UNIT ORIENTATION GUIDE
2016

Welcome to Bendigo Health
# Intensive Care Unit

## UNIT DESCRIPTION

Welcome to the Bendigo Hospital Intensive Care Unit.

The following are included here:

- Summary of your role & daily duties
- Outline of daily ward routine & business functions.
- Daily ward round presentation

## KEY CONTACTS

**Intensivists:**
- Jason Fletcher (Director)
- Emma Broadfield (Supervisor of Training)
- Sanjay Porwal
- Cameron Knott
- John Dyett
- Janice Yeung

**Nurse Unit Manager:** Sue Tomlinson

**ICU Clinical Nurse Consultant:** Jenni Tuena
**ICU Educators:** Kim Fuzzard
  - Sally Evans

**Liaison Nurses:**
- Sally Evans
- Kelly McCuskey
- Sarah Dyer
- Marie McLeod
- Judith Downie

**Research Nurse:** Julie Smith

## UNIT DETAILS

**Combined ICU/CCU**

- 11 physical beds
- 6 ventilators
- 3 non-invasive ventilators
- 2 haemofilters
- IABP
### NURSING SHIFTS

There are 3 nursing shifts each day:
- **07:00 - 15:15**
- **13:30 - 22:00**
- **21:30 - 07:30**

The staff for each shift comprises Charge Nurse (ACN) and 7 patient-care nurses.

### NURSE: PATIENT RATIOS

- **Patients designated ICU 1:1**
  - Patients on ventilator, haemofilter, inotropes and full-face non-invasive ventilation

- **Patients designated ICU 1:2**
  - All other patients who are not Coronary Care, including all peri-operative AMIs

- **Patients designated CCU:**
  - 1:2 by day/evening, 1:3 at night

### DUTY HOURS

#### ICU JUNIOR DOCTOR ROSTER

ICU has 5 registrars and 2 residents. This will increase to 5 HMOs in January 2016, with an associated change in rostering arrangements.

Registrars provide cover 24 hours per day in 12.5 hour shifts.

Residents work 7 days on, 7 days off, with 12 hour day shifts and 9.5 hour day shifts

#### Roster changes

Roster changes for personal reasons will be accommodated as far as possible. However rostered overtime generated by internal shift “swaps” will not be authorised.

Rostered overtime generated by leave cover or changes initiated by the Hospital will be paid as long as the doctor exceeds the total fortnightly hours (76 for residents, 86 for registrars).

Unrostered overtime must be approved by the ICU Director.

#### Resident hours

The residents work 08:00-2000 on a day shift, and 2000 to 0530 for night shift.

On occasion residents will be asked to remain in the unit until the night registrar arrives (20:30), e.g. if a registrar is ill.

Residents are backfilled if on annual or extended sick leave.

For late notice short term sick leave, the resident will not be backfilled.

We have 5th year students regularly attached to the unit, please use them as residents as far as possible.
Minimum requirement:
ICU must at all times have at least 1 doctor ON DUTY in the Unit.

Roster

- The roster will be provided 6 weeks in advance of the roster period.
- Changes to the roster will be published 6 weeks in advance unless cover is required for sick leave, late swaps or changes generated by the doctors.
- The Reliever/Non Clinical registrar will provide cover for the duties of any ICU registrar who is on annual or study leave. This may include weekend and night duties. There will be no additional backfill provided by the hospital.
- The Wednesday afternoon registrar (13:30-17:30 to attend the teaching) will not be rostered when there is a registrar on leave.
- When no registrar is on leave and there are 5 registrars on the roster, the Reliever/Non-Clinical registrar will have non-clinical duties including:
  - Tuesday afternoon (14:00-17:00) pre-admission clinic
  - Audit
  - MET & Code Blue review meetings
  - Teaching
  - Bedside echocardiography teaching
  - Research & study
  - They will also provide a “second pair of hands” in exceptional circumstances

**On average** the registrars will be working 42.8 hours per week or 85.6 hours per fortnight (including a minimum of 4 hours education per week plus the 35 hours per “non-clinical” week which is training/educational time). Some weeks will be more than 43 hours per week and some less: work hours are averaged and overtime will not be paid whilst working these hours. Registrars are paid for 86 hours per fortnight, which includes 76 hours clinical commitment and 10 hours education/training per fortnight. This is in accordance with the Award.

Annual leave and Study/Conference Leave

- Registrars are entitled to 5 weeks annual leave and 2 weeks study leave per annum.
- Leave taken is calculated at an average of 43 hours per week, regardless of rostered hours for that time period.
- All leave applications (annual and study) must be submitted 6 weeks in advance.
- Only one registrar can be on leave at any one time (allocated on a “first come first served” basis).

Sick Leave

- Notify both the HMO Support Unit (Out of hours contact HMO Coordinator via Switchboard) and the Intensivist on-call if you are unable to work. Please do this as soon as you realise you will be unable to work, so that contingency plans can be made.
- You can provide a Statutory Declaration form for 1 day of “sick leave” on no more than 3 occasions per annum.
- If you are unable to work for more than 1 day you will need to provide a Doctors Certificate and a PAY 12 form both of which should be forwarded to the HMO Support Unit.
Consultant duty hours:
Weekdays: 8:30 am – 5:30 pm & evening ward round (~21:30)
Weekends: Minimum of 2 ward rounds
Morning round starts between 8:30 and 09:00 am
Other rounds by arrangement

EXPECTATIONS

General duties
The registrar is responsible for the “Clinical Administration” of the Unit. The registrar allocates tasks such as admitting or discharging a patient, performing procedures, and conducting the daily routine assessment of each patient. The registrar must also direct the students. Both registrar & resident must teach the students.

Critical events
When critical events occur, ICU patients require the same basic management as any patient who decompensates. Immediate basic resuscitative management (ABC) and Advanced Life Support (ALS) are required, but assistance can reach you. ALS certification is compulsory and unless you have recently completed such a course in another hospital (a certificate of completion will be required) we expect you to have an ALS update at Bendigo Health within the first month of starting. If you require an update, please inform Dr Porwal.

Codes
ICU provides a Medical Emergency Team (MET) medical responder, and a doctor for the Code Blue (Cardiac Arrest) team. You must carry your pager at all times.
When there is a Registrar and a Resident available in the Unit, only one should attend MET, Code Blues and Trauma Calls. The registrar is expected to attend these emergencies, but if there are conflicting obligations can delegate to the resident.
ICU doctor attendance at Trauma Calls is not obligatory, but the Registrar should attend if available.

ICU procedures
The Consultants will assess your ability and assist you with procedures as necessary (DOPs forms are on the G:/drive). It is the Registrar’s task to allocate which procedures can be done by the residents and students and to supervise these situations.

Registrars are expected to become independent in –
- Central line insertion (blind and US guided)
- Arterial line insertion
- Vascath insertion
- Chest tube insertion
- Basic airway management
You will be exposed to the following procedures:

- Percutaneous tracheostomy
- Intubation
- Bronchoscopy
- Trans-thoracic echocardiography

Audit

There are a number of ongoing audits that the registrars must become familiar with and undertake:

- Percutaneous Tracheostomy
- Emergency Department admission time (AKA NEAT Audit)
- ICU discharge auditing
- Procedure database
- CLABSI audit

You will be given individual audits to complete as well.

Retrieval

On occasion the Registrar may rarely be asked to retrieve time-critical patients to or from Bendigo; this will be at the discretion of the Duty Intensivist.

**LINES OF RESPONSIBILITY**

**Availability**

You are expected to be *immediately available* to the Unit when on duty. Please ensure that the ACN knows where you are at all times.

**Referrals to the Unit**

Referrals may come directly to the registrar or the resident (who is expected to inform the registrar). The registrar should assess all referrals, but may task the resident to assess the patient if there is an unstable situation in the Unit.

All patients, except from theatre, referred to the Unit must be assessed within 30 minutes of the referral and discussed with the ACN and the Duty Intensivist.

All referrals to ICU from theatre for unplanned surgery should be accepted and discussed with the ACN and Duty Intensivist, unless one of the following occurred –

- There are no ICU beds. ICU should then assist in advising appropriate disposition (inter-hospital transfer or ward)
- There is suspicion that the patient actually may not require ICU admission. This is a rare occurrence and in this setting the Duty Consultant should assess the patient in recovery and discuss their opinion with the referring doctor or team (ie surgeon and/or anaesthetist).
- The decision as to whether a patient should remain intubate is up to the anaesthetic team, but should be communicated as soon as possible to the ICU staff for bed management purposes,
- We request that the anaesthetists err on the side of caution when considering whether to put a CVC in. And if patients are critically ill, to put a CVC in with more rather than less lumens.
No patient may be admitted or refused admission (even if no beds are available) without the approval of the Duty Intensivist. ALL REFUSALS MUST BE ENTERED IN TO THE REFUSALS BOOK. 

NB. Intensive Care is an acuity-based discipline. As such a critically ill patient is our problem, whether we have beds or not. It may be appropriate for ICU staff to become involved in management of a patient outside the Unit in the event of a bed shortage.

**Parent Unit Registrars** must inform their Consultant of any patient who is admitted to the Intensive Care Unit.

**Elective Admissions**

The vast majority of elective surgical admissions are seen in the ICU pre-admission clinic on a Tuesday afternoon. Please familiarise yourself with the Pre-Admission flow diagram at the end of this guide with regards to the process. If a patient is accepted for ICU/HDU admission post-operatively, please document either “accepted and recommend surgery cancelled if no ICU bed” or “accepted and recommend surgery proceeds if no ICU bed”. This should be discussed with the Intensivist in Clinic (Outreach).

**ICU patients**

ICU functions as a closed Unit. This means that the Intensive Care Team is responsible for patient management, although the patient remains under the bed-card of the Parent Unit. You will provide full cover for ICU patients, reporting directly to the Intensivist, and consulting where necessary with the Parent Unit.

**Coronary Care patients**

CCU also functions as a closed Unit. CCU patients remain under the bed-card of the Parent Unit, and cared for by the Cardiology Referrals to Coronary Care must be approved by the Cardiology Consultant (all hours). The Medical (After Hours) or Cardiology Registrar is responsible for admitting the patient and writing the notes and drug chart.

After hours and at weekends the ICU registrar is the first port of call for any clinical issues, with escalation to the Cardiologist on-call (not the Intensivist). The ICU registrar’s priority however is still primarily with ICU patients and therefore if they are not able to respond in a timely manner due to other ICU commitments, this should be made clear at the time and the cardiology issues escalated directly to the Cardiologist on-call.

Please familiarise yourself with the Coronary Care – Clinical Escalation process which is at the end of this guide.

**Admission and Discharges**

Admission and Discharges must be completed electronically using ICUsum and the Parent Unit notified that the patient is cleared for the ward, as soon as the Intensivist has cleared the patient (usually after the morning ward round). We suggest that the Discharge Summary is started on admission of the patient to ICU, and updated and edited daily. If there is a delay and the patient is discharged after hours, please notify the covering team and document this (ICU doctor handing over and who the covering doctor notified is) in the final section of the discharge summary “New issues since being cleared for the ward”.


There are two versions of the final ICU discharge summary –

1. A GP copy must be given to the ward clerk – this is reviewed by the duty consultant for accuracy and then sent to the patient’s GP.

2. A ward copy, which is placed in the medical notes. This version contains more information than the GP copy.

The Drug Chart should also be re-written.

All patients who are discharged after 20:00 must be reviewed 2-4 hours after discharge by the ICU Registrar. Please also request a “Doctor Review” on Patient Flow, as a safety net once the patient has been discharged to the ward.

**Resources**

There is an electronic policy filing system known as PROMPT. Both PROMPT and UpToDate® are available on all hospital terminals. Please ensure that you understand how to access hospital policies using this system.
Perform patient assessment & consider:

**IV ACCESS:**
Order removal of CVC if no longer required. Consider alternate access & insert IVC if required.

**FLUID REQUIREMENTS:**
Ensure enough IV fluid orders for next 24 hours.

**PATHOLOGY/RADIOLOGY**
Check results & correct as necessary. Ensure next day's slips are written up if required.

**DRUG CHARTS**
Rationalise/renew drug charts as necessary. Remember that wards do not have protocols for electrolyte replacement.

HAND OVER TO PARENT TEAM

COMPLETE ELECTRONIC DISCHARGE SUMMARY (print off both GP and ward summaries)

AFTER HOURS DISCHARGES: REVIEW AFTER 2-4 HOURS
WARD-rounds

General responsibilities
Attend all rounds in the Unit including Parent Unit rounds, & present the patients. Make notes on the chart of all decisions taken during rounds, including:
- Management plan
- Laboratory investigations
- Feeding plan and fluid plan
- Antibiotics
- Procedures & investigations ordered

Hand-over
This is the most important part of your role.
At 08:00 the day and night registrars conduct a handover round. At 20:00 the night and day registrars conduct a handover round. The rolling paper handover sheet must be updated prior to each shift handover, unless clinical commitments during your shift prevent this. The consultants will also contribute to the handover sheet.

Consultant business round (08:30)
All major management decisions should be taken at this round. Ensure that a definite plan has been decided upon before moving on. Presentation 5 minutes maximum: emphasise the relevant and pertinent issues only using ISBAR principles of handover:

**IDENTIFY**
Patient details and demographics.

**SITUATION**
Day of ICU admission (eg Day 6 ICU). Diagnosis, major problems & relevant current issues.

**BACKGROUND**
Relevant pre-morbid history pertinent to this admission.

**ASSESSMENT**
Current clinical status on an organ systems basis (ie. examination findings). Outline features on daily pathology and radiology. Progress and events (changes in condition, procedures, investigations). Current plan of management: Discharge / Prognosis / Resuscitation status

**REQUEST**
For clarification / advice on active management issues

Parent Unit rounds
Join all parent unit rounds. Ensure adequate documentation of any suggested alterations in management plan or treatment made by the Parent Unit, including the time and who ordered it. This is the responsibility of the parent unit. Parent Units are not to write drug and fluid orders. Parent Units are encouraged to offer opinions about patient management.
Administration “paper” rounds (07:00, ~12:30, 19:00)
Registrar driven rounds to check progress and ensure orders are current and signed. We expect documentation in the patient’s notes that these rounds have occurred. A checklist is provided.

Microbiology results
Microbiology results for all patients prior must be checked before the afternoon round. This includes screening for MRSA and VRE, which occur on admission and every Monday morning for all patients. All microbiology should be entered on the pink microbiology forms.

Consultant and registrar ward round

<table>
<thead>
<tr>
<th>ADMISSIONS</th>
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<tbody>
<tr>
<td>NON-OPERATIVE ADMISSIONS</td>
</tr>
<tr>
<td>• Diagnosis</td>
</tr>
<tr>
<td>• Time of admission to hospital</td>
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<tr>
<td>• Reason for Unit admission and category (1:1 or 2:1)</td>
</tr>
<tr>
<td>• HOPC</td>
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<tr>
<td>• Past history, pre-morbid condition &amp; ADL</td>
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<tr>
<td>• Medications entered in the Medication Management Plan (MR114.8)</td>
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<tr>
<td>• Allergies</td>
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<tr>
<td>• Examination findings (all systems)</td>
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<tr>
<td>• Lab &amp; XR findings</td>
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<tr>
<td>• Assessment</td>
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<tr>
<td>• Management plan, including physiological parameter aims &amp; NFR status</td>
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<tr>
<td>• Monitoring and lines inserted</td>
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<tr>
<td>• Interventions undertaken</td>
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<tr>
<td>• Progress since admission</td>
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</tbody>
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POST-OPERATIVE ADMISSIONS

| • Procedure, operative findings & complications |
| • Anaesthetic, lines inserted & complications |
| • Reason for Unit admission and category (1:1 or 2:1) |
| • Fluid status & urine output |
| • Inotropes |
| • Other medications (NB antibiotics) |
| • Condition on arrival |
| • HOPC, past history, pre-morbid condition & ADL |
| • Medications |
| • Allergies |
| • Examination findings (all systems) |
| • Lab & XR findings |
| • Assessment |
| • Management plan, including physiological parameter aims & NFR status |
| • Interventions undertaken after admission |
| • Progress since admission |
PATIENT REVIEW AND DAILY PROGRESS NOTES

Every patient must be examined at least once per shift, and the examination findings recorded on form **MR 94B: daily progress notes**. This form starts at **midnight**.

**Daily progress notes (MR 94B)**

- Commence at midnight.
- Night registrar fills in all data required on the form.
- Each registrar must make at least one note during the shift.
- All examination findings must be recorded.
- Any incident or alteration in condition must be recorded.
- All interventions, lines and diagnostic procedures (eg CT) must be recorded along with relevant results / findings.
- Every entry must have date, time and doctor’s name clearly displayed.

Ventilator Associated Events

Bendigo ICU provides surveillance data for VICNISS. As part of this we submit data on all ventilated patients. The data is collected on a self-explanatory form which can be found with the other “doctor related” forms, and is to be completed by the doctor performing the patient daily review. For the majority of entries this simply involves documenting the date, the day of ventilation, the mode of ventilation, the minimum PEEP and FiO2 in the previous 24 hours (midnight to midnight).

**Observation chart**

Night registrar must ensure that the relevant data required on the observation chart is entered when the chart is initiated at midnight. (Diagnosis, days in IU, current issues, etc)

**Patient review**

- Every patient must be fully examined during the day. The Registrar may allocate the daily examination of some patients to the Resident.
- The night registrar should perform an examination of relevant systems.

**Drug orders**

- All drug orders must be signed by a doctor.
- Drug charts must be reviewed daily and rewritten if they get confusing.
- All drugs and infusions must be prescribed according to existing ICU protocols.

**Fluid orders**

- Review daily fluid balance at the morning round and include a fluid management plan in the daily management plan.
- Review feeding and ensure that the feed amount is included in the day’s fluid plan.
- All fluids must be written up in the Fluid Orders chart.
Investigations: X-Rays

- All intubated patients have a CXR every morning, unless admitted and X-rayed after midnight.
- Routine post operative patients require a CXR on admission (unless done in theatre) and then only as clinically warranted.
- Routine X-ray investigations can be booked by the Ward Clerk.
- For urgent or complex investigations please speak to the Radiologist directly.

Investigations: Pathology

- All patients must have FBE & U&E daily at about 05:00, plus any other laboratory investigations necessitated by their clinical status, unless stated by the Duty Intensivist.
- Coagulation profile should be checked on admission and then as clinically indicated.
- CRP and LFTs should be routinely requested on Mondays, Wednesdays and Fridays and only in between if clinically warranted.
- Daily pathology results must be checked before the morning ward round.
- All microbiology results must be recorded on the pink Micro sheet daily.
- Urgent and after hours investigations require a phone call to the laboratory.

MET CALLS

The MET team comprises an ICU doctor (registrar or resident, depending upon the situation in ICU), a medical registrar and a senior ICU nurse. METs are initiated (usually) by a ward nurse in all hospital areas except ICU, ED, theatre and cath lab. Please note the CCU nurse may call a MET. Your role is to:

- Respond within 5 minutes (as clinical circumstances allow. If you cannot attend due to an unstable patient in ICU, or you are scrubbed for a procedure, let the Access nurse know of your inability to attend).
- Assess and manage airway, breathing, circulation and conscious state (ABCD).
- Assess whether the patient requires transfer to either ICU or CCU.
- Ensure the parent unit has been contacted by the ward nursing staff to ensure adequate follow up. This is of critical importance as it allows adequate follow-up and prevention of further MET calls.

If the decision is made that the patient does not require transfer to ICU, ensure handover to the medical registrar.

Complete the MET sticker and place it in the medical record.

All patients with an epidural require notification and attendance (as able) by the anaesthetic registrar.

NB. Any patient who has had two or more MET calls in a given 24 hour period requires the responsible parent consultant to be notified by the parent unit, or (after hours) by the covering HMO or registrar. Please ensure that this has been requirement has been handed over to the parent / covering unit. The in-hospital mortality rate of patients requiring multiple MET calls is over 30%, which is 2 -3 times the mortality rate of those patients in ICU.
DEATHS

- A patient who dies must be discharged formally from the Unit
- The registrar on duty at the time of death must:
  - Inform the Duty Intensivist and the Parent Unit Registrar of the death.
  - Fill in a death certificate and other relevant forms at the time of death.
- Do not declare a death to be a Coronial case without discussion with the Duty Intensivist.

**NB.** The Duty Intensivist will contact the patient’s GP the next business day.

**Coroner’s Cases**

- **Discuss the case with the Intensivist** on-call prior to phoning the Coroner
- **Phone the Coroner’s Court**: 1300 309 519 ([http://www.coronerscourt.vic.gov.au/](http://www.coronerscourt.vic.gov.au/)). This is a 24/7 telephone line, answered by a clerk. You then give your details, the patient’s details, a brief history and the reason for reporting to the Coroner. The clerk will give you a Coroner Court reference number. Please document this number in the patient’s medical notes for future reference.
- All patients requiring a coroner’s post mortem need a “Statement of Identification” (the form can be found on the website or on the unit amongst the coroner’s information in the drawer by the central radiology viewing computer). This can be completed by the next of kin and witnessed by the medical staff i.e. the family do not have to wait for the police to arrive.
- The coroner will contact the local police (or tell you to): they then accompany the body to the mortuary. The police will need to see the “Statement of Identification”. If this is not available the family will be called back in, so please make sure this is done prior to the family leaving.
- A medical officer (Intensivist or registrar) will also need to complete an online **Medical Deposition form**. This outlines the patient’s details, history and questions for the Coroner. Please place a copy of the Medical Deposition form in the patient’s medical notes.
- The notes are kept on the unit until the pathologist requests them (usually the following day) upon the Coroner’s request.

The Coroner’s report will usually take at least 3 months to be completed. More information can be found on the Coroners Court website: [http://www.coronerscourt.vic.gov.au/](http://www.coronerscourt.vic.gov.au/).

**M&M**

- Every Wednesday 13:30
- Patients for presentation:
  - Morbidity
    - accidental extubation
    - Nosocomial infection (CLABSI, VAP etc)
    - Cardiac arrest in Unit
    - Readmission to ICU within same hospital admission
  - Mortality
    - Deaths in Unit
    - Deaths in hospital after discharge from ICU
- Night registrars must ensure the day registrar knows of any patient who died, suffered cardiac arrest or was re-admitted **during their shift**.
- Liaison nurses will inform registrar of any ex-ICU patients who died in the ward.
- The day Registrar will present them at the meeting. There is a template to aid structure of the presentation on the G: drive of the intranet. If the M&M is cancelled, the Registrar will hold the presentation over to the next week.

**AUDIT**

Various audit activities occur within the Unit: you are required to take part as directed by the Intensivists. All registrars are expected to complete at least one quality assurance exercise during their rotation. These will be allocated at your initial educational supervision meeting.

**iLearn**

iLearn can be accessed via the intranet, on the home page. The username and password is the same as your email account.

**ICU Hub**

The ICU Hub is an ICU intranet forum, which provides a wide range of information relating to the unit. The information ranges from social activities and rosters, to guidelines, communication memos and news. The link icon can be found on all the ICU computers.

**RESEARCH**

The Unit is an active member of the ANZICS CTG and is usually involved in 3 – 6 multicentre clinical trials. Individual projects are encouraged and we will assist you where we can. Please contact the Research Nurse for details of the trials in which we are currently involved.

**DRESS**

Infection control practice dictates that you should not wear ties or scarves or carry a handbag. Sleeves must be short or rolled up. Shoes must be closed. Please bear in mind that the patients and relatives have certain expectations and it is therefore incumbent upon you to dress smartly and appropriately.

**INFECTION CONTROL**

Dress as above
Please ensure that you use alcoholic hand wash or wash your hands –
- Before patient contact
- After patient contact
- Before a procedure
- After a procedure
- Between ANY patient or equipment contact, INCLUDING notes.
Plastic aprons must be worn for any extensive patient contact such as helping move or turn patients, and for any procedure that does not require sterile gown-up.
Gloves are not necessary unless contact with body fluid is expected.
PROCEDURES

Unit policy mandates that for all lines including arterial lines and invasive procedures such as thoracentesis and ICC insertion, FULL sterile procedure is required, including cap, mask, sterile gown and gloves.

For less invasive procedures such as peripheral lines and urinary catheters, sterile gloves must be worn.

A “procedure sticker must be completed and entered in the medical notes for all arterial and central lines, even if the procedure failed.

Please enter all procedures into the ICU data base, found either by either –

- a desktop short-cut (G:\CCU\Clinical\ICU_Log_Book)
- URL http://goo.gl/forms/xr2n98tYU1

INTUBATION

Please do not use the emergency trolleys to obtain equipment for elective intubations. All the equipment required can be found in the “respiratory room”. If you do not know where to find equipment please ask.

Please use the McGrath video laryngoscope as the default for all intubations, unless there is a good clinical reason not to. The rationale for this is that we do not intubate many people on ICU, and if the first time you need to use the “difficult airway equipment” is in an emergency you will not be familiar or confident with using it. If you have not used one previously please discuss this with the Duty Intensivist and obtain the relevant training.

EDUCATION

*protected teaching time
TUESDAY  1400 – 1700  ICU preadmission clinic
WEDNESDAY  1335 – 1415  ICU M&M*
     1415 – 1500  ICU grand round*
     1500 – 1700  ICU teaching* (& anaesthetic teaching)

The ICU teaching is a mixture of didactic teaching, journal review and case presentation. It is led by the ICU registrar with ICU consultant facilitation. All ICU registrars and on-duty HMOs are expected to attend.

During the rotation registrars will have an ICU consultant allocated as mentor. You should aim to have your first meeting with them within the first couple of weeks of starting. This is your responsibility to organise.

ADMISSION REFUSALS

No admission is to be refused without discussion with the Duty Consultant.

Details of ALL admission refusals, whether due to bed shortage or inappropriate referral, must be
entered into the REFUSAL BOOK.

Patients refused admission who are subsequently admitted to a General Ward must be followed up within 8 hours.

This can be done by the ICU Liaison Nurse if available, but after hours must be done by the ICU Registrar or Resident.

**ENQUIRIES ABOUT THE ICU BEDSTATE**

Do not respond to enquiries about ICU’s current capacity (or “bed state”) from non-ICU staff. When non-ICU staff hear or think that we are full, they often transfer patients out **without checking with our ICU**. However, as ICU capacity and occupancy is fluid, often we actually do have a bed and the transfer is unnecessary.

If you are asked whether we have a bed, ask in return if the caller has a patient, and if so, they should make a formal referral: we will then assess the patient and make a decision accordingly.

**“HEADS UP” ABOUT UNWELL PATIENTS**

Do not accept phone calls or requests for you “to be aware of a sick patient on the ward”, i.e. a “heads up” about an unwell patient. This gives the false impression that ICU has either responsibility or jurisdiction, or both, in the management of this patient. Either the staff member is making a referral for admission to ICU, or they are not.

If you are approached like this, ask for a formal referral, or tell the caller that they should call a MET if they are concerned about the patient.

**IV PARACETAMOL**

Do not prescribe regular intravenous paracetamol unless authorised by the Duty Consultant.

a. Oral or enteral paracetamol is absorbed in the stomach, so is effective in patients who are “nil by mouth” or have an ileus.

b. Each time an intravenous line is accessed, the risk of a line infection increases.

c. Intravenous paracetamol is much more expensive than oral / enteral paracetamol, and is no more effective if the patient has a working GIT.

**COLOXYL AND SENNA**

Do not prescribe stimulant aperients to patients with a new anastomosis. If an aperient is being considered in a patient post laparotomy or bowel surgery, please discuss with the Intensivist and surgical prior to prescribing (consider lactulose).

**SHARPS**

After any procedure in which sharps are involved (from tracheostomy to peripheral lines) it is the responsibility of the proceduralist (i.e. you) to dispose of the sharps. DO NOT delegate this...
responsibility to the Nursing staff or the Medical Student.

**PROLONGED ABSENCE FROM THE UNIT**

If the Registrar is absent from the Unit for more than 60 minutes (e.g. prolonged resuscitation in ED), the Intensivist on duty must be informed, regardless of the time of day.

**PAGER/CISCO PHONE**

The Registrars and Interns will all be assigned individual pagers. These must be carried at all times when rostered on for duty. There is one cisco phone shared between all teams.

**National Safety and Quality Health Service Standards (NSQHS)**

Bendigo Health operates AT ALL TIMES within the framework of the ten National Safety and Quality Health Service standards (NSQHS) and your work and patient records will be audited during your time here within this framework.

The primary aims of the NSQHS standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of quality are met.

There is a professional obligation for all Bendigo Health Medical Staff to maintain their minimum annual competency training, have a good working knowledge of Bendigo Health Policies and Procedures via our Electronic system PROMPT, Be compliant with minimum professional standards with regard to documentation, and signing off on this orientation manual commits you to this.

**UNIT GUIDE REVIEW**

This unit guide will undergo annual revision which is the responsibility of each Unit. If you feel that information in this guide is outdated or incorrect or would benefit from additional content, please email (Unit representative).

**DISCLAIMER**

Information provided in this guide is not prescriptive or exhaustive. It is intended as a guide only to facilitate orientation to the unit.
REGISTRAR DETAILS

INTENSIVE CARE UNIT

Date: _______________________

Name: _______________________

Term: _______________________ to _______________________

Year of qualifying: ___________ University: ______________

PGY level: 3  4  5  6  other ______________

ACLS:  
Done in last 12 months  Y  N

Hospital: _______________________

Emergency Contact details

PRIMARY TELEPHONE CONTACT: _________________________

MOBILE NUMBER (if different): ___________________________

HOME NUMBER (Bendigo): _______________________________

HOME NUMBER (Other): ________________________________

Any other telephone contact: _____________________________

FAX NUMBER: _________________________________

e-MAIL: _________________________________

Please note that your contact information will be stored securely and will only be used in a disaster situation.
Elective surgical admissions to ICU/HDU

*Over 90% of elective patients are seen in the ICU pre-admission clinic, but occasionally they are unable to attend due to distance from the hospital or lack of time between booking and date of surgery. Take a pragmatic approach!

**If the patient attends the pre-admission clinic the ICU Liaison Nurse sorts out the paperwork with the ward clerk. If they are not seen in the pre-admission clinic, please make sure that you personally ensure the documentation is put in the Bart Simpson folder AND MOST IMPORTANTLY IN THE ALLOCATION BOOK.
Coronary Care – Clinical Escalation

Process for in business hours - Monday to Friday 8am -5.30pm

- If the response is unsatisfactory at any stage then please move onto the next level.
- If you have any concerns about inappropriate responses please document and leave on Managers desk to follow up with the relevant Medical line management.
- Please communicate the level of urgency to the Dr and the timeframe you need them to respond to your concern

![Diagram of the escalation process]

**Note:** Communication of the urgency of the situation at times has not been clear. Please ensure that a clear level of urgency and required response timelines are recorded on the pager or phone as necessary.
Process for out of business hours - Monday to Friday 5.30pm – 8am, Saturday, Sunday and public holidays.

- If the response is unsatisfactory at any stage then please move onto the next level.
- If you have any concerns about inappropriate responses please document and leave on Managers desk to follow up with the relevant Medical line management.
- Please communicate the level of urgency to the Dr and the timeframe you need them to respond to your concern

After Hours (including weekends)

Initial contact
Inform ANUM

Contact ICU Registrar

If emergency, no initial/delayed response or inappropriate response from Registrar. Discuss with ANUM

ANUM to Contact – Duty Cardiologist
Document call on Cardiologist log in ANUM folder.

If emergency, no initial/delayed response or inappropriate response from Cardiologist

ANUM to contact Dr Voltaire Nadurata

Note: Communication of the urgency of the situation at times has not been clear. Please ensure that a clear level of urgency and required response timelines are recorded on the pager or phone as necessary.
### Bendigo Health Care Group

#### Learning Objectives (Term Description)

<table>
<thead>
<tr>
<th>Title of Term</th>
<th>Intensive Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Post (intern or PGY2)</td>
<td>PGY2-3</td>
</tr>
<tr>
<td>Last reviewed</td>
<td>February 2015</td>
</tr>
<tr>
<td>Name of Term Supervisor</td>
<td>Dr Emma Broadfield</td>
</tr>
<tr>
<td>Plan for Contact with junior doctor during the term</td>
<td>Daily contact – The HMO will work under the supervision of the Registrar and/or Consultants</td>
</tr>
</tbody>
</table>

### Unit orientation arrangements

The Intensive Care Unit is located on the Bendigo Hospital Campus on Level 4 of the NR Phillips block. Please report to the Unit on your first day. You will be advised via email who to report to and at what time.

### Resources to read prior to orientation:

- HMO ROVER guide
- Unit orientation guide

### Education opportunities available during the term

The ICU teaching is a mixture of didactic teaching, journal review and case presentation. It is led by the ICU registrar with ICU consultant facilitation. There are series of didactic teaching led directly by Intensivists (around 8-10 weeks)

1. Daily ward/teaching rounds
2. ICU follow up clinic Monday weekly 14:00 – 1700
3. ICU preadmission clinic Tuesday weekly 1400 - 1700
4. Protected JMO education sessions Tuesday weekly 12:30 -13:30
5. ICU Morbid & Mortality meeting Wednesday weekly 13:30 – 14:30
6. ICU Grand Round Wednesday weekly 14:30 – 15:30
7. Registrar protected education sessions every Wednesdays 1530-1700.
8. Echo teaching (2-3 hand on sessions per week with Non clinical registrars and few didactic sessions)
9. Audits – Compulsory for registrar, residents are encouraged to participate in Audit activity.
11. Simulation based Learning at Monash Skills lab or mini Simulation in the unit.

### Learning objectives for the term

1. Assessment, resuscitation, and early management of critically ill ICU patients.
2. Writing focussed ICU notes. (gets audited weekly or fortnightly)
3. Learning new skills like Arterial line/CVC line/Airway
4. Presentation Skills (Short term/Long term ICU patients)
5. Basic Ventilation,
6. Basic Cardiac output monitoring,
7. Basic knowledge of renal support (CRRT)
8. Basic knowledge of Antibiotics
9. Nutritional Support
10. Standard ICU care provision (FASTHUGS)

### Use of the term description

It is essential that this term description is provided to the junior doctor prior to commencement of the term and is discussed with the junior doctor by the Term Supervisor in the first week with an emphasis on the learning objectives. Refer to the *PMCV Performance Assessment and Feedback Guidelines for Junior Doctors 2014.*
Unit Orientation Checklist (minimum standard)

Unit orientation should happen on the doctors first day and should provide a clear understanding of what is expected of them during the term.

Discussion points:

- The major clinical focus of the unit
- The role and responsibility of the doctor & expected daily tasks
- Structure of ward and patient flow
- Ward rounds
- Meetings on the ward
- IT systems relevant to the working area (PFM, EMED, etc.)
- Antibiotic prescriptions
- Procedure for urgent requests (bloods, imaging, medications)
- MET calls – expectation, what to do
- Discharge summaries (expectation, location for completion)
- Unit specific hints

Walking tour:

- Ward layout
- Computers, printer, fax machine
- Meet ward clerks and other key staff members
- Paperwork refills (where kept, who to ask if empty)
- Where to put request forms for collection of non-urgent bloods/imaging
- Doctors office (expectations: cleanliness, food and drinks)
- NUM office
- Unit specific (e.g. theatres, location of theatre lists)

Unit orientation was delivered

By: _____________________________________________________________

Date: _____________________________________________________________

Signed: _________________________________________________________

Please list the doctors in attendance: