INTENSIVIST ORIENTATION

1. Structure of Bendigo Health

1.1 Administrative

Eleven divisions of which four are clinical –

1. Medical
2. Surgical
3. Psychiatry
4. Continuing and Community Care (ie. sub-acute and residential services)

Each division has an Executive Director, overseen by the Chief Executive Officer (John Mulder) – this group is the “Executive” and are in charge of the operational functioning of the organisation.

They in turn are overseen by a Board of Directors, chaired by Bob Cameron, who are responsible for the organisation’s strategy. They cannot direct the operations of the hospital.

Each clinical division also has a Director of Nursing (DON) and a Business Manager (ours is Brian Jenner).

1.2 Clinical

The (acting) Chief Medical Officer is Dr. Grant Rogers. He is responsible for clinical governance (including credentialing) and medico-legal matters.

<table>
<thead>
<tr>
<th>Division</th>
<th>Department</th>
<th>Director</th>
<th>NUM</th>
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</thead>
<tbody>
<tr>
<td>Medical</td>
<td></td>
<td>Robyn Lindsay (ED)</td>
<td>Judith Walloscheck (DON)</td>
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<tr>
<td>ICU</td>
<td></td>
<td>Dr. Jason Fletcher</td>
<td>Susan Tomlinson</td>
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<tr>
<td>ED</td>
<td></td>
<td>Dr. Di Badcock</td>
<td>Carol-Anne Lever</td>
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<tr>
<td>General Medicine</td>
<td></td>
<td>Dr. Mark Savage</td>
<td>Tracy Harrip</td>
</tr>
<tr>
<td>Cardiology / Cath Lab</td>
<td></td>
<td>Dr. Voltaire Nadurata</td>
<td>Clare Harris</td>
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<tr>
<td>Radiology</td>
<td></td>
<td>Dr. Sarah Skinner</td>
<td>Luke Adorni</td>
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<tr>
<td>Medical Oncology</td>
<td></td>
<td>Dr. Rob Blum</td>
<td>Karen Wellington</td>
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<tr>
<td>Nephrology</td>
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<td>Dr. Chris Holmes</td>
<td>Kathleen Fair</td>
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<tr>
<td>Pathology</td>
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<td>Dr. Alexandra Duguesclin</td>
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<tr>
<td>Pharmacy</td>
<td></td>
<td>Paul O’Brien</td>
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<tr>
<td>Surgical</td>
<td></td>
<td>David Rosaia (ED)</td>
<td>Sue Jennings (DON)</td>
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</tbody>
</table>
1.2.1 Clinical Services not offered at BH

All these patient groups can be admitted to ICU pending definitive transfer.

- Neurosurgery
- Cardiac surgery (thoracic surgeon available Monday and Tuesday)
- Major trauma (BH is major regional trauma centre admitting large amounts of non-major trauma)
- Burns
- Neonatal ICU
- Paediatric ICU (but we do admit intubated children > 14 and non-intubated critically ill children)
- Spinal surgery
- Vascular surgery
- Neurology*
- Rheumatology*
- Dermatology*
- Infectious Diseases*
- Upper GIT (ERCP is available though)
- Haematology*
- Major interventional radiology **
- Emergency PCI (cath lab open Monday, Wednesday and Fridays)

* Telephonic advice available primarily via the Austin Hospital

** Interventional Radiology available on Fridays for elective / semi-elective procedures
1.2.2 Other clinical services offered (but are not yet discrete departments)

- Respiratory medicine – call switch
- Endocrinology – call switch
- Gastroenterology – ad hoc via John Gorey or Les Fisher

1.2.3 Clinical Framework

Each department has a clinical director and a group of senior medical staff. However, all the units are staffed entirely by fractional specialists except –

- ICU 3 staff 3 fractional
- General Medicine 3 staff 5 fractional
- ED 3 staff > 10 fractional
- Anaesthetics 9 staff > 10 fractional
- O&G 1 staff ~ 4 fractional
- Paediatrics 2 staff ~ 4 fractional

This structure is evolving as the scope of clinical services expands. The ratio of full-time to fractional specialists is likely to change with an increasing cohort of full-time staff.

2. ICU

2.1 Administration

2.1.1 Nursing

Sue is the Nurse Unit Manager of the nurses – hence her title as NUM ICU/CCU. Sue’s role is primarily administrative (budgeting, staffing, payroll) but she is primarily responsible for the nursing clinical governance. To this end, she is assisted by a Clinical Nurse Consultant, Jenni Tuena, whose role is essentially one of clinical governance (risk management, quality assurance, performance reviews and professional development).

2.1.2 Medical

Jason is the Clinical Director for ICU only, while Voltaire Nadurata, as the Director of Cardiology inherits the title of Director of CCU.

Clinical Governance (to be completed)

- Professional Development
- Credentialing
- Safety
- Risk
Rostering

Unless authorised by me, all weekday shifts require at least two intensivists on duty to provide the necessary redundancy to run both the ICU, but also outreach, while providing the ability to provide back-up as needed.

The intent is to give people the flexibility we all need while maintaining continuity of care.

Each roster will be for a 6 month period, with the final version completed 2 months before the start of the roster.

There is no obligation to complete your contractual obligations each quarter (but it is better that there is a rough equity). Rather, they should be done by the end of each financial year. Within reason, and with approval, by me, there is the capacity for you to “carry over” on-calls that you haven’t done to the next financial year.

Step 1 (4 months out) – Requests for leave / periods of unavailability.

There is now a traffic light system in place –

1. Green – available
2. Orange – tentatively unavailable, but will work if needed to. Prior to being rostered on, you will be contacted to obtain your consent.
3. Red – definitely unavailable. You will not be rostered on.

Step 2 (3 months out) – Draft 1 roster circulated and feedback given (within 7 -14 days)

Step 3 (2.5 months out) – Draft 2 roster circulated and feedback given (within 7 – 14 days)

Step 4 (2 months out) – Final roster “locked”.

Step 5 - Any roster swaps must be organised on a person to person basis.

Leave

Leave is given on a “first come first served” basis. Give me your leave forms ASAP.

CME leave

For local conferences and meetings that you do not want to be “retrieved” from – put in a CME leave form. Otherwise, and if your attendance will benefit the unit, request a non-clinical day.

There are 10 CME leave days available per 1.0 EFT. Your maximum allowance is carried over for one year.

Public Holidays

These are divided equally on a pro-rata basis.
Christmas and New Year’s Eve is shared equally on a pro-rata basis. Therefore, the full-time intensivists will work this period one out of four, while the part-timers will work one in four between them (ie. one in every 12!)

2.2 Clinical

The ICU is a closed unit. This means that you have the authority and responsibility to admit, discharge and manage patient care as you see fit. Practically, many decisions are delegated to the parent unit, while many others are made collaboratively.

Delegated decisions primarily relate to surgeon management of drains and wounds. Collaborative decisions may include post-operative feeding, difficult decisions pertaining to admission and withdrawal of active treatment, and other areas requiring specialist input.

All other decisions are made by ICU. Parent units are not allowed to write on drug charts, or alter patient management without the approval of the ICU team. They are actively encouraged to offer suggestions (most of which we adopt) and they are required to both write notes on a daily basis, while the ICU medical staff must either accompany the parent unit while they review a patient or failing this, liaise with the parent unit prior to them leaving ICU.

2.2.1 Referrals

The ICU registrars are instructed to call the intensivist after they have assessed each and every referral. Practically, some registrars are senior enough to admit without contacting the intensivist – this will happen via evolution.

However, all patients felt not to need ICU require intensivist approval. There are three categories –

1. Refused admissions – appropriately referred patients that cannot be admitted due to a lack of beds.
2. Declined admissions – patients who are unlikely to benefit from ICU as they are either too well or too sick

All of these refused and declined patients are entered into the “Refusals” book in ICU so that the ICU LN and outreach Intensivist can review them the following day. This is both a service provision (“can we help”) and a quality activity (“did we make the right decision? If not, now we can rectify it”).

All refused admissions are reported to both ANZICS and as an ACHS clinical indicator. It allows us to measure unmet need and forms the primary basis for gaining extra resources (read beds).

ICU remains involved in the care of the patient until they are safely disposed of (whether by external transfer, delayed ICU admission, or they are admitted to the ward and their risk of needing ICU admission has resolved). Offer your assistance if patient is stuck in ED or
theatre awaiting transfer. This maintains inter-departmental relationships, is good for the patient, and allows you to triage the transfer (ie. it may be prudent to transfer a stable patient from ICU rather than the unstable patient in ED or theatre)

2.2.1.1 Elective referrals

Most are seen in the ICU pre-admission clinic held on Tuesday afternoon. There will be others than can usually be handled over the phone between you and the referring doctor.

In clinic, three decisions need to be documented –

1. Does the patient need ICU?
2. If so, does the operation need cancellation if there is no ICU bed
3. What is the resuscitation plan?

The following procedures definitely require ICU admission post-op and should be cancelled if there is no ICU bed –

1. Oesophagectomy (Ivor-Lewis)
2. Gastrectomy
3. Pneumonectomy
4. Major head and neck resections likely to produce airway swelling
5. Radical cystoprostatectomy and ileal conduit formation

The following procedures definitely require ICU admission post-op BUT should not be cancelled if there is no ICU bed unless there are co-morbid conditions that mean ICU admission is required –

1. Lobectomy / wedge resection
2. Bowel resections involving an anastomosis in age > 60 (the rationale being that a large proportion become hypotensive on the ward as they usually have an epidural)

Procedures that used to be referred and admitted to ICU but now are usually admitted to the ward (but whom you may receive a referral and are wondering why....) include –

1. Prostatectomy
2. Nephrectomy
3. VATS
4. UPPP
5. Thyroidectomy

These and other cases are therefore assessed on a case by case basis, cognisant that there is –

1. In the surgical wards outside of some telemetry
2. No continuous monitoring on the orthopaedic ward
3. Surgical patients on the medical ward (or any other boarders”) have worse outcomes
On the morning of theatre, the only person who can authorise the elective case referred to ICU for post op admission to commence or be cancelled is the Patient Flow Coordinator (PRC aka as the “Bed Manager”). That is because the Bed Manager authorised discharges from ICU to the ward. Do not accept phone calls from theatre or anaesthetics enquiring about whether they can start a case – refer them back to the PFC.

2.2.1.2 Emergency Referrals

Always talk to the ICU ACN before definitively accepting a referral.

A. ED
- Registrar review within 30 minutes of referral.
- Try and admit to bed within 2 hours.
- Don’t need to be admitted by parent unit first, but do need parent unit assignment.
- Use your judgement as to whether lines best inserted in ED (keeps their skills up, patient safety) vs. do in ICU (reduce patient time in ED, improved patient flow).
- If the ICU is full, try to avoid using the ACCESS nurse to care for patients referred from ED.

B. Theatre
- If anaesthetics refers a patient, accept them unless there is limited ICU beds. In that instance, either personally review them and discuss with the anaesthetist (if you’re in the hospital), or discuss with the anaesthetist over the phone. Refusing an anaesthetists referral via the ICU registrar usually ends up with an upset anaesthetist....
- If the ICU is full, try to avoid using the ACCESS nurse to care for patients referred from theatre.

C. Ward
- A MET call is not a referral to ICU.
- A “heads-up” IS a referral to ICU. .....but we do not encourage “heads-ups”.
- If the ICU is full, it is appropriate for the ACCESS nurse to care for patients who need emergent transfer to ICU from the ward.

D. External
- All external referrals should come through ARV.
- Any referrals from an external hospital should be directed to ARV.
- All referrals from ARV should theoretically involve a conference call with the ICU ACN, Intensivist, the PFC, the referring unit and the ARV coordinator, but this does not usually happen. Usually, if the PFC says we can accept the patient, then it becomes a discussion between ARC and an intensivist or a senior ICU registrar.
2.2.2 Admissions
ICU has electronic admission software called “ICUSUM”.

2.2.3 Discharges
- Identify possible discharges the day before if possible.
- Patients ready for discharge remain under ICU care until they are discharged.
- Patients are sometimes discharged to CCU (~1%) and home (~5%).
- The junior doctors and nurses have clear guidelines as to what needs to happen when a patient is discharged, including discharge summary, verbal handover, new drug chart and IV fluids when appropriate, and a “time out” to ensure all these things have occurred prior to the patient leaving.

2.2.4 Death in ICU
- Almost all deaths are planned withdrawals of active treatment. Talk to the parent unit about your plan. You do not need their permission to withdraw though, but it is almost never a surprise for them either.
- Almost all patients who have active treatment withdrawn are able to die in ICU. Some patients will be stable enough to be transferred to hospice. If in your opinion death will take more than 6 – 12 hours, consider referral to palliative care for consideration of hospice admission.

2.2.5 External transfers
- Transfers to non-Bendigo ICUs go through ARV (ie. SJOG transfers can be organised without ARV)
- If a patient is wardable and comes from another hospital, they may be suitable to be directly transferred from ICU to the ward of the destination hospital. Talk to the parent unit.

2.2.6 St. John of God (SJOG)
- SJOG Bendigo is the local private hospital, equipped with a collocated ICU and CCU. It has two ventilators and a haemofilter. Patients ready for ward discharge at BH may not be able to be cared for on the ward at SJOG (ie. threshold for ICU admission is lower).

- Three types of patients will be transferred to SJOG ICU –
  1. Elective transfer of private patient to due to patient preference.
  2. Semi-elective transfer of private patient due to lack of ICU beds at BH.
  3. Non-elective transfer of public patient due to statewide lack of public ICU beds. This only occurs under the auspices of ARV or with prior approval of the Executive Director of Surgery. This approval will be sought by the Director (or the duty consultant if Director absent) if there is no ICU bed for a category 1 elective surgical case.
- Only “non-elective” transfers of critically ill public patients need to go through ARV. Otherwise, local ambulance will suffice.
- Three things to do before a patient is transferred –
  1. Make sure private health cover (if relevant) is adequate – ACN will liaise with SJOG.
  2. Make sure the pertinent consultant is happy – you.
  3. Book the ambulance – ACN.

2.3 Structure of the day

**ICU Clinical**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Ward and CXR round</td>
</tr>
<tr>
<td>1500</td>
<td>Telehealth conference with Echuca HDU (as needed)</td>
</tr>
<tr>
<td>~ 1600</td>
<td>Afternoon round</td>
</tr>
<tr>
<td>~ 2130</td>
<td>Evening round</td>
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</tbody>
</table>

**ICU outreach**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>Outreach round – ICU LN will lead you</td>
</tr>
<tr>
<td>Monday pm</td>
<td>ICU follow-up “clinic”.</td>
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<tr>
<td>Tuesday pm</td>
<td>ICU pre-admission clinic</td>
</tr>
<tr>
<td>1330 – 1630</td>
<td>ICU teaching (Wednesday only, consultant takes CISCO phone)</td>
</tr>
<tr>
<td>1330 – 1415</td>
<td>ICU M&amp;M</td>
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<tr>
<td>1415 - 1500</td>
<td>ICU round – all medical staff</td>
</tr>
<tr>
<td>1500 – 1630</td>
<td>ICU teaching</td>
</tr>
</tbody>
</table>

2.3.1 Ward rounds and handover

**Handover**

**Consultant**

All consultant to consultant handover must be at least verbal, but preferably in person.

Sometimes handover may have occurred the day prior to you starting, particularly if you are transitioning from non-clinical or outreach to ICU clinical. In that instance, there is no need for the person handing over to accompany the morning ward round.

Otherwise –

1. If the person handing over the unit is working the following day, they should accompany the ward round if possible.
2. If the person handing over the unit is not working the following day, handover can be verbal, either before or after the round. Use your judgement as to the timing of the phone call, taking into patient complexity, registrar competence and junior doctor continuity. (Sometimes the Sunday registrar will commence annual leave on the Monday and the Monday registrar will be “new”).
Registrar
The major handover occurs on the Wednesday “Grand Round” which both the outgoing and incoming day registrars attend.
Otherwise, there is 30 minutes rostered at the end of each 12 hour shift given to handover.

Resident
There is no formal resident to resident handover. They do attend the morning registrar handover, but are often called away to a MET call.

Ward Rounds
Document your management plans or amendments decided on the ward round on the ICU observation chart.
The morning ward round must include filling out the checklist (sedation, sleep, bowels etc)

A. Morning 0830 (0900 on weekend or public holidays)
Multi-disciplinary –
- Medical – intensivist, registrar, HMO
- Nursing – bedside nurse, ACN, +/- CNC
- Dietitian (weekdays only)
- Physiotherapist
The morning ward round is a “business” round where the overall management plan is documented, including decision(s) to discharge. It should usually be completed by 1000 for three reasons –
1. To allow the ACN to attend the “bed meeting”, held at 1000, where patient admissions, discharges and internal transfers are arranged.
2. To free up the allied health staff.
3. To give enough time to the bedside nurses to complete their tasks.

B. Afternoon ~ 1600
This round is attended by the same clinicians as the morning round except the allied health staff. This round can be delayed on the weekend when clinically appropriate to 1900, in which instance two rounds will suffice.

C. Evening ~ 2130
This is an optional round. It is remnant of when the ICU did not have registrars at night, but is beneficial in reducing the number of calls received overnight, particularly when a patient has been admitted since the afternoon round, where there is access issues requiring consultant level triage of referrals, or when there is an unstable patient. The nurses appreciate a quick walk around in these circumstances.
2.4 Interface with other units

2.4.1. ED

- Try and pull patients out of ED.
- Personally review delayed ED admissions.
- Consider sending ICU nurse down to ED to care for, or transfer patient awaiting ICU – this may be best if ED full but still delivering care for the patient (ie. half way through lines, CT etc etc). Talk to the ACN.
- Avoid keeping patients in ED overnight while awaiting an ICU bed – usually best to transfer them out.

2.4.2 General Surgery

- They manage drains and wound.
- We manage their nutrition, but guided by them, but .....unless there is a reason to keep an elective surgical patient on a restricted diet, our evidence based approach is –
  - Day 0 – fluids as tolerated
  - Day 1+ - diet as tolerated.
- We manage everything else
- Don’t use laxatives without talking to surgeons (particularly stimulants post-anastomosis)

2.4.3 Urology

- Similar to General Surgery except can be a little more directed in their advice to us regarding areas such as nutrition (often more conservative then general surgeons), avoidance of vasopressors (after certain procedures viz ileal conduit formation) and epidurals (one urologist in particular).
- One future task is to address these issues with them.

2.4.4 Orthopaedics

- Beware more than 24 hours of antibiotic prophylaxis. If there is no reason (and there usually isn’t), then cease them. There is no need to consult with them. They know we are going to do it.

2.4.5 Paediatrics

- The only unit with whom we “co-manage” patients with.

2.5 Clinical management

A balance of –

a. Clinical judgement vs standardisation.

We are trying to standardise as much treatment as possible - including stress ulcer prophylaxis, VTE prophylaxis, transfusion triggers, nutrition, antibiotics (type and duration), prokinetics, ventilation and resuscitation planning are
some examples. This is an attempt to reduce unnecessary variation and give a framework for the junior docs and nurses to work in.

b. Parent unit input vs. using your judgement. Listen to their input and opinion. It will often need to sought out. Be as collaborative as you can without letting them drive care that is not in keeping with your judgement.

c. Giving the ICU junior doctors and nurses authority vs patient safety

We give the registrars as much responsibility as they can handle. Let the ICU registrar take the ward rounds and make decisions, even if they are different to how your approach and provided it’s not against patients’ best interests.

ICU registrars are told –
1. Make a management plan and institute it provided you and the nurses are happy.
2. Call us if –
   - You are anxious about the plan
   - The nurse is unhappy with the plan
   - The plan isn’t working

2.5.1 Respiratory

There are two protocols –
1. “Care of the Adult Invasively Ventilated Patient” protocol which includes VAP prevention, SUP, VTE etc
2. “Assessment of Pain, Delirium and Sedation of Intubated Patients in Intensive Care” which stipulates a RAAS aim or 0 to -2 (unless otherwise ordered) and authorises the nurses to give sedation breaks when patient oversedated.

Stress ulcer prophylaxis is ranitidine (either IV or NGT) with low threshold to cease if enteral feeding in place. PPIs used if previously on them or have GIT bleeding.

Sedation is usually M&M but trend for more propofol and fentanyl. Use your judgement. Dexmedetomidine available.

Ventilation mode is up to you. Most patients are either SIMV-VC or CPAP-PS.

Tend to tracheostomy early using FOB. Rarely need to be done in theatre.
2.5.2 Cardiovascular

Vasopressors
Noradrenaline (or rarely adrenaline)
Vasopressin added in once noradrenaline gets to 20mgc/min
Consider CO monitoring once vasopressin used.

Cardiac output monitors
Three CO monitoring methods available -
1. Echo
2. PiCCO
3. PAC

Inotropes
1. Adrenaline
2. Dobutamine
3. Isoprenaline
4. Milrinone
5. Levosimenden
6. IABP

There is no dopamine in the hospital ;-)

2.5.3 Renal / CRRT

- CVVHDF using citrate (mostly), heparin (if can’t use citrate) or nothing (rarely)
- There are prescription stickers that are stuck on the ICU observation chart for each method of anticoagulation.
- Renal unit available for consult – usually not needed, but utilise if looks like needing dialysis > 1 week. This will expedite gaining a dialysis chair if patient otherwise able to leave ICU. Think about permacath if looking like long term HD (> ~ 4 weeks)

2.5.4 Nutrition

Highly protocolised.
- GRV of 300ml before feeds reduced.
- Prokinetics are used early. Metoclopramide 10mg tds and erythromycin 250mg Bd
- Target enteral feeds are1ml/kg Osmolite.
- Nepro, TwoCal, Jevity and Promote also available.

Dietitian attends round and will usually manage
We tend to use TPN early if GIT not functioning, particularly if patient poorly nourished prior to ICU (fasting pre-procedure, EtOH etc etc)
2.5.5 Endocrine
- BGL aims 4-9 mmol/l
- Insulin infusion protocol
- Try to transition to long acting insulin for patients with stable caloric intake viz if close to discharge

2.5.6 Infection and antimicrobials
- Antibiotic stewardship in place
- Use TG Antibiotics as much as possible.
- Use Austin ID for advice as needed
- Watch out for-
  1. Unnecessary surgical prophylaxis
  2. Unnecessary use of ceftriaxone

2.5.7 Care bundles
- Junior doctors schooled in FASTHUGS
- Supported by checklist on ICU observation chart
- VTE – heparin Bd preferred
- SUP – ranitidine or nothing
- Beware prescription by junior doctors of SUP in non-ventilated patient

2.5.8 Resuscitation and Advance Care planning
- All patients admitted to ICU have a resuscitation plan documented.
- Documented on the “MR85”
- Shows that we have thought about it, which is helpful for nurses
- Most patients are for full resuscitation.
- If any limitation is in place, make sure it also documented –
  1. On Patient Flow Manager (junior doc’s job)
  2. On the Alert Sheet (front of history)
  3. In history (if need to document decision making rationale)
- ACP available in ICU – most patients not suitable as not competent

2.5.9 Analgesia
- Acute pain service advises us on post-surgical pain. The service has transitioned from having “free rein” to being advisory only. It is almost always nurse practitioner led (who has prescribing rights). We usually act on her advice, but not always.
• IV paracetamol is only used if GIT not accessible. Used to be only under authority of consultant but that is impractical for the night ICU registrar.

• Strong preference is for hypotensive patients with epidural post bowel anastomosis is for them to be sent to ICU for vasoactives rather than buckets of fluid and turning epidural off / down with the subsequent pain and mobilisation issues.

2.6 Outreach

The outreach consultant fulfils three roles –

1. Support of clinical intensivist – particularly if unit busy, you may be called on to assist inside (procedures, viz tracheostomies) and outside of unit (referrals, management of critically ill patient on the ward who is awaiting ICU admission)

2. Attendance on the outreach round runs from 0900 each day, unless also rostered on for SJOG. Ring ahead (5454 7936) if you are going to be late).

3. Backfill of clinical intensivist if unplanned leave (including recuperation if busy night)

The outreach round covers the following areas –

• ICU discharges – review until risk of ICU admission has reached that of general ward population

• MET call patients – ICU LN will ask you to review high risk or problematic patients (many of whom have inadequate / unclear resuscitation planning)

• Refused or declined referrals (including those still in ED)

• Nutrition support (primarily TPN) – dietitian accompanies you on this part of the round.

• Tracheostomy service

• Vascular access service

2.6.1 Vascular access service

Historically, IUC has provided vascular access to the hospital, primarily via PICC lines but also CVCs as needed (Oncology insert their own PICC lines thought)

There is a two-step process –

1. Authorise the PICC line – some requests are unreasonable (ie. < 1 week antibiotics in an inpatient with no vascular access issues, or could be managed with oral antibiotics)

2. Organise insertion – this can be organised to be done by radiology, or you can do yourself, or you can oversee a junior ICU doctor – up to you.
2.7 Follow-up Clinic
Facilitated by the ICU CNC since 2011, all patients requiring more than 72 hours of ICU admission have been invited to attend the ICU follow-up clinic so that the ramifications of critical illness can be identified and addressed. Patients are now phoned and those who wish to attend the clinic, held once monthly on an as needs basis.

2.8 Non-clinical expectations (to be completed)
So that you and the unit can meet the significant non-clinical expectations of ICU and intensivists (from AHPRA, CICM, ANZICS, PMCV and the organisation), you are given a significant amount of non-clinical time. Some of this is rostered, some will be found while you are rostered on for both ICU and outreach.

As an intensivist, this is the time for professional development, education and research so that you can meet (at a minimum) the CPD requirements of CICM (and therefore AHPRA).

2.8.1 Mandatory competencies
As a senior medical staff member, there are also a number of mandatory competencies required of you-

<table>
<thead>
<tr>
<th>Competency</th>
<th>Frequency</th>
<th>Method</th>
<th>Via Intranet – “Education, Training and Development”</th>
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</thead>
<tbody>
<tr>
<td>Fire Training / Emergency codes</td>
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<td>Via Intranet</td>
</tr>
<tr>
<td>ALS**</td>
<td>Annual</td>
<td>Face to face</td>
<td><a href="mailto:kfuzzard@bendigohealth.org.au">kfuzzard@bendigohealth.org.au</a></td>
</tr>
</tbody>
</table>

* Maintain your own records
** Maintain your own records – competencies obtained elsewhere are valid

2.8.2 Professional Development Reviews (PDR)
Another mandatory annual requirement, PDRs are to ensure that your career goals are being met by you, me, the unit and the organisation. Each PDR will –
1. Review how you went in achieving the goals set during the last PDR.
2. Remediate areas where additional resources / time is needed to meet goals
3. Set new goals for the coming year

Any concerns re your clinical performance are addressed as close to real time as possible – there will be no surprises for you during the PDR.
2.8.3 Portfolios