CCSO Office Use Only:
This application was received by: _____ on date: _____ Request ID:_____
After carefully reviewing the application, this request was ☐ Approved ☐ Declined ☐ Pending
Comments:

CRITICAL CARE SERVICE INVENTORY

CHANGE REQUEST FORM

Please note the following before completing this form:

1. The form must be completed in full and signed by the appropriate signatories (Hospital CEO and Critical Care LHIN Leader) before it can be processed.

2. Our acknowledgement of your submission does not imply that the request will be approved. A review and approval process follows receipt of the completed application. Applicants will be informed of the outcome of each request via email/letter.

3. Each change request form will be reviewed based on alignment with the accountabilities outlined in the Hospital Accountability Agreements and based on the principle of maintaining and sustaining critical care capacity across the province.

PLEASE COMPLETE ONE FORM FOR EACH CHANGE REQUEST

PLEASE SEE PAGE 6 FOR A LIST OF DEFINITIONS OF THE TERMS USED IN THIS FORM

For information about this form, please contact:
Critical Care Services Ontario
Phone: 416-340-4800 x 5577
Email: ccsadmin@uhn.ca

HOSPITAL INFORMATION

LHIN Name: _____

Hospital Corporation Name: _____

Site Name (if applicable): _____

Unit Name: _____

(Please use the unit name in the Critical Care Information System)

Unit Administrator (Contact person regarding queries about the application):

Name: _____

Telephone: _____

Email: _____

TYPE OF CHANGES

Please select type(s) of changes requested:

☐ Bed capacity – Section 1

☐ Unit name and/or site name and/or corporation name – Section 2

☐ Level of care and/or type of unit – Section 3

☐ Addition of a new unit – Section 4

Note: This does not include anticipated seasonal/temporary bed changes to service levels (for example, constructions, summer/bed closures or operating room closures etc.).

CHANGE DETAILS

SECTION 1 – Change to the bed capacity

Please fill out this section to request an increase and/or decrease in the number of critical care beds and/or beds capable of mechanical ventilation.

1.1. BED INCREASE if applicable:

☐ Increase in the total number of critical care beds from ____ to ____ beds.

☐ Increase in the total number of beds capable of mechanical ventilation from____ to ____beds.

Please identify the funding source for the bed increase. For CCSO funding, direct funding from the LHIN, and PCOP funding please refer to the funding letter for details required below. Please check all that apply:

☐ 1. Administered through Critical Care Services Ontario (via the Local Health Integration Network):
please reference the date on the Funding Letter: _____ (MM/DD/YYYY)

☐ 2. Direct funding from the Local Health Integration Network:
please reference the date on the Funding Letter: _____ (MM/DD/YYYY)

☐ 3. Capital expansion through the Ministry of Health and Long-Term Care (PCOP):
please reference the date on the Funding Letter: _____ (MM/DD/YYYY)

☐ 4. Reallocation of hospital base funding

☐ 5. Open critical care beds in one unit because of critical care bed closure in another unit

☐ 6. Other (please specify below):

1.2. BED DECREASE if applicable.

Each change request in this category is evaluated based on the previous MOHLTC or LHIN funding received by the hospital/unit to support their critical care capacity and services. Please answer questions below prior to proceeding with the bed decrease request (check all that applies).

Has the unit /hospital received funding from MOHLTC or LHIN to support critical care capacity and services?

☐ Critical Care Capacity Funding

☐ Nurse Training Funding

☐ Critical Care Response Team (CCRT) Funding

☐ PCOP Funding

☐ Other funding from MOHLTC or LHIN (please specify)

Efforts to support critical care capacity or access to critical services with any of the above mentioned funding may impact the approval of your application.

Bed Decrease Request:

☐ Decrease in the total number of critical care beds from ____ to ____ beds.
☐ Decrease in the total number of beds capable of mechanical ventilation from____ to ____beds.

Please identify the reason(s) for the bed decrease:

☐ Insufficient internal hospital budget
☐ Insufficient staffing resources
☐ Current capacity not required due to patient volume
☐ Closure of critical care beds in one unit to open critical care beds in another unit
☐ Other - please specify below:

Additional comments:

SECTION 2 – Change to the unit name and/or site name and/or corporation name

The new **UNIT** name is: _____

The new **SITE** name is: _____

The new **CORPORATION** name is: _____

SECTION 3 – Change to the unit level of care

3.1. Unit Level of Care Increase

Please indicate the new functional level of care for the unit:_____

3.2. Unit Level of Care Decrease

Each change request in this category is evaluated based on the previous MOHLTC or LHIN funding received by the hospital/unit to support their critical care capacity and services. Please answer questions below prior to proceeding with request to unit level of care decrease (check all that applies).

Has the unit /hospital received funding from MOHLTC or LHIN to support critical care capacity and services?

☐Critical Care Capacity Funding
☐Nurse Training Funding
☐Critical Care Response Team (CCRT) Funding
☐PCOP Funding
☐Other funding from MOHLTC or LHIN (please specify)

Efforts to support critical care capacity or access to critical services with any of the above mentioned funding may impact the approval of your application.

Level of Care Request:

Please indicate the new functional level of care for the unit: _____

Please specify the reason(s) for the change in the level of care below:

SECTION 4 – Change to the unit type

New type of unit: (Choose only one response).

☐ General ICU

☐ Coronary Care Unit (CCU)

☐ Cardiac Surgery Unit/Cardiovascular Unit

☐ Mixed ICU/CCU (integrated coronary care and general intensive care unit)

☐ Paediatric ICU

☐ Burn Unit

☐ Neurosurgical ICU

☐ Other: Please Specify:_____

Please provide the following contact information for the **lead physician** for this unit (e.g. ICU Director):

Name: _____Title: _____

Telephone: _____E-mail: _____

Please provide the following contact information for the **lead nurse** for this unit (e.g. Nurse Manager):

Name: _____Title: _____

Telephone: _____E-mail: _____

CEO AUTHORIZATION

I have reviewed the Critical Care Information System 'Change of Request' form and confirm that it accurately reflects the current critical care capacity in this unit.

_____	_____	_____
Hospital CEO Name	Hospital CEO Signature	Date

CRITICAL CARE LHIN LEADER AUTHORIZATION

I have reviewed the Critical Care Information System 'Change of Request' form and confirm that it accurately reflects the current critical care capacity in this unit.

_____	_____	_____
CC LHIN Leader Name	CC LHIN Leader Signature	Date

PLEASE NOTE: our acknowledgement of your submission does not imply that the request will be approved. A review and approval process follows receipt of the completed application. Applicants will be informed of the outcome of each request via email/letter.

Completed form with **appropriate signatures** should be returned to**:**

1. **Critical Care Services Ontario via fax or email**
   Fax: (416) 340-4920
   Email: ccsadmin@uhn.ca
2. **Your LHIN CEO**
3. **Your Critical Care LHIN Leader**

DEFINITIONS

1. **NUMBER OF CRITICAL CARE BEDS**: The normal maximum number of beds in operation outside of periods when beds are closed due to issues such as staffing or infectious situations.

2. **NUMBER OF MECHANICAL VENTILATED BEDS**: The total number of beds in your unit that are capable of supporting patients who are invasively ventilated. Note, this should be the normal maximum number of beds that can support invasively ventilated patients and should not exceed your unit's total bed count.

3. **LEVEL OF CARE**: Defined according to the main criteria of the type of support provided to ventilated patients.

   Level 2

   Capable of providing service to meet the needs of patients who require more detailed observation or intervention including support for a single failed organ system, short-term non-invasive ventilation, post-operative care, patients "stepping down" from higher levels of care or "step ups" from lower levels of care. These units provide a level of care that falls between the general ward (Level 1) and a "full service" Critical care unit (Level 3).
   Level 2 units do not provide invasive ventilation support.

   Please Note: Critical care units that provide invasive mechanical ventilation for a short period (for example $\leq$ 48 hours) but need to transfer those patients who require more long-term invasive ventilation to a Level 3 unit are considered Level 2 for the purposes of the service inventory.

   Level 3

   Capable of providing the highest level of service to meet the needs of patients who require advanced or prolonged respiratory support, or basic respiratory support together with the support of more than one organ system. This is generally considered a "full service" Critical Care unit despite the fact some specialized services may not be available (e.g. dialysis). All Level 3 units are capable of invasive ventilation support.

4. **TYPE OF UNIT**: Primary mandate of the unit based on the patient population managed in the unit (i.e. medical, surgical, vascular etc.).