Standard Operating Procedure		NHS Worcestershire Acute Hospitals NHS Trust

Operational and Admission Policy for the Coronary Care Unit, including Admission into Cardiology Ward

Department / Service:	Coronary Care Unit, Alex site
Originator:	Kelly Fee (Version 1)
	Reviewed for the Alex Site Marion Freeman, Matron Catherine Reid, Ward Manager
Accountable Director:	Dr Jasper Trevelyan
Approved by:	Divisional Management Board
Date of approval:	1st October in sub – DMB 25th November 2025 Directorate Cardiology meeting
First Revision Due:	1st September 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Coronary Care Unit
Target staff categories	Medical doctors Nursing staff Bed managers and flow coordinators Site Team ED physicians and nurses Cardiologists and cardiac specialist nurses

Clinical Guideline Overview:
This Standard Operating Procedure (SOP) document outlines for working practices for the Coronary Care Unit (CCU) at Alexandra Hospital. The purpose of this SOP is to ensure that patients with acute, life-threatening cardiac conditions receive specialised, intensive monitoring in the coronary care unit, improving clinical outcomes and optimising resource use. The SOP applies to all healthcare providers responsible for the triage, assessment, and admission of patients with cardiac conditions in hospital. This will also include one Coronary Care trolley in the procedure room which is ring fenced for special procedure such as temporary pacing, TOE, DCCV & ILR insertion. This ringfenced trolley will contain all the necessary sterile equipment and supplies needed for urgent or routine invasive cardiac procedures and emergency interventions.

Latest Amendments to this SOP:

Contents page:

Supporting Documents

Supporting Document 1 Equality Impact Assessment

Definitions

- CCU: Coronary Care Unit
- CPAP: Continuous Positive Airway Pressure
- TPW: Temporary pacing wire
- ACS: Acute Coronary Syndrome

Appendix 1

Levels of Care

1. Introduction

This SOP document outlines the anticipated working practices for the Coronary Care Unit (CCU) – Alexandra Hospital - within Worcestershire Acute Hospitals NHS Trust. The Coronary Care Unit (CCU) is situated on the ground floor near Ward 6. CCU consists of 4 mixed sex beds monitored beds which aims to deliver high quality, safe and effective medical and nursing care to patients who meet the criteria set out in this SOP.

CCU beds are designated for patients who have received or require cardiac monitoring and/ or acutely unwell because of their cardiac presentation. The purpose of the ring-fenced trolley in the pacing room is to ensure beds are always kept free 24/7 to facilitate special procedure and direct admission of patients requiring Temporary Pace Wire, DCCV, TOE as intervention for Acute Cardiac Condition.

CCU provides high level acute care to both male and female adult patients who requires specialist cardiology medical and nursing input using specialised equipment such as CPAP and TPW.

1.1 Operation of CCU

- Operational period from Monday to Sunday 24 hours
- Ratio of 1:2 registered nurses on CCU. The nurse in charge to have the CCU course. Cardiac competencies being launched.
- The Cardiology ward nurses and Consultants will be responsible for the care of all patients admitted into each bed.
- Cardiology Consultant review once daily from the hours of 8- 9am 7 days a week for patients within CCU.
- Multidisciplinary assessments/ treatment as required by the patients
- Patients that meet the criteria and have been discussed with the on-call Cardiologist if criteria uncertain can be admitted to CCU.
- Patients who are diagnosed with Acute Myocardial Infarction and require PCI following assessment will be admitted to directly to CCU.
- Bed capacity and decision making with regards to admissions will be the responsibility of the CCU Senior Nurse/ co-ordinator on duty who will liaise with the clinical site lead and capacity site managers.
- Once a Cardiologist review has happened and CCU care deemed no longer required, patients will be transferred to the Cardiology Ward for their on-going care or discharged if appropriate

- Once patient is deemed medically stable to transfer from CCU, patients must be transferred to same sex bay within 6 hours in accordance with Trust policy, CCU has mixed sex patients.

- Patients and relatives are included within the discussions regarding treatment and care if appropriate

- Continual close cardiac monitoring systems available to monitor patients' observations on a continuous basis if appropriate within CCU.

- Allocated pharmacist and technician cover for medicine management and review as appropriate (commencing May 2025)

- 8 Portable telemetry system available for patients requiring cardiac monitor within CCU, Cardiology Ward and other wards within the hospital

1.2 Admission Criteria / Inclusion to CCU

Admission criteria include

- Assessment, diagnosis and treatment of patients with Acute Myocardial Infarction and other Acute Coronary Syndromes (WAHT-CAR-043)
- Patients with haemodynamically significant brady or tachyarrhythmias (WAHT-CAR-040, WAHT-CAR-039)
- Acute Cardiogenic Pulmonary oedema with haemodynamic compromise who may require CPAP
- Cardiogenic shock
- Patients with ICD or pacemaker issues
- Patients following cardiac procedures (angioplasty, ablations)
- Patients awaiting Cardiac Surgery at local tertiary centres
- Heart Failure patients requiring advanced treatment (eg diuretics infusions, inotropic support, CPAP)
- Type B aortic dissection if antihypertensive control required (shared care with vascular surgery)
- Pulmonary Embolism requiring thrombolytic therapy
- Infective Endocarditis (at times)

1.3 Source of admission

- Direct via email advice and guidance service after consultant review
- ED
- AMU
- PPCI
- Elective procedure to remain over night from Cath Lab
- Clinic
- Repatriation from tertiary centres
- All ward areas depending on cardiac presentation and acuity of care

1.4 Exclusion Criteria

- **End-stage non-cardiac illness with limited life expectancy**
  - Advanced malignancy, end-stage liver disease, or end-stage renal failure not suitable for dialysis.
  - Patients under palliative or hospice care.

Do-not-resuscitate (DNR) or advanced directives limiting interventions

- Patients who have expressed a desire to forego aggressive life-sustaining treatment.

Non-cardiac primary diagnosis

- Patients admitted primarily for non-cardiac conditions (e.g., sepsis, trauma, stroke) that do not require specialized cardiac monitoring.
- These patients may be better managed in a general ICU, step-down unit, or other specialty ward.

Patients needing multi-organ support beyond CCU capabilities

- For example, mechanical ventilation with acute kidney injury requiring dialysis and vasopressor

Patients with conditions not benefiting from intensive monitoring

- Example: irreversible anoxic brain injury post-cardiac arrest without meaningful neurologic recovery.

Psychiatric **or behavioural issues without acute cardiac illness**

- Unless there's a concurrent cardiac condition needing specialized care.

1.5 Same Sex Accommodation

Ward and department managers are responsible for ensuring that no accommodation has mixed sex patients. In the event of a mixed sex incident or patient complaint this should be reported as an adverse incident using the Datix system and escalated to the Divisional Director of Nursing.

Level 2 Intensive Care Units, High Dependency Units, Coronary Care Units and Non-Invasive Ventilation Units can be a mixed sex environment (DH,2010)

Patients in these areas require more detailed observation or intervention in a critical care area to support a single failing organ system, or post- operative care and those ‘stepping down’ form higher levels of care. There is a higher ratio of nursing staff in

this area to assist patients to maintain their privacy and dignity. Compliance with DSSA is required within 6 hours of the patient being identified as sufficiently 'stable' to be transferred to a level 1 or 0 area within the Trust. This is WAHT local agreement. CCU has 4 beds, if one patient is awaiting a move to a cardiology step down bed and all other patients in the Unit are still requiring level 2 care, this would constitute one breach.

Decisions should be based on the needs of the individual patient while in CCU environments and their clinical needs will take priority. Decisions will be made to move patients around and step down to the Cardiology ward, Ward 6 to prevent a breach.

If a patient is ready to leave the Unit but this cannot be implemented there should be clear documentation and a record of actions to be taken to ensure transfer of the patient to appropriate same sex accommodation. WAHT-CG-521

2 Scope of this document

This document outlines the anticipated working practices of the Coronary Care unit and Cardiology ward and guidance criteria for admission into the CCU.

Guidelines for the treatment of ACS can be found in document

3 Responsibilities and Duties Responsibility

Matrons and ward managers are responsible for:

- Implementing this policy within clinical areas
- Investigating any incidents related to the use of this policy

The wards will remain open and operational 24 hours every day throughout the year.

When admission to the ward is required, we will endeavor to ensure that the length of stay is minimised, whilst delivering safe and effective care. The ward will support the Trust in delivering the organisational objectives relating to Cardiology care services.

All members of staff are responsible for ensuring their practice complies with this policy. The cardiology team is responsible for keeping up to date with current research and best practice and disseminating the information.

There is a named clinical lead for Cardiology and a named Cardiology consultant of the week 7 days a week with a named-on call cardiology interventionist on call for the service of PPCI.

- All nurses are responsible for practicing within the NMC code of conduct, performance and ethics for nurses and midwives.
- A full nursing assessment will be undertaken and re-evaluated as specified and clearly documented as per Trust Guidelines.

- Escalation to appropriate multidisciplinary team, i.e. medical doctors, Acute Heart Failure Nurse, Arrhythmia Nurses and Cardiac Rehabilitation Nurses, night practitioners and Critical Care outreach
- Assessment and monitoring of patients' physical, emotional and psychological needs
- Establish patient centered goals in collaboration with patient and carers participation including advice and support
- Timely coordinated discharge planning incorporating patients, family and carers

4 Policy detail

CCU and Cardiology ward will accept patients 17 years of age and over* (16 and over already) presenting with cardiology conditions for assessment, investigation and diagnosis, in relation to the most appropriate plan of care and treatment. Patients will be accepted for acute, chronic and palliative management of cardiology conditions.

(*NB patients that are 16 and 17 years of age will be managed with adherence to the Trust policies on Safeguarding)

A) Objectives

- Deliver and maintain high quality, safe and effective patient care
- Respect patients' rights to autonomy, privacy and dignity
- Benefit patients and minimize the risk of harm
- Provide fair access to all patients
- Maintain a safe, comfortable and clean environment for all patients and relatives.
- Implement relevant Trust policies and protocols to practice evidence-based medicine
- Operate using a multi-disciplinary team approach to facilitate early and safe discharge.
- Maintain support for staff, including providing an acceptable working environment and facilities, opportunity for professional development and a supportive team environment
- Maintain staffing at safe and appropriate levels
- Meet educational needs for staff and trainees and for the wider health community
- Reliably collect data about all aspects of care to demonstrate, in a way that would support external review, that we are delivering care to the highest standards.

B) Benefits

The provision of focused CCU high care within a specialist ward brings with it an opportunity to establish a new way of working. This will particularly reflect the Trust's priorities as below:

- improve patient flow through the hospital system

- reduce length of stay for inpatients
- reduce readmission rates
- provide consistent single sex accommodation for patients, where possible
- provide specialist acute cardiology medical and nursing care
- establish a multidisciplinary team approach to caring for patients in a holistic manner
- maintain training in specialist Cardiology care and competencies of staff working on the ward

C) Admission Procedure

A. Transfer of a cardiology case should take priority over any non-cardiac internal medical transfer into CCU. If there are no cardiology outliers and no suitable Cardiology patients in ED, we will accept and admit non-cardiac patients to help the flow within ED and the hospital.

An empty CCU trolley in the Procedure Room will be always maintained for special procedures.

Admission to a CCU bed will only occur after discussion with the appropriate Cardiology consultant, registrar or ward nurse in charge, (whichever is available at the time of transfer).

Transfer from ED, Emergency admissions from Cardiac Catheter Lab and Worcester Heart Centre or cardiology out-patients may also occur during the day following assessments from Cardiology Consultant and Cardiac Specialist nurses. This will be communicated with Capacity to make sure they are aware of admissions.

5)Admission Criteria to CCU

Priority will be given to the following groups of acutely unwell Cardiology patients, requiring Level 1a and 2 specialist cardiology care, from the ED, and other hospital wards or other trusts:

- All patients requiring medical and nursing assessments for Acute Coronary Syndrome
- All patients requiring angiograms must be managed on CCU or Ward 6 (high care or non-high care bed depending on patient stability and ward case mix) and receive priority transfer.
- Patients requiring pacemaker insertion as an inpatient
- Patients stepping down from Level 2 critical care (ICU); who do not require the medical or nursing input provided by High Care Unit, but have specialist cardiology nursing requirements

- Patients with any feature of an acute (exacerbation) of heart failure and may require CPAP
- Patients being treated for Endocarditis in which the diagnosis has been confirmed by a Cardiologist
- Patients who require medical and nursing intervention for life threatening arrhythmia
- Patients post cardiac arrest who do not require ventilator support
- Any patients in which the cardiology consultant have asked to be transferred to CCU as a priority above other patients awaiting transfer due to clinical need not listed here.
- Patients with severe symptomatic aortic stenosis
- Patients with haemodynamically unstable arrhythmias

Admissions from other hospitals / trusts: Patients requiring transfer to CCU for repatriation following surgery, transfer for pacemaker insertion from WRH should be discussed with and accepted by the cardiology consultant or registrar and on liaison with ward staff and the bed manager the patient can be transferred when a suitable bed becomes available.

b/. Step down from High Care Unit

CCU patients should be "stepped down" when no longer fulfilling the admission criteria. They should be moved into a cardiology ward bed (Ward 6). If a suitable cardiology bed is not available, another patient who does not require cardiology care should be transferred to a medical ward.

Patients admitted from another specialty ward for acute CCU treatment should be moved back to this ward, if appropriate, for further specialist care once ccu care no longer required.

Patients from CCU should not be outlined directly to other wards unless discussed with the Cardiology medical team first.

Patients that are identified to be able to step down from CCU should be move out within 6 hours or bed spaces arranged, to not cause a mixed sex breach. In the event that this is not possible, it should be escalated to senior nursing and medical team, datix should be submitted and the patient should have a recording on OASIS.

c/. Discharge Process

The ward will comply with Trust policy in that planning for discharge will commence on initial assessment of the patient.

The electronic discharge summary (EDS) will be completed by the medical staff prior to the patient leaving CCU.

Should a patient require a follow-up clinic appointment, this must be documented on the EDS and booked through the established channels for each of the subspecialty clinics. Follow up with other teams requires direct communication, Ward Clerks liaising with secretaries for follow up on patient discharge.

d/. Infection control and patient isolation

There are general principles to be adhered to within the Trusts Isolation and Bed Management Policy (WHAT-INF-045). There is no side room on CCU. If CCU are unable to isolate due to clinical need then strict standard infection control or transmission-based precautions should be adhered to and that clinical need will outweigh the IPC issues except where a high consequences infectious disease is present e.g. Viral Hemorrhagic fever. Please contact IPC, ward manager and matron.

e) Medical Care

The consultant responsible for the ward patients at any one time is named according to an agreed rota, available both on the ward and via the secretaries in the cardiology department. This will be clearly documented in the electronic patient record and above the bed space.

All patients on CCU will be reviewed by a doctor on a daily basis 7 days a week including bank holidays. Those identified as unstable will be seen first and once the most unwell patients have been seen the team will endeavor to support discharges as early in the day as possible.

The medical team, led by the ward consultant, and nurse in charge will conduct a full board round of ward patients before the physical ward round 7 days a week. There will be a trouble shooting board round in the afternoon between at least one doctor and the nurse in charge to expedite discharges and manage emerging clinical and bed allocation issues.

The nursing staff will alert the doctors when patients need to be reviewed outside these times, in accordance with Trust NEWS trigger policy.

In the event of a cardiac arrest or a patient requiring urgent medical assistance, a cardiac arrest call will be placed via switchboard (2222). The medical emergency team will attend the ward in line with the Trust policy.

All new doctors starting with the cardiology team will receive a local induction for orientation to the ward and cardiology team.

f) Nursing Care

CVCU will be staffed 24 hours a day, 7 days a week.

A dedicated nursing lead will be allocated. Each shift will have an overall nurse in charge who will take responsibility for the adequate staffing and smooth running of CCU. This nurse will be able to advise on whether a patient meets the admission criteria for CCU. This nurse will also attend to operational demands of each shift and will support the nurse in charge of each individual team to ensure that all aspects of hospital policy are adhered to, e.g. documentation, infection control etc.

These teams will provide a coordinated and appropriate level of cardiology care, with a shared workload, in order to provide equitable care for all patients. All nurses will be expected to assist with other teams in order to deliver safe care.

The senior nurse will ensure ward rounds are undertaken in a timely fashion and inform bed managers daily of specialist beds required and those suitable to step out of CCU, to facilitate patient flow and ensure specialist input is received.

There will be a formal nursing handover process from one shift to the next to ensure safe and efficient care for the patients and early discharge planning. And contribute to MINAP data collection.

g) Model of Multidisciplinary Team Approach

A multidisciplinary board round will take place daily to discuss assessments, care plans and to contribute to a safe and efficient discharge process, as part of the SAFER patient flow bundle. Those attending the board round include Consultant, NIC, Registrars (if available), junior doctors, Physician Associates, Physiotherapist, occupational therapist (if available) and ward pharmacist.

The Coronary Care Unit and Ward 6 will use a multi-disciplinary approach to enable the holistic care of patients and to enable early safe discharge whenever possible. This will incorporate the skills of the following services:

- Specialist Cardiology nurses
- Nurse practitioners
- Palliative Care Specialist Nurses
- Physiotherapists
- Occupational Therapists
- Speech and Language Therapists
- Pharmacists
- Social Services
- Onward care team
- Dieticians
- Diabetes specialist nurses
- Tier 2 physicians assistants at times

Specialist Cardiology Nurses:

The cardiology specialist nurse (CNS) team within the hospital will support patients with discharge.

Physiotherapists:

Physiotherapists based on cardiology will have a special interest in cardiology physiotherapy, enabling faster recovery from acute illness.

The physiotherapy team will attend the ward daily to review new and known referrals. They will also liaise with other teams to improve patient discharge flows.

For patients with an urgent Cardiology problem requiring physiotherapy out of hours, the on-call physiotherapist is available and can be contacted via Switchboard.

Occupational Therapists (OT):

The occupational therapy team will be directed to patients requiring their input by the nursing, medical or physiotherapy staff, by means of a telephone or electronic referral. They will endeavor to see these patients at their earliest opportunity to enable a safe discharge to the community.

Speech and Language Therapists (SALT)

The Speech and Language Therapy (SLT) are available to assess and manage patients with dysphagia and can be contacted via ICE.

Pharmacists:

The ward-based pharmacy team will visit daily (Monday to Friday) to complete patient medicines reconciliation, clinically check medication to ensure safe and appropriate prescribing, provide clinical advice or information as appropriate, and facilitate timely supply of medication to the ward and the dispensing and checking of discharge prescriptions. They will also join the clinical ward rounds wherever possible to integrate into the team approach to patient care.

Social Services/Patient Flow Centre

Social workers will be involved in arranging placements and packages of care to patients discharged from the ward and will be contacted by the nursing staff by means of electronic or telephone referral systems.

Support Staff/Admin/Clerks/Housekeepers

CCU and ward 6 have a shared ward administrator, ward clerk and housekeeper, Monday – Friday enabling timely patient admission or discharge and the provision of efficient clerical service.

6 Implementation

6.1 Plan for implementation

The Corporate nursing team will oversee the effective communication of the approved SOP to all relevant staff. This includes informing general managers, heads of department, heads of nursing, matrons and ward managers, that the policy is accessible via the policy link on the Trust Intranet.

The policy will be discussed within the cardiology directorate meeting.

6.2 Dissemination

The Policy will be placed on the Trust's Intranet cardiology page and all staff made aware using the Trust Update, Trust-wide e-mail process and in regular Trust briefings.

Line managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new key documents and policy changes.

The key staff identified in this policy will be informed of the policy and any changes to it directly by their line managers and advised that adherence is an essential requirement of their practice.

Staff may print key documents at need but must be aware that these are only valid on the day of printing and must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet-based system.

Individual members of staff have a responsibility to ensure they are familiar with all key documents that impinge on their work and will ensure that they are working with the current version of a key document. Therefore, the Intranet must be the first place where staff looks for a key document.

Relevant key documents and guidelines will be available on the Trust's Internet.

6.3 Training and awareness

Awareness will be raised by the dissemination of this policy to all staff via the Intranet and through Trust updates. Access to key documents is also included in the Trust's induction programme.

Mandatory Annual Training & Cardiology Competencies:

Clinical staff providing care to patients are expected to complete Annual Mandatory Training. In addition to this, staff will be expected to complete on-going and bespoke training including specific cardiology competencies including CPAP, TPW on the Worcester site/Alex Site. The Senior Management and Clinical team review Mandatory Annual Training and cardiology Competencies compliance for all staff on an on-going basis.

Risk Register

The risk register will be reviewed any Cardiology risks will be identified and action taken to minimise these risks. The units will review the risk register according to the timescales outlined. Significant risks will be reviewed and actioned at Divisional Quality Assurance meeting.

Adverse Incident Reporting

All staff are encouraged to report adverse incidents and near misses through the Datix system. This reporting mechanism will help to improve standards of care and will minimise risk to patients, staff and visitors. Learning from adverse incidents occurs via team meetings.

7 Monitoring and compliance

Lead clinicians, Matrons, Ward and Department managers are responsible for ensuring staff comply with this policy.

Individual staff members must be aware of the policy and ensure that their clinical practice is in line with its guidance.

Monitoring and compliance against this policy is the responsibility of the Cardiology Medical Directorate Group, as outlined below:

- Audit:
- Patient & Staff Surveys: Annual surveys and review.
- Complaints, incident and Datix review: discussion and review at the Cardiology Directorate clinical governance meetings as required.
- Capacity & Demand: reviewed weekly, actions taken if necessary.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Appropriate Patients admitted into CCU and General Cardiology ward beds	Clinical eligibility Essential cardiac tests Risk stratification Referral pathway Bed appropriateness Documentation Timeliness Initial management Safety and Handover Datix	Directorate cardiology meeting	Cardiology Directorate	Cardiology Directorate Meetings	6-10 times a year
	Organisational aspects of care delivery for ACS patients	MINAP Timely access to care Staffing and senior review Diagnostic capability Treatment pathways Medication and secondary prevention Data recording audit Communication and handover	Directorate cardiology meeting	Cardiology Directorate	Cardiology Directorate Meetings	6-10 times a year
	Monitor ACS standards	PCI database and regional ACS dataset Data completeness Data accuracy Timeliness of entry	Directorate cardiology meeting	Cardiology Directorate	Cardiology Directorate Meetings	6-10 times a year

		Alignment with SOP definitions Validation and quality checks Governance and sign off Data security and confidentiality Feedback to clinical teams and to track improvements against audits/information at Directorate meetings				

8 Policy Review

This SOP will be reviewed every year.

9 References

Safer Nursing Care Tool	Supported by NHS England

10 Background

10.1 Equality requirements

The assessment conducted for this policy reveals no equality issues. The record of the assessment is held in the Clinical Governance Department. (Supporting Document 1)

10.2 Financial risk assessment

A financial risk assessment has been performed and reveals there are no financial implications to this policy. (Supporting Document 2). – No financial impact

10.3 Consultation

Contribution List

This key document has been reviewed in the cardiology Directorate meeting and has been circulated to the following individuals for consultation;

Cardiology Consultants	Dr A Ammar
	Dr M Apostolakis
	Dr F Formisano
	Dr W Foster
	Dr D Goyal
	Dr C Mcaloon
	Dr L Mughal
	Dr D Ramnarase
	Dr H Routledge
	Dr W Roberts
	Dr A Saffy
	Dr O Shaikh
	Dr D Smith
	Dr R Taylor
	Dr J Trevelyan
	Dr D Wilson
Lead nurse cardiology specialist nurse teams	Kerry O'Dowd

Director / heads of Nursing, Matrons	DDN Rebecca Moore
	DDDNJuliet Hawkesford-Barnes
	Matron Marion Freeman Catherine Reid, Ward Manager
Medical Director	David Raven
Head of Clinical Governance & Risk Management	Dominique Thorne
Health and Safety Manager	Julie Noble

This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Committee
DMT sub committee – 1st October 2025
Directorate Cardiology Meeting – 25th November 2025

10.4 Approval Process

Divisional Management Board pending

Appendix 1: Levels of Care

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	Care requirements may include the following • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • Early Warning Score is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	Care requirements may include the following • Increased level of observations and therapeutic interventions • Early Warning Score - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation / invasive monitoring • Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.	Care requirements may include the following • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability / Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) • Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End-of-Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse - Continuous cardiac monitoring and invasive pressure monitoring

Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	• Deteriorating / compromised single organ system • Post-operative optimisation (pre-op invasive monitoring) / extended post-op care. • Patients requiring non-invasive ventilation / cardiology support; CPAP • Requires a range of therapeutic interventions including: • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced cardiac support and / or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems • Cardiac compromise requires mechanical / invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection