involvement, by use of relevant experience expert reviewers, and the stakeholder process facilitated by the National Institute for Health and Clinical Excellence (NICE) Short Clinical Guidelines Technical Team.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Physiological Observations in Acute Hospital Settings

Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have:

- Physiological observations recorded at the time of their admission or initial assessment
- A clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:
 - Patient's diagnosis
 - Presence of comorbidities
 - Agreed treatment plan

Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.

As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring:

- Heart rate
- Respiratory rate
- Systolic blood pressure
- Level of consciousness
- Oxygen saturation
- Temperature

Identifying Patients Whose Clinical Condition Is Deteriorating or Is At Risk of Deterioration

Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy (see "Graded Response Strategy" below).

Choice of Physiological Track and Trigger System

Track and trigger systems should use multiple-parameter or aggregate weighted scoring systems, which allow a graded response. These scoring systems should:

- Define the parameters to be measured and the frequency of observations
- Include a clear and explicit statement of the parameters, cut-off points, or scores that should trigger a response.

Physiological Parameters To Be Used by Track and Trigger Systems

Multiple-parameter or aggregate weighted scoring systems used for track and trigger systems should measure:

- Heart rate
- Respiratory rate
- Systolic blood pressure
- Level of consciousness
- Oxygen saturation
- Temperature

In specific clinical circumstances, additional monitoring should be considered; for example:

- Hourly urine output
- Biochemical analysis, such as lactate, blood glucose, base deficit, arterial pH
- Pain assessment

Critical Care Outreach Services for Patients Whose Clinical Condition Is Deteriorating

Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation, and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.

The response strategy for patients identified as being at risk of clinical deterioration should be triggered by either physiological track and trigger score or clinical concern.

Trigger thresholds for track and trigger systems should be set locally. The threshold should be reviewed regularly to optimise sensitivity and specificity.

Graded Response Strategy

No specific service configuration can be recommended as a preferred response strategy for individuals identified as having a deteriorating clinical condition.

A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. It should consist of the following three levels.

- Low-score group:
 - Increased frequency of observations and the nurse in charge alerted
- Medium-score group:
 - Urgent call to team with primary medical responsibility for the patient
 - Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team, or a specialist trainee in an acute medical or surgical specialty.
- High-score group:
 - Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway management and resuscitation skills. There should be an immediate response.

Patients identified as "clinical emergency" should bypass the graded response system. With the exception of those with a cardiac arrest, they should be treated in the same way as the high-score group.

For patients in the high- and medium-score groups, healthcare professionals should:

- Initiate appropriate interventions
- Assess response
- Formulate a management plan, including location and level of care

If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant in critical care.

Transfer of Patients from Critical Care Areas to General Wards

After the decision to transfer a patient from a critical care area to the general ward has been made, he or she should be transferred as early as possible during the day. Transfer from critical care areas to the general ward between 22.00 and 07.00 should be avoided whenever possible, and should be documented as an adverse incident if it occurs.

Care on the General Ward Following Transfer

The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:

- There is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan
- That the receiving ward, with support from critical care if required, can deliver the agreed plan

The formal structured handover of care should include:

- A summary of critical care stay, including diagnosis and treatment
- A monitoring and investigation plan
- A plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
- Physical and rehabilitation needs
- Psychological and emotional needs
- Specific communication or language needs

When patients are transferred to the general ward from a critical care area, they should be offered information about their condition and encouraged to actively participate in decisions that relate to their recovery. The information should be tailored to individual circumstances. If they agree, their family and carers should be involved.

Staff working with acutely ill patients on general wards should be provided with education and training to recognise and understand the physical, psychological and emotional needs of patients who have been transferred from critical care areas.

CLINICAL ALGORITHM(S)

The original guideline document contains a clinical algorithm for Care Pathway (Assessment and Monitoring, Response, and Critical Care).

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence supporting each recommendation is identified and discussed in the "evidence review" sections of the original guideline document.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Reduced mortality, morbidity, and length of stay in both the hospital and in a critical care area

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer and informed by the summary of product characteristics of any drugs they are considering.
- The Guideline Development Group took into consideration the overall benefits, harms and costs of the evidence it reviewed. It also considered equity and the practicality of implementation when drafting the recommendations set out within this guideline. However, healthcare professionals need to use their general medical knowledge and clinical judgement when applying recommendations that may not be appropriate in all circumstances. Decisions to adopt any particular recommendation should be made in the light of the individual patient's views and circumstances as well as available resources. To enable patients to participate in the process of decision-making to the extent that they are able and willing, clinicians need to be able to communicate information provided in this guideline. To this end, recommendations are often supported by evidence statements that provide summary information to help clinicians and patients discuss options.
- The Guideline Development Group assumes that the healthcare professionals will use general medical knowledge and clinical judgement in applying the general principles and specific recommendations of this document to the management of individual patients. Recommendations may not be appropriate in all circumstances. Decisions to adopt any particular recommendation must be made by the practitioner in light of the circumstances presented by individual patients and available resources. Clinicians will need to share appropriately the information within this guideline to enable patients to participate in the decision making to the extent that they are able and willing.

DESCRIPTION OF IMPLEMENTATION STRATEGY

Key Priorities for Implementation

- Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have:
 - Physiological observations recorded at the time of their admission or initial assessment
 - A clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:
 - Patient's diagnosis
 - Presence of comorbidities
 - Agreed treatment plan

Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.

- Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.
 - Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
 - The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy.
- Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation, and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.
- A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. It should consist of the following three levels.
 - Low-score group:
 - Increased frequency of observations and the nurse in charge alerted.
 - Medium-score group:
 - Urgent call to team with primary medical responsibility for the patient
 - Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty.
 - High-score group:

- Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway management and resuscitation skills. There should be an immediate response.
- If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant in critical care.
- After the decision to transfer a patient from a critical care area to the general ward has been made, he or she should be transferred as early as possible during the day. Transfer from critical care areas to the general ward between 22.00 and 07.00 should be avoided whenever possible, and should be documented as an adverse incident if it occurs.
- The critical care area transferring team and the receiving ward team should take shared responsibility for the care of the patient being transferred. They should jointly ensure:
 - There is continuity of care through a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan
 - That the receiving ward, with support from critical care if required, can deliver the agreed plan

The formal structured handover of care should include:

- A summary of critical care stay, including diagnosis and treatment
- A monitoring and investigation plan
- A plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
- Physical and rehabilitation needs
- Psychological and emotional needs
- Specific communication or language needs

Piloting and Implementation

It is beyond the scope of the work to pilot the contents of this guideline or validate any approach to implementation. However, every effort has been made to maximise the relevance of recommendations to the intended audience through the use of a guideline development group with relevant professional and patient involvement, by use of relevant experienced expert reviewers and the stakeholder process facilitated by National Institute for Health and Clinical Excellence (NICE) Short Clinical Guidelines Technical Team. Implementation support tools for this guideline are available from the Implementation Team at NICE.

Audit Methods

The guideline recommendations have been used to develop clinical audit criteria for use in practice. Audit criteria are essential implementation tools for monitoring the uptake and impact of guidelines and thus need to be clear and straightforward for organisations and professionals to use.

Audit criteria are available on the NICE website (www.nice.org.uk; see also the "Availability of Companion Documents" field, below).

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides
Resources
Slide Presentation

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. London (UK): National Institute for Health and Clinical Excellence (NICE); 2007 Jul. 106 p. (Clinical guideline; no. 50). [63 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Jul

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group Members: Mrs Sheila Adam, Nurse Consultant in Critical Care; Dr Mary Armitage (*Guideline Development Group Chair*) Consultant Physician; Mr Peter Brewer, Patient/carer representative; Dr Brian Cuthbertson, Clinical Senior Lecturer and Consultant in Intensive Care; Dr Jane Eddleston (*Guideline Development Group Clinical Adviser*) Consultant in Intensive Care Medicine; Mr Peter Gibb, Patient/carer representative; Dr Paul Glynne, Consultant Physician in Acute Medicine and Critical Care; Dr David Goldhill, Consultant in Anaesthesia; Dr John Hindle, Geriatrician/Consultant Physician and Clinical Director for Medicine; Dr Paul Jenkins, Consultant in Acute Medicine; Dr Simon Mackenzie, Consultant in Critical Care; Dr Patrick Nee, Consultant in Emergency Medicine and Intensive Care Medicine; Professor Brian J Rowlands, Consultant Surgeon; Mrs Kirsty Ward, Registered Nurse

Short Clinical Guidelines Technical Team: Dr Tim Stokes, Guideline Lead and Associate Director – Centre for Clinical Practice (from December 2006); Nicole Elliott, Commissioning Manager; Michael Heath, Project Manager (from December 2006); Toni Tan, Technical Analyst, (from January 2007); Janette Boynton, Senior Information Scientist; Francis Ruiz, Technical Adviser in Health Economics; Emma Banks, Coordinator; Dr Jayne Spink, Associate Director – Centre for Clinical Practice (until December 2007); Dr Philippa Davies, Technical Analyst (until January 2007); Dr Françoise Cluzeau, Technical Adviser (until December 2007)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

A full list of all declarations of interest made by this Guideline Development Group is available on the NICE website (www.nice.org.uk).

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](http://www.nice.org.uk).

Appendices are also available in Portable Document Format (PDF) format from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](http://www.nice.org.uk).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. 7 p. (Clinical guideline; no. 50). Electronic copies: Available from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Acutely ill patients in hospital. Costing template. Implementing NICE. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. Various p. (Clinical guideline; no. 50). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Acutely ill patients in hospital. Costing report. Implementing NICE guidance in England. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. 27 p. (Clinical guideline; no. 50). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Acutely ill patients in hospital. Audit criteria. Implementing NICE. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. 15 p. (Clinical guideline; no. 50). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Acutely ill patients in hospital. Implementation advice. Implementing NICE. London (UK): National Institute for Health and Clinical Excellence; 2007. 22 p. (Clinical guideline; no. 50). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- Acutely ill patients in hospital. Presenter slides. Implementing NICE. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. 23 p. (Clinical guideline; no. 50). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- The guidelines manual 2006. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 April. Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).

PATIENT RESOURCES

The following is available:

- Monitoring patients in hospital and caring for them if their health becomes worse. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2007 Jul. 7 p. (Clinical guideline; no. 50).

Electronic copies: Available in [English](#) and [Welsh](#) in Portable Document Format Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1288. 11 Strand, London, WC2N 5HR.

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