

# Key Capabilities for High Dependency Critical Care Units in Small and Remote Hospitals

This guidance is designed to complement the Minimum Standards and Quality Indicators for Critical Care in Scotland Version 4 (Scottish Intensive Care Society Audit Group and Scottish Intensive Care Society) and the Guideline for the Provision of Intensive Care Services Version 3 2025 (The Faculty of Intensive Care Medicine and Intensive Care Society).

For the purpose of this document, High Dependency Care includes both Level 1 and Level 2 Care.

These key capabilities are intended to support the delivery of person-centred, safe, effective, equitable and evidence-based care. They provide a framework to enable small and remote hospitals to:

- Identify and reduce unwarranted variation
- Drive local and national improvement initiatives

Key capabilities represent skills that all High Dependency Units (HDUs) in small and remote hospitals should aim to achieve, and serve as fundamental assurances of safety and competence.

Please note that PICU (Paediatric Intensive Care Unit) was not within the remit of the Centre for Sustainable Delivery (CfSD) small and remote Task and Finish Group responsible for creating this document.

Key Capabilities
Should provide a senior decision maker ward round every day.
Ensure that a specialist doctor with autonomous practice sees every emergency HDU patient within 14 hours of admission.
Should be able to provide continuous invasive and or non-invasive monitoring of patient vital signs.
Should be able to manage invasive monitoring safely, such as arterial and Central Venous Catheters lines.
Should ensure that a minimum registered nurse-to-patient ratio of 1:2 for Level 2 patients receiving direct care.
Should be able to safely manage patients without the physical presence of a resident anaesthetist.
Should be able to safely manage infusion pumps.
Should be able to safely manage peripheral and/or central vasoactive infusions, such as vasopressors.
Should be able to manage enhanced respiratory support safely (e.g. High flow nasal oxygen and Non-invasive ventilation).



Should be able to safely manage a patient with an intercostal chest drain.
Should have a supportive network structure that helps all staff feel confident in caring for HDU patients.
Should have immediate access to telemedicine advice from a linked Level 3 unit or retrieval service. The linked Level 3 unit should be resourced to reflect its role in providing support, advice and education to partner referring units.
Should hold regular, structured multidisciplinary or clinical governance meetings with a linked Level 3 unit (or retrieval service). These meetings should review morbidity and mortality, inter-hospital transfers, and include learning from all deaths, critical incidents, near misses and examples of good practice.
Should have necessary resources in place to participate in and submit accurate data to a national critical care audit programme.
Should have a clear knowledge of referral pathways for tertiary referrals (e.g. neurology, neurosurgery, liver and cardiology).



## Appendix 1 – Definitions

**Small and Remote Units** – Small and remote critical care units are those of a small size (catchment population of less than 200,000) or their remoteness (more than 30km from the next nearest intensive care unit). For the purpose of this group, these small and remote hospitals provide Level 2 beds accompanied by a stabilisation and transfer service for Level 3 care. This definition has been taken from the '[Guidelines for the Provision of Intensive Care Services, The Faculty of Intensive Care Medicine V3](#)'.

**Senior Decision Maker** - Refers to a clinician, typically a consultant or other highly experienced healthcare professional, who is responsible for making timely, informed decisions about a patient's care, especially at critical points such as admission, discharge, or escalation of treatment.

**Specialty and Specialist (SAS) Doctors** – SAS doctors (Specialist, Associate Specialist and Specialty Doctors) are experienced doctors in permanent posts. There are two current SAS contracts available:

- Specialty doctors have at least 4 years of full-time postgraduate experience, including 2 years in their relevant specialty.
- Specialists have at least 12 years postgraduate experience, including 6 years in their relevant specialty.

Specialists work independently within their clinical areas.

