Health
South Eastern Sydney
Local Health District

Prince of Wales

Intensive Care Unit

Orientation Handbook – 2021 Edition

Welcome to the Prince of Wales Intensive Care Unit!

The POWH ICU comprises of the General ICU and HDU (Level 1), and the combined Cardiothoracic Intensive Care and Prince of Wales Private ICU Units (Level 3).

Please read this handbook with care before you begin your term. It is by no means the definitive answer to all ICU protocols and policies; however, it serves to optimise patient care by 1) orientating all new medical staff to the units and the wider campus; 2) assisting in communication; and 3) creating an easy reference tool aimed at standardising some aspects of patient management. The guiding principles outlined here are common to all units on campus unless specified.

Assistance is always available from the duty Consultant and senior nursing staff. Use your time in the units to get the most out of the large clinical caseload. Ask questions about clinical problems, equipment and procedures with which you are unfamiliar.

Herein are contributions from various ICU staff and other specialty services within the hospital. The contents are produced from the consensus views of the senior medical staff and were accurate at the time of publication. Useful links are included throughout; please note intranet access is required to access some. There is a compulsory orientation session at the beginning of the year and at commencement of each Registrar term.

The ICU Intranet Page has a number of handy materials, particularly regarding clinical practice guidelines and protocols. The eRIC Intranet Page and eRIC course catalogue on HETI are also valuable resources.

Have fun!

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STAFF

Senior Medical Staff

Director – Level 1	Dr David Collins	Resident Supervisor, Teaching Program
Director – Level 3	Dr Zarir Nanavati	Roster Supervisor
Consultants	Dr Sumesh Arora	Data collection, WH&S, QA, and Incident Information Monitoring System (IIMS)
	A/Professor David Bihari	Fellow and Registrar Training Supervisor
	Dr Gordon Flynn	Organ Donation Coordinator
	A/Professor Yahya Shehabi	Director of Research
	Dr Gavin Salt	Level 1 Only
	Dr John Awad	Level 3 Only
VMO	Dr Monique Leijten	Level 1 Only
	Dr Joe Wilbers	Level 1 Only
	Dr Chris Andersen	Level 1 Only

Contact numbers for medical staff are available at the central desk area in all units. Alternatively they can be contacted through Switchboard (dial 9382 2222 if external or dial 9 for internal). Personal contact numbers for staff must not be given out.

Level 3 – for easy identification of on call staff, refer to the whiteboard near pathology chute.

Senior Nursing Staff

Level 1	Nurse Unit Manager	Megan Pinfold
	Clinical Nurse Unit Manager	Dee Power, Lucy Mahoney
	A/Clinical Nurse Educators	Melinda Paraggio (0.42), TBA
	Nurse Educator	Alicia Montague
	Clinical Nurse Consultant	Warren Stewart
	Equipment Nurse Manager	Maureen O'Brien
Level 3 Public	Nurse Unit Manager	Lisa Jericevic
	Clinical Nurse Consultant	Genevieve Gardner, Alex Tekiko
	Clinical Nurse Educator	Cathy Feeney
Level 3 Private	Nurse Unit Manager	Debbie Gregory
	Clinical Support Coordinators	Jodie Lawson, Leanne Maguire
	Nurse Educator	Cornelia Hibbert

Non-Medical Staff

Level 1	Physiotherapist	Nick Mendens, Peter Trewin
	Pharmacist	Jessica van Schreven
	Social Worker	Selena Consandine
	Organ Donation Coordinator	Christian van Reede
	Data/Research Manager	Solomon Thambiraj
	eRIC Manager	Phil Marshall
	Secretary	Kym Bax

Junior Medical Staff Overview

Career Medical Officers (CMO)

- A non-specialist medical officer working in a non-training position. Generally a CMO has a similar level of seniority as Fellows but are not expected to progress with CICM training.

Fellows

- A Fellow is an Advanced Trainee in the College of Intensive Care Medicine (CICM or equivalent) who has completed or nearly completed training. This person may take first call at night and the position gives experience of responsibility at a Consultant at level.
- The CICM has accredited POW for 24 months of Core training in Intensive Care.

Fellows and CMOs have rostered non-clinical time and are expected to undertake Quality Assurance and educational projects supervised by the senior staff. CMOs will be expected to have more substantial non-clinical portfolios.

Registrars

Usually Trainees in the CICM or equivalent.

Residents (RMO)

Vocational trainees, trainees in other programs (e.g. ACEM - Emergency, RACP - Physician Training, etc.) or Residents on general rotations.

Formal assessments are conducted as per the requirements of the relevant training program. Although the term supervisor completes them, we collate continuous assessment information during the course of the term. If we perceive you may be experiencing problems, a member of the senior medical staff will approach you. If you are not in a training program we strongly recommend you still meet with the most appropriate supervisor (see next section) for professional advice.

General Supervisors of Training at POWH

Intensive Care	A/Professor David Bihari
Medicine	Dr Jemma Cranney
Anaesthetics	Dr Alan Rubinstein
Emergency	Dr Marian Lee, Dr Therese Becker

Counselling & Conflict Resolution

Please talk to one of the Consultant Intensivists, your Supervisor, or Dr David Collins if you have any problems you wish to discuss, either personal or professional. Alternatively, please refer to the various JMO Support Services, including the JMO Help Line (1300 566 321), or general NSW Health Staff Support Services.

FACILITIES

Level 1 – General ICU / HDU

- POWH is a 450-bed teaching hospital affiliated with the nearby University of New South Wales (UNSW). The ICU is situated on Level 1 of the Dickinson Building. The ICU currently has 22 beds in total, with approximately 130 admissions per month.

- The case-mix is roughly equally split between medical and surgical patients. POWH is a major tertiary referral centre for all surgical and medical specialties including neurosurgery and obstetrics. It is also a quaternary referral centre for interventional neuroradiology, acute spinal injuries and hyperbaric medicine. Paediatric services are provided by the Sydney Children's Hospital, co-located on High Street.
- The units have approximately 100 nursing staff. Our nurses are a valuable resource and are often able to give guidance whether it is regarding patient management or equipment function. If in doubt, always consult a senior member of the medical staff. It is important to establish good rapport with your fellow workers to enhance patient safety for the good of staff morale and for your own personal happiness.

Level 3 – Cardiothoracic ICU / POWH Private ICU

- Level 3 is a split public/private unit which runs slightly differently to the Level 1 unit. Whilst it functions largely independently from Level 1, the medical staff rotate between Level 1 and 3.
- It is located on the third floor of the Dickinson Building. While it has many of its own facilities, Junior Medical staff rostered on Level 3 should feel free to use the Level 1 facilities and are invited to attend teaching sessions.
- It is made up of 4 public cardiothoracic beds and 8 private beds. The private beds are a combination of general ICU/HDU patients (predominately post-surgical) and private cardiothoracic patients. They function for the most part completely independently – private nurses may only look after private patients, etc.

The Circulatory Room is a 'low risk' room on Level 5 of the private hospital where patients go if the Level 3 ICU is full. Patients on Level 5 are managed by Intensive Care staff and must be reviewed medically as any other critical care patient would be.

Staff Rooms

- The Registrar room is currently being used to store equipment for COVID-19. The code to this room is **CXZ456**, however is temporarily unavailable until further updates.
- There is an interim Registrar room with a couch and computer located in the Secretary Office opposite the main the entrance to the general ICU (just outside Dr Collins's office). There is no code for entry and door remains unlocked overnight. There is another Registrar room with table, chairs and computer located at the end of hallway behind HDU, next to the Nurses Drive exit door.
- These rooms are for use during your term. In order to protect room contents and personal belongings, please ensure to close door when exiting. You must not use these facilities when your term is over.
- Changing rooms equipped with toilets, lockers and showers are available in both areas. The code for the change rooms will be given to you at the beginning of your term.
- The tea room on Level 1 has tea and coffee-making facilities, a microwave and fridge.
- There is a separate Conference Room used for meetings and clinical handover.

BEFORE YOU BEGIN

Security ID Swipe Card

- Security ID Swipe Card request form available from the Intranet or from the ICU Secretary.
- Take completed and signed form to Security, located outside on Nurses Drive, opposite the POW Adult Emergency ambulance bay.
- Please wear your Security ID card at all times while working.
- Security is available to safely escort you round campus after-hours. Their contact is 9382 2847.

Pagers

- Pagers are passed from the Day Registrar to the Night Registrar, and vice versa, at the end of each shift.
- Replacement or spare pagers are available at Switchboard, located on Level 2 near the High Street entrance.
- The HDU, ICU and CTICU Registrars carry pagers for their respective units.
- These pagers are used by the hospital to alert us to the need for consults and the occurrence of emergencies throughout the hospital. It is expected that that these pagers are carried at all times. In the event one Registrar is unable to answer their pager expediently, their counterpart in HDU/ICU or senior should carry it for them until they are available.

Computer & Network Access

- The hospital will only send electronic information to your Health email address. It is hospital policy to check your Health email regularly.
- NSW Webmail, accessible from work and at home, is located HERE.
- A username and password will be required to access the electronic Medical Record application (eMR/PowerChart) and the radiology internet facility (PACS). Computer and network access is arranged through the Medical Workforce Unit or through the ICU Secretary.
- If you're already a SESLHD employee, your username and password will remain the same at POWH. If you're coming from outside SESLHD, your username is your StaffLink number. On initial login your password will be the generic **PasswordSEH1,** which you will be prompted to change.
- You will need to receive general eMR training (including eMR handover) as soon as possible if you have not already. eMR training is included in the Orientation, however if you need further assistance throughout the term, the training team can be contacted at SESLHD-NHNeMRTrainers@health.nsw.gov.au or 9382 4542.
- The public units are paperless and use a state-wide specific Intensive Care program called eRIC (electronic Record for Intensive Care). eRIC training is included in Orientation. Your log in is the same used for the computer/eMR. Further information and user guides are available on the eRIC intranet. For eRIC support during business hours, please contact 044 4556 267 / 9751 6054. Outside business hours please call 1300 28 55 33.
- Level 3 is a hybrid area, as the private hospital remains paper-based.

Staff Lockers

- Keys for changing room lockers are subject to availability and can be obtained through Clinical NUM Dee Power. A deposit is required.
- Please remember to return your key at the end of term so the next group of JMOs can access lockers.

ROSTERS

Roster Outline

- RMO and SRMO Rosters are written by the JMO Manager at the Medical Workforce Unit, with assistance from ICU Secretary.
- Registrar Rosters are supervised by Dr Nanavati and written by a Registrar allocated for the year.
- Fellow/CMO Rosters are supervised by Dr Nanavati and written by a Fellow allocated for the year.
- Please contact ICU Secretary or Dr Nanavati to find out who the allocated roster-writers are.

Day Shift 0800-2000 (30 min meal break)

- General ICU team consisting of Consultant, Fellow/CMO (finishes at 1700 on weekends), Registrar and Resident (bed spaces 1 to 12).

- HDU team consisting of Consultant, Registrar and/or Resident (bed spaces 13 to 22).
- Level 3 team consisting of Consultant, Fellow/CMO (finishes at 1700 on weekends), Registrar and Resident.

Note: the HDU Consultant functions as a second-on Consultant and hands over to the General ICU Consultant at the end of the working day. The HDU Consultant may round at the weekends if need be.

Night Shift 1930-0830

- General ICU team consisting of Fellow/CMO (Mon to Fri inclusive, finishing at 0800), Registrar and Resident (bed spaces 1 to 12).
- HDU team consisting of Registrar (bed spaces 13 to 22).
- Level 3 team consisting of Fellow/CMO (Mon to Fri inclusive, finishing at 0800), Registrar and Resident.
- The Day Fellow/CMO on Level 1 takes first on-call overnight on the Saturday and Sunday, while the Day Fellow/CMO on Level 3 takes first on-call overnight only on Saturday. This is to comply with the CICM Senior Registrar training requirements. If there is a shortage of Fellows/CMOs to cover all roster duties, then the night Fellow/CMO is taken off and the Day Fellows/CMOs and Consultants take first on-call.
- The Consultant takes ultimate responsibility and any issue that needs to be communicated to the Consultant should be, regardless of the hour (see section on Calling Criteria). The General ICU Consultant is on-call for both units on Level 1 (on occasion the HDU Consultant may take on-call) and Level 3.

Note: the overlaps in roster hours ensure adequate time for handover. At busy times it may be that assistance is required from other teams in a particular area, especially between General ICU and HDU. If there is a Junior staffing shortage at night, deployment between Level 1 and Level 3 may be necessary after discussion with the rostered-on Consultant.

Roster Guidelines

- All rosters are primary designed to meet training and patient care requirements, and take into account overall staff numbers and skill-mix.
- In addition, State Award requirements, Workplace Health & Safety considerations, and individual's preferences and requests are taken into account and influence rostering practices. Some things to bear in mind when making roster requests:
    - Requests can significantly complicate the roster and you should therefore exercise some restraint.
    - Requests cannot be granted if they disadvantage other staff, compromise skill-mix or overall staffing numbers necessary for the shift.
- Leave is in accordance with the relevant State award. JMOs are required to complete a Leave Application Form and give at least 4 weeks' notice for a leave request (unless special circumstances prevail). Completed leave forms should be forwarded to:
    - Dr Zarir Nanavati for approval and signature
    - The allocated roster-writer (see above)
    - The ICU Secretary or Medical Workforce Unit for updating in HealthRoster
- In case of emergency or sickness, ensure the appropriate Consultant is made aware and inform Medical Workforce or ICU Secretary. Others may be asked to help out to facilitate smooth running of the unit. A doctor's certificate is required if 2+ days of sick leave is required.
- If there is an issue with the roster, please notify the person responsible for your roster as soon as possible. If it is urgent, e.g. inability to work impending shift, the duty Consultant or Dr David Collins must be informed.
- Your shifts are entered into HealthRoster by the Medical Workforce Unit. Your timesheets can be viewed via Employee Online (EOL). You can 'agree' or 'disagree' with a timesheet if you notice a discrepancy (any disagreements are automatically sent through to MWU for review). Alternatively, please flag pay issues to the ICU Secretary or the Medical Workforce Unit.

- It is your responsibility to arrange shift swaps, however swaps and adjustments to roster must be approved by Dr Nanavati and flagged to the ICU Secretary/Medical Workforce Unit for appropriate pay adjustment.
- Overtime and Callbacks can be submitted and tracked online through the Unrostered Overtime and Callbacks application, accessible via Stafflink. For accurate reporting, please only entered unrostered claims for time worked outside your normal rostered hours; for example, if your rostered hours are 0830-1700 and you instead work 0800-1800, you must submit two separate claims for time worked pre- and post-shift.
- Due to the structure of pay, junior medical staff in ICU are currently entitled to 1 ADO every 6 weeks. ADOs are automatically deducted and put into the system while working in the ICU.
- Payroll forms such as Leave forms, Secondary Employment forms, etc., are available on the hospital intranet or from ICU Secretary.

DUTIES

General Expectations

- While duties are generally assigned to specific members of the medical staff, we work as a team and it is important that duties are shared wherever appropriate. For example, if Residents are saddled with responsibility for all documentation, they would get little opportunity to do anything else. In principle, you should not ask another person to do something you are not familiar with yourself.
- It is expected that all staff acquaint themselves with the key elements of ICU equipment, to a degree in accordance with their level of seniority, and where they are located. Especially emergency equipment!
- Although we expect 2 x formal ward rounds a day, ICU patients generally require continued medical supervision and as such, most patients need to be sighed several times a shift, night and day, with changes documented appropriately (see below).
- Much of what is in this handbook outlines inter-professional communication. Do not forget communications with patients and families is a key aspect of patient care.
- All staff should be actively involved in teaching, working towards suitable higher qualifications and, where possible, attending appropriate courses and conferences. The Senior Medical staff are, at their discretion, keen to facilitate this financially for those embarking on ICU training. The Senior Medical staff may also assist trainees and postgraduate Fellows/CMOs to address specific experience requirements, such as echocardiography.
- As a minimum we expect all Registrars and Fellows/CMOs to have DETECT, BLS and ALS/ILS training (also see teaching) and to have attended a course such as the BASIC course. There will be regular Registrar and multi-disciplinary ICU simulation training including cardiothoracic resuscitation (you will be emailed closer to the time – places are limited). Registrars and Fellows/CMOs must familiarise themselves with the cardiothoracic ALS algorithm (see attachments).
- All medical staff are required to take responsibility for the **accurate collection of ANZICS data** as this assists in resource allocation and Key Performance Indicator reporting. It is also used by the CICM to assist in the accreditation determination. It is advisable that this be done contemporaneously as the data is difficult to collect when patients have discharged from the unit. This is particularly pertinent for high turnover patients. The nursing staff collect data for the Level 3 private patients.

General Duties

Documentation

- ICU patients can be very complex and so documentation needs to be organised in a systematic and standardised manner in order to facilitate the recording of clear, relevant information that is essential for continuity of care and handover, audit, and medico-legal review. Entries should establish a balance, being

concise but still accurately recording all relevant information and events. All patients should have at least one daily medical entry.

- In morning ward round notes it is important to clearly identify the active issues and the overall impression, along with the management plan for the day. If this is not made clear to you, please check with the Consultant or Fellow/CMO. Two well-recognised ways of documenting are:
    - *Systems* – Nervous (e.g. LOC, orientation, sedation, GCS, PNS findings); Cardiovascular (e.g. Haemodynamic variables and support); Respiratory (e.g. Ventilation mode and parameters); Gastrointestinal (e.g. Feeds and assessment of absorption, LFTs); Renal (e.g. Fluid status, biochemical parameters and support); Haematological (e.g. FBC and clotting); Metabolic (e.g. electrolytes, acid/base balance); Microbiological (e.g. Culture results and antibiotic therapy).
    - *ABC Format* – A = airway; B = breathing; C = cardiovascular; D = disability (neuro); E = electrolytes; F = fluid balance (includes urine output); G = gastrointestinal; H = haematology; I = infection (includes cultures and antibiotics); J = joules (feeding); K = Kelvin (i.e. temperature); L = lines; M = metabolic (includes BSL), medication and musculoskeletal.
- There is an informal walk around prior to the Consultant leaving for the day (conducted by Fellow/CMO at the weekend). Any changes (see below) must be documented in the medical record.
- Evening ward round notes should include a brief overview to ensure that the events of the day, including investigation results, are clearly documented, if not already. A night shift plan, which follows on from the day plan, should be in place. If necessary, points regarding this may need to be clarified with the Fellow/CMO or Consultant.
- Additional notes must be made at any time for the following: significant changes in physical condition and/or management plan, invasive procedures (e.g. tracheostomy), PAC/CVC insertion, results of specific investigations or tests (e.g. CT Scans, endocrine tests), changes in the focus of care (e.g. non-escalation of treatment, Advance Directives and family discussions).
- For all new admissions, please ensure formal handover is received from the delivering team. All new admissions to the unit need formal clerking and entrance into eRIC, medication reconciliation on eRIC, a full set of routine bloods, chest x-ray (CXR), and an ECG. Where a patient has returned from theatre, a procedure, or the radiology department, a summary of events is required. If a significant change in condition has occurred, they may also require repeat bloods and CXR (see section on admissions and cardiothoracic admission attachment).
- A transfer between units is not a new admission (although a transfer from public to private, and vice versa, is.
- All discharges must have a discharge summary, including a detailed plan of ongoing management and outstanding investigations, which is written and embedded in the transfer of care document (see section on discharges). Maintaining good ward round notes in eRIC will significantly improve the quality of discharge summaries as much of the information is saved across.

Pathology

- We use the arterial blood gases for all biochemistry except the urea area, creatinine, magnesium, phosphate and liver function tests (LFTs), which are done in a normal syringe from either arterial or venous blood. We also use the arterial blood gases for the ionised calcium. It is a good practice to look at blood films and differentials regularly and document any abnormalities.
- On Level 1 microbiology results and antibiotic usage are recorded on an excel spreadsheet, which is kept on the desktop in the ICU and HDU. Once results are available, they can be filled in and an up-to-date document kept in the Pathology folder. Ensure any positive results are brought to the attention of the Fellow/CMO and/or Consultant. Keeping up-to-date records also allows for the smooth running of the twice-weekly Consultant-led anti-microbial stewardship rounds.

Prescribing

- eMEDS are not used in any of the units. It is important to cease all eMEDs when a patient is admitted. Likewise, it is our responsibility to chart eMEDs for a patient being discharged out of the unit.
- Medications are prescribed within the eRIC system, unless on Level 3 private.
- Please make note of when microbial are commenced and the indication (even if they are empirical). It is good practice to review medication orders on a daily basis. If you are unsure of dosing please check.

Requests

- The day Resident orders chest x-rays for the next morning. Please note the quality of the formal report obtained in any radiographic investigation is often dependent on the clinical note on the order. Simply noting 'intubated' is not enough.
- Chest x-rays are not required on every patient every day; seek guidance from the Fellow/CMO or Consultant.
- The day Resident also organises daily routine blood pathology request forms with necessary tubes prepared in a pack and placed bedside ready for the nurse to take at night. Ensure that the forms are correctly labelled. Mislabelled specimens may be rejected or can result in clinical error.
- Please note our nurses take bloods only from arterial lines and are doing so to assist us. It is not strictly their role. Blood-taking other than morning bloods, or if there is no arterial lines, is the responsibility of the medical staff.
- Routine bloods requested are ABG, Urea and Creatinine, FBC, Mg and PO_4 (note electrolytes and calcium are not requested since more accurate values are obtained from the blood gas).
- Consider other blood tests where appropriate as directed by the team (e.g. LFTs, Coags, drug levels, procalcitonin (PCT).
- Consider reducing the number of tests (particularly LFTs, Coags, Mg and PO_4) in long-term stable patients. The majority of tests requested in ICU are urgent and hence the medical staff should obtain results expediently.
- Level 3 private ICU investigations are ordered using SEALS private pathology forms and Southern Radiology forms. Pathology appears on the Détente/HRIS system and radiology appears on the Visage system (only the computer near the blood gas machine can access this). Refer to instructions attached to the main computer for these.
- Note for the night Resident on Level 3:
    1. Write the medication chart, fluid chart and opioid chart (public only) for the CABG and valve surgery patients as per the guide (found in the black folder that is located next to the main printer). Use creatinine to help guide fentanyl vs morphine.
    2. If there is time, order post-operative bloods and chest x-ray for the expected admissions.
    3. For private patients, document morning blood results on the hardcopy flow sheet (they should be taken around 0300-0500 hours).
    4. Complete the M&M database.
- Level 1 Handover occurs at 0800 and 1930. It is attended by the night and day teams, the senior nursing staff and other key members of non-medical staff. It is held in the Conference Room, though you can attend remotely via Skype with the below links:
    - https://lync.health.nsw.gov.au/meet/solomon.thambiraj/J6V435D1
    - Or https://join.health.nsw.gov.au/ using Google Chrome. Enter conference ID **43049399**
    - You can also sign in by phone – dial 97415444, follow prompts and enter conference ID **376642349**
- Level 3 handover is performed at the bedside.
- Other points to note for Handover:

- Handover is enhanced using eRIC (and eMR if necessary) in the Level 1 Conference Room. In general aim for three sections – 1) Summary of the presentation. 2) A problem-based summary of the admission events (this does not necessarily mean a day-by-day account). 3) A management plan.
- The Resident plays a central role in the morning and evening handovers. They should train themselves to prioritise patients presented within the constraints of time.
- Remember to handover any patients awaiting transfer to the unit, or who warrant further review.
- All levels of medical staff are expected to participate in the regular morning education talks. Please refer to teaching timetable.

Specific Duties

Resident	• Outlined above.
Registrar	• General clinical management of patients on Level 1 and Level 3. • The ICU Registrar (on Level 1 and Level 3) receives the Code Blue (medical emergency and cardiac arrest) and adult trauma calls around the clock. You are expected to attend emergencies in the Eastern Heart Clinic.
Registrar/Fellow/ CMO	• All non-elective referrals are forwarded on to the Fellow/CMO or Registrar who takes the details, sees the patient and discusses the situation with the Consultant. Find out if the patient needs to be seen immediately. If so, attend immediately. If not, patients should still be seen within 30 minutes. • After reviewing the patient, document findings and instructions for further management in the eMR. Clearly state whether the patient is or is not to be admitted to ICU/HDU after discussion with the Consultant. From time to time you may be asked to assist in the management of a patient who will not require admission. This is acceptable as long as you are not over-run in the unit (we do not provide a vascular access service except in emergencies). • If a patient requires admission to ICU and there is no bed available in POW, the retrieval services need to be contacted by us in order to obtain an alternative bed. If the patient is **being retrieved out of our hospital for intensive care services elsewhere, it is our responsibility** to assist in their management until they leave. A clear plan of management until transfer must be documented. • **Please note only a Consultant can refuse an admission** (see below). • All refusals and requests for review/consultation need to be documented on the forms provided at the central station (on the back of the request for elective admission forms). Please note we collect time of referral and review data, so please complete that section. • Elective requests for admission should be directed to the Fellow/CMO or Consultant. Ensure detailed information is available, particularly the reason for admission, whether a HDU bed will be adequate, the patient's MRSA status, and that admission form is filled in. The primary team must also confirm bed availability with the bed manager on the day of intended admission, prior to commencing surgery. • Transfer of patients from ED/ward to scan, etc. - prior to being accepted as an ICU patient - is the responsibility of staff of those areas. However, we take responsibility for the transfer of intensive care patients for investigations such

as CT, MRI and routine non-cardiac angiography. Out-of-hours non-urgent transfers must not occur. If in doubt, ask the Consultant (see section on intra-hospital transfers).

- Trauma admissions to ICU from outside the hospital must have a formal trauma call in the ED if they have had trauma in the preceding 48 hours, no matter where they have come from (this policy is currently under revision).

Registrar/Fellow/ CMO on Level 3

- Assisting in in-hospital cardioversions in consultation with the cardiothoracic anaesthetic Registrar and/or Consultant rostered-on for CTICU if necessary.
- Weekly Monday case presentations (see meetings timetable). The night Registrar from preceding week presents data and the cardiothoracic Registrar presents a topic for discussion.
- Emergency assistance in CCU and Eastern Heart Clinic as necessary.
- Transfer of intubated or unstable patients around the hospital as necessary (angiography, radiology, etc.).

Fellows/CMOs are responsible for the implementation of all Consultant instructions for patient management in the unit. This will include designated 'on-call' periods (including after hours) as the Consultant. In such cases the Consultant of the week will still be available for consultation at all times. The Fellow/CMO rostered on night duty is expected to review all new admissions, refusals, unstable patients within the units, and attend whenever staff are concerned.

Other specific duties include:

- Ensuring their presence and availability during rostered hours (particularly the weekends until 1700 unless there has been prior arrangement).
- Ensuring the Consultant is kept informed. In particular, calling the Consultant at the end of the day shift over the weekend or the night shift following a weeknight and prior to leaving the hospital, in order to handover.
- Attending and participating in educational talks, grand rounds, meetings and presentations in critical care areas.
- Ensuring that patient eRIC information is accurate and up-to-date.
- Ensuring ANZICS data collection is kept up-to-date.
- Presenting the weekly M&M meeting (see meetings).
- Developing a non-clinical portfolio directed by Senior Medical staff which should include, but not be limited to, initiating and participating in Quality Assurance activities and research projects, and performing management and administrative duties (protocol updates, etc.).

CONSULTANT CALLING CRITERIA

The rationale for specific calling criteria is to mitigate adverse patient outcome or events by ensuring high-risk conditions are made known to the Consultant on-call. Notification should occur in a clinically meaningful time i.e. allowing the Consultant time to intervene before major deterioration or intervention takes place. The ICU Fellow/CMO, when acting as 'first on-call', may choose not to inform the Consultant about certain criteria if such has been previously discussed and mutually agreed.

The Consultant on-call must be spoken to about any of the events described below (day or night):

- In the event of a deteriorating post-operative cardiothoracic patient, escalate to Senior Intensive Care medical staff and the appropriate surgical staff **immediately** (see escalation algorithm attached).
- Patient movement –
    - Acceptance of consideration of acceptance of unplanned patient admission to any unit
    - Refusal of patient admission to any of the units (whether or not due to lack of beds, medical inappropriateness, or other). Please fill out a refusal form (kept in the unit).
    - Unplanned discharge of a patient from any of the units. All discharges should be planned ahead of time.
- Clinical deterioration –
    - In principle, any major deterioration in the patient's condition or a clinical problem evidenced by examination or investigations that is not immediately amendable to currently-planned treatment in the ICU; in particular, a significant derangement of vital signs or Glasgow Coma Score (GCS).
    - Also particular events prompting notification include but are not limited to –
        1. Life threatening dysrhythmias or cardiac arrest.
        2. Significant bleeding despite planned therapy.
        3. Hypotension resistant to treatment with IV fluid volume totalling 1.5 litres.
        4. Introduction of new inotropic or vasopressor drugs.
        5. Increase in patient's pre-existing inotrope or vasopressor requirement by more than 50% from last review by Consultant.
        6. Increase in a patient's inspired oxygen fraction (requirements to maintain stable arterial oxygen saturation) to a FiO2 > 0.6 or a rise of 20% or more or increase in airway pressures by more than 10cmH2O.
        7. Unplanned intubation, extubation or reintubation; any threat to patient's airway.
        8. New onset oligo-anuria (less than 10mls per hour) for three consecutive hours despite urinary catheter flush and reasonable fluid loading.
        9. Any new information that mandates a major change to current treatment plan which may have become suboptimal or dangerous in view of new information.
        10. Review by non-ICU medical team requesting major change in management including anything that involves patient transport.
    - Any proposed change to the daytime management plan, for example antibiotic regimen or consideration of commencing Dexmedetomidine, must be discussed with the duty Consultant prior to implementation.

STAFF PRESENCE

Please note hospital administration has decreed you are not to sleep (except for Fellows/CMOs) while on night duty. The units must never be left unattended. In the case of staff being overstretched, the Consultants must be made aware.

DAILY SCHEDULE, MEETINGS & TEACHING PROGRAM

Daily Schedule Guide

Level 1

0630	Night Resident to collect pathology results and prepare handover
0800	Handover in the Conference Room by night Resident

0830	Teaching (except Mondays); night team attendance is optional
0900	Ward round commences
1230	Check microbiology results
1330	Progress round by Fellow/CMO/Registrar
1400	Pharmacy round (combined with Infectious Diseases when appropriate)
1630	Consultant closing round (1700 for Fellow/CMO round at weekends, with call to Consultant)
1930	Handover to night team
2000	Night team ward round
2230	Night team and/or Fellow/CMO to ring duty Consultant and provide updates

Level 3

0800	Bedside handover
0830	Teaching on Level 1
0900	Ward round
1130	Check microbiology
1630	Consultant closing round
1930	Handover to night team
2000	Night Registrar ward round
2200	Night Registrar and/or Fellow/CMO to ring duty Consultant and provide updates

Meeting Program

All meetings are held in Level 1 ICU Conference Room unless otherwise specified.

Level 1 Weekly M&M Meeting	Held Thursday mornings, presented by Fellow/CMO in PowerPoint format. Please ensure any action points discussed throughout meeting are entered into the presentation slides in real-time. The presentation should then be forwarded to the Fellow/CMO who will be presenting the monthly M&M.
Level 1 Monthly M&M Meeting	Held on second Tuesday of every month in place of Grand Rounds. The presentation is prepared by the ICU Fellow/CMO. This presentation should be a summary of the weekly M&M meetings, including actions the actions taken, and should include any interesting M&M cases. If in doubt about M&M content or format, please discuss with Dr Arora. In addition, our data manager will present general unit statistics and agreed Key Performance Indicators.

Note for M&M – in order for accurate M&M meetings, it is the responsibility of **all** medical staff to enter events into the M&M book, kept at the nurses' station in General ICU.

ICU Grand Rounds	Every Tuesday 1230-1330 except when monthly M&M meeting scheduled. Sponsored lunch often provided.
Infectious Diseases Ward Round	Level 1 only, at the bedside. Occurs at 1400 hrs on Tuesdays and Thursdays. Please ensure microbiology Excel document is up-to-date (see Duties/General Duties).
Radiology Meeting	Level 1 only. Held Wednesdays, time flexible. There is a 'Golden Radiology' book for medical staff to list interesting cases for the week. The Resident of Registrar takes the

	list of patients whose images are to be discussed to the radiology department mid-morning.
Level 3 Cardiothoracic Case Review	Held weekly on Mondays at 0730 in the Level 3 Conference Room. Presented by the night Level 3 Registrar and cardiothoracic Registrar (see above).

Teaching Program

Morning Teaching Sessions	• The morning teaching sessions are an opportunity for junior staff to present a planned topic relevant to care of the ICU patient. The forum is one of small group teaching with open discussion. • The list of topics is provided in advance. Please check the roster to see when you are scheduled to present. If there is a good reason for not presenting on a particular day (e.g. study or annual leave), please discuss with Dr Collins or the duty Consultant well in advance. This will allow for a stand-in presentation or swap to be arranged. • Seek advice from senior colleagues on the important areas to cover during your presentation. It should run for approximately 20 minutes. • A copy of the talk should be saved on the general ICU computer in the education folder (located on the desktop).
Journal Club	• Presented on Fridays by the Level 1 day Fellow/CMO. The article(s) should be checked beforehand with a Consultant.
Examination Preparation	• You should met with your supervisor of training at beginning of term to discuss your personal development needs and formulate an active training plan. All the Consultants are keen educators. • Anaesthetic primary sessions are usually run by Dr Collins and held on Thursdays at 5pm. Please contact Dr Collins or ICU Secretary to confirm if sessions occurring. • For Fellows wishing to sit the CICM clinical examinations, specific teaching will be tailored to their needs.
Multidisciplinary Crisis Resource Management (Simulation Learning)	• All junior staff are expected to have formal DETECT, BLS and ALS/ILS training. POW offers DETECT, BLS and Australian Resuscitation Council-accredited (ARC) training, which you can book through NERU. If you are intending on a career in anaesthetics or critical care, we strongly encourage you attend ARC's two-day accredited course (ALS2) or the EMST course. Contact any one of the Consultants for further information. • Level 1 will hold regular multidisciplinary in-house ICU scenarios. • The cardiothoracic ALS (CALS) course is a simulation day of ICU-based scenarios designed for Level 3 nurses and ICU Registrars o enhance learning in a safe environment. This course is usually held 4 x per calendar year. You will be emailed closer to the dates and invited to submit expression of interest for attendance. Places are limited.

ADMISSIONS, DISCHARGES AND DEATHS

Admissions

- All admissions must be approved by the duty Consultant or Fellow/CMO. Please also discuss the admission with the NUM and/or nurse in-charge as soon as it has been accepted by the Consultant.
- The ICU staff manage a patient during their stay in all units. In other words, we operate a closed-unit system. This means suggestions from primary care teams need to be discussed with the Consultant Intensivist.
- There are many potential obstacles to communication between teams. We ask that attending teams document and verbally communicate their suggestions in eRIC (**NOT eMR).** This is especially so during early morning, prior to handover. We should encourage them to come and talk to us during handover if necessary.
- Resuscitation or admission must not be delayed where the presenting condition is imminently life-threatening (e.g. profound shock or hypoxia).
- Admission is reserved for patients with actual or potential vital organ system failures, which appear reversible with the provision of higher level support.
- Patients are admitted under the name of the original primary care team, who should be informed of the transfer.
- Patients admitted from outside the campus must be accepted and admitted under a non-intensive primary care team, who should be notified of the patient's admission prior to transfer being initiated. If the patient is unstable or there are delays in locating a primary care consultant, it is reasonable to initiate inter-hospital transfer.
- There is a no-refusal policy on the basis of bed availability for acute spinal, interventional neuroradiology (including endovascular clot retrieval), and hyperbaric patients. If there is a problem accepting such patients, the Consultant must be informed.
- Patients being admitted from elsewhere with radiology images on CD must have all their films loaded onto the campus PACS system. The radiology department is happy to do this when presented with such CDs. This way unnecessary repetition of investigations can be avoided.
- Admission disputes must be referred to the Consultant.
- Regarding Level 3 public cardiothoracic admissions (please refer to attached example):
    1. There is a theatre list kept on the middle table (behind pathology chute) so you know what to expect. This frequently changes however.
    2. Most admissions follow a protocolised clinical pathway of extended recovery.
- Regarding Level 3 private admissions:
    1. Level 3 private ICU remains a paper-based unit.
    2. Paperwork is located in pigeonholes behind the blood gas machine, next to the private radiology computer.
    3. If a patient was initially public but then elects to become private, everything needs to go on to private paperwork (admission notes need to be transferred over if accidentally written on public paperwork). **As soon as a patient becomes private, send off a private G+H and crossmatch**, even if there is a valid one in the public system. This is an extremely stressful and frustrating experience if the patient urgently requires blood.
    4. If the public hospital elect to lease a bed for a patient in the private to mitigate bed stress then:
        - All notes need to be written on private hospital paperwork
        - Pathology requests go on a public hardcopy request form and use the public stickers.
        - Radiology request forms are handwritten on the normal public radiology form and use the public stickers.

Discharges

- All discharges **must** have:

    - Approval by the unit Consultant
    - Current issues, outstanding results, and management plan discussed with the treating team. When a discharge occurs out of hours, the covering medical staff should be contacted.
    - Review of the information that eRIC collates to form the discharge summary. This discharge summary is then included in a broader electronic transfer of care document. This document is then automatically loaded onto eMR. Keeping clear daily records will assist in this process.
    - **A flag entry and notation in the hospital eMR handover tool if necessary.**
    - Ensure that you have eMR training for this and a census task list made (see attached guides).
    - Level 3 private ICU – if a patient is ready to T/F to ward, then make sure 'the stamp' is used in the notes and the Consultant is notified. Active issues must be verbally handed over to the private Consultant.
- Treatment limitation/non-escalation Directives must be discussed with the patient or patient's family and the primary care team, and clearly documented in the notes. Not-for-CPR forms remain in paper form on the wards at the time of writing.
- In some cases it may be appropriate to modify the PACE (patient with acute condition for escalation – emergency response system) calling criteria for a patient to go to the wards. All these forms are now electronic.
- Discharges after hours must be discussed with the Consultant as these potentially incur higher morbidity and mortality.

Deaths

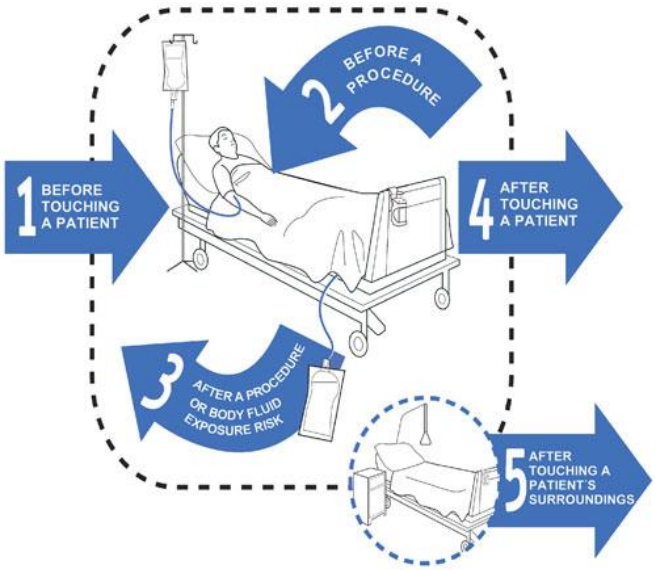
- Withdrawal or limitation of therapy is a Consultant responsibility. Documentation of such a management plan is done by the Consultant or Fellow/CMO.
- The unit Consultant and Admitting Medical Officer (AMO) must be informed of all deaths.
- Every death fulfilling the trigger criteria for organ donation (see attached) must be discussed with the donor coordinator on-call.
- For each death the Registrar must ensure:
    - A coronial checklist is completed and the Coroner informed if appropriate.
    - A death certificate and cremation form is completed (check cause of death with Consultant or Fellow/CMO if not clear).
    - The primary care team is notified.
    - Referring doctors (i.e. GPs, other specialists and hospitals) are notified.
- Where indicated, consent for a post-mortem should be obtained from relatives by the Fellow/CMO or Consultant as soon as possible.
- If a referral is made to the Coroner of for a post-mortem, consult senior staff regarding the pertinent clinical information required.

INFECTION CONTROL

General Measures

- Prevention and containment of nosocomial infection is a fundamental principle of effective medical practice.
- The critically ill patient is highly vulnerable to nosocomial infection, which results in significant morbidity, prolonged length of hospital stay, increased cost and an attributable mortality.
- It is the responsibility of every member of the healthcare team to ensure compliance with hospital and unit infection control policies. This may include reminding senior colleagues or visiting teams to conform to basic issues such as hand washing or barrier nursing measures.
- It is expected that all staff are bare below the mid-forearm (with the exception of one plain mobile ring) when in contact with patients.

- Hand hygiene remains the only established method of effective infection control and must be assiduously performed by all members of the healthcare team. There are five moments of opportunity to perform hand hygiene:



- Hand rub with alcohol solution:
    - Before wearing gloves.
    - Before and after patient contact.
    - Before and after contact with patient's environment.
- Hand wash with soap:
    - If any contact with blood or body fluids.
    - If hands visibly soiled.
- Hand wash with chlorhexidine:
    - Prior to clinical procedures.
    - After contact with patients with multi-resistant organisms.
- On Gloves:
    - Disposable gloves must be worn for all contact with patient's bodily fluids, dressings and wounds.
    - Gloves must be disposed of within the patient cubicle upon exiting.
- Plastic aprons must be worn while making physical contact with the patient (e.g. turns, examinations)
- A 'modified contact precaution' sign must be places as a reminder at the entry of cubicles with patients regarded as infection risk
    - When transferring such patients around the hospital, we use reverse isolation.
    - Consumable stock within patient cubicle should be kept to a minimum.
    - Notify appropriate staff if patients are transported to theatre for procedures, or for ambulance transport.
    - Once the patient has been transferred or discharged, the area should remain vacant until cleaned in accordance with POW policy.
- Additional precautions may be required
    - Clostridium difficile – requires soap and water for hand hygiene.
    - Surgical masks are required for droplet precautions. Note that if such patients are on CPAP or BiPAP, they are treated as requiring airborne precautions (see below).
    - N95 masks are required for airborne precautions and the cubicle room door must be closed.
- Aseptic technique is to be used for all patients undergoing major invasive procedures. This includes:
    - Hand disinfection with antiseptic liquid soap for 60 seconds.

    - Sterile bassier with full gown, mask, hat, gloves and sterile drapes (please note your hat and mask must be placed prior to hand washing at all times).
    - Skin prep with chlorhexidine 1% in 75% alcohol, let the skin dry.
- Traffic
    - Movement of people through the unit should be kept to a minimum. This applies equally to visiting clinicians and large numbers of relatives.
    - All visitors are expected to conform to the above infection control measures and should be tactfully reminded or instructed when necessary.
- There are 10 segregation cubicles on Level 1. Of these, 8 share the unit's air-conditioning and 2 are negative pressure rooms. There are 2 segregation cubicles on Level 3.
- All new admissions are screened for MRSA.
- Patients arriving directly from an overseas hospital or who are known to have had an admission to a healthcare facility outside Australia in the last 12 months are isolated routinely and must have extended screening.

PROCEDURES AND CONSENT

- All competent patients undergoing invasive procedures (including packed red cell transfusion) in any department should have a standard consent form completed and signed by the patient.
- For incompetent patients (sedation, coma, delirium or encephalopathy):
    - Third party consent is not necessary for many procedures (blood transfusion, endotracheal intubation, arterial lines, CVCs, pulmonary artery catheters, transvenous pacing wires, underwater seal drains, oesophageal tamponade tubes and bronchoscopy). However, relatives should be informed prior to the procedure if possible.
    - Major invasive procedures (such as percutaneous tracheostomy, coronary angiography, intra-aortic balloon counter-pulsation, permanent pacemaker insertion or major surgical procedures) require the completion of a consent which is signed by a third party (person responsible).
- If relatives cannot be contacted, emergency life-saving treatment should proceed immediately after discussion with the Consultant.
- Ultimate responsibility for consent lies with the operator performing the procedure.
- **Time out** should be performed for all invasive procedures in ICU. The only exclusions to this at present are peripheral cannulas and arterial lines.
- It is the responsibility of the operator to document a procedure in eRIC. Both the time out and consent also need to be documented on specific forms in eRIC for Level 2 procedures, but on paper for Level 3 procedures. This process is subject to change.
- When a central venous catheter (CVC) has been inserted, complete the CVC insertion form in eRIC, including both the time out and consent documentation.
- Sterile syringe labels are available to use when drugs are required to sit on the sterile field awaiting use. They are not necessary when a drug is drawn up and administered immediately.

AIRWAY MANAGEMENT

- Airway emergencies are rare but have potentially devastating consequences. The cornerstones of airway management are preparation and training. Truly elective airway procedures should only occur in office hours. Elective and semi-elective airway access (intubation, tracheostomy placement, or changing of either of these)

must be planned and have appropriately trained staff in attendance. This may well mean the off-site or on-call staff coming in and/or anaesthetic assistance being organised. Should there be an airway emergency, help (in the form of the most senior available on campus medical staff and the emergency response team) must be called for.

- Useful local policies can be found at the following intranet links: Tracheostomy management policy; Laryngectomy management policy.

EMERGENCY CALLS

Medical Emergencies

- The POW medical emergency number is 2222. Code 'blue' is the colour code term for medical emergencies.
- The team attending includes the ICU Registrar and a senior member of the nursing staff. Code blues are called for both the seriously deteriorating patient and the cardiopulmonary arrest victim.
- At the site of the emergency –
    - Follow the Australian Resuscitation Council (ARC) guidelines for cardiopulmonary resuscitation.
    - Basic Life Support (BLS) is done by attending nursing and medical staff and may be directed by either ICU or medical Registrar.
    - Advanced Life Support (ALS) is directed by the medical Registrar unless they feel unable to.
    - Document your involvement with the resuscitation in the patient notes.

Trauma Calls

- On receiving a trauma call the ICU Registrar should proceed directly to the resuscitation bays in ED.
- Trauma resuscitation –
    - POW follows the Early Management of Severe Trauma (EMST) guidelines.
    - The team leader is designated by the current Trauma Service Directive (found on the wall in Resus).
- The role of the ICU Registrar
    - Primarily as a backup for acute life-threatening situations in the event that sufficiently experience personnel are not available in resus or until the patient is stabilised.
    - Initial airway assessment and management.
    - Establishing effective ventilation.
    - Assistance with vascular access and restoration of circulation.
    - Once anaesthetic and trauma team members are present and the situation is under control, return to ICU after asking the team leader if it is appropriate to do so. Do not leave ICU unattended for lengthy periods of time. If prolonger resuscitation is anticipated, call more senior ICU or trauma staff and/or delegate to the anaesthetic/resuscitation Registrars if necessary.
- Transportation of trauma patients to CT scan, angiography etc., is not the responsibility of ICU.
- Document your involvement with the resuscitation in the patient notes.
- There is a no refusal policy on the basis of bed availability with regard to admission to POW for acute spinal injuries. All potential admissions must be discussed with the duty Consultant.

Hospital Emergencies

- Emergency number is 2222. State the nature and location of emergency.
- Copies of the hospital emergency procedures are kept in clear sight at the nurses' station in all units.
- Hospital emergencies constitute: fire/smoke, medical emergency (see above), bomb threat, internal emergency (e.g. power failure), personal threat, external emergency and evacuation.
- The Chief Fire and Emergency Officer is the overall controller during a fire or smoke emergency (code red).

    - Become familiar with the location of fire exits, extinguishers and blankets in the unit.
    - Unless a fire is small and easily contained, do not attempt to fight the fire yourself.
    - Remove yourself from the immediate vicinity of fire, alerting other staff members as indicated, and position yourself behind the automatic fire doors.
    - Wait for the arrival of the Fire Chief and assist in any patient movement/evacuation only as indicated by the Fire Chief.
- Ensure the duty Consultant is informed of any emergency that affects any unit, including an external emergency with large patient numbers expected (in the case of a major disaster, the Consultant should have been contacted by the hospital disaster controller).

INTRA-HOSPITAL TRANSPORTATION OF INTENSIVE CARE PATIENTS

- All transports must be authorised by the Consultant. Only urgent, management-changing investigations will be considered out-of-hours.
- In general, ICU patients require a medical escort.
- Patients must be appropriately monitored during the transport and observations recorded on the flow chart.
- Document any problems that may occur during transport.
- As a general rule, ICU staff are responsible for transportation of ICU patients.
- Anaesthesia staff are responsible for transport of the following:
    - Patients to and from theatre.
    - Prolonger investigations/treatments (e.g. angiographic embolisation, initial or complex interventional neuroradiology [not subsequent surveillance angiography]).
    - Patients that are as yet not admitted to the ICU such as ED transfers to radiology or the Easter Heart Clinic.

INCIDENT MANAGEMENT AND MONITORING SYSTEM (IIMS)

The IIMS is an electronic package for the purpose of reporting all incidents and near misses, e.g. drug errors. All staff are required to complete an IIMS for these situations. A description of the procedure is attached and will be part of your orientation.

WORKPLACE HEALTH & SAFETY

- Our medical WH&S Officer is Dr Sumesh Arora.
- You are required to be credentialed in the following –
    - Personal Protective Equipment (PPE)
    - Mask-fitting
    - Fire safety – there are regular compulsory fire training sessions
- All staff are required to be up-to-date with their immunisations (see below).
- All staff must be aware of the medical risk register. It is located in ICU on the bookshelf of the nurses' station.

- Staff Health (CHESS clinic) is the first point of call for any needle stick injury or occupational exposure to hazards. They also provide staff immunisations.
- CHESS is located on Level 2 down the first left-hand corridor after the Campus Centre and Pharmacy. The office-hours contact is 9382 2859 or page 42782. After-hours, contact the needle stick assessor 'on call' via Switchboard. CHESS email is SESLHD-POWH-IPC-OccupationalScreening@health.nsw.gov.au.
- During orientation you will receive a protocol for needle stick injury to hang on your lanyard.
- It is a condition of employment that you are compliant with this policy - https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_017.pdf. You must be appropriately immunised to Hep B, Varicella, Diphtheria, Pertussis, Tetanus, Measles, Mumps and Influenza. Contact CHESS if you require any of these immunisations.
- TB Screening is also a condition of employment. The TB Chest Clinic can be contacted at 9382 4643.

QUALITY ASSURANCE & RESEARCH

- Members of the medical and nursing staff are encouraged to become involved in quality assurance activities and research during their service within the unit. The senior medical and research staff will provide a formal orientation but are happy to talk anytime.
- The POW ICU is a full member of the Australia and New Zealand Intensive Care Society Clinical Trials Group (ANZICS CTG). It is an active participant in many multi-centre studies endorsed by the ANZIC CTG and primarily funded by the National Health and Medical Research Council (NHMRC). A/Professor Shehabi is the Director of ICU Research and is supported by the Data and Research Project Manager.
- Registrars and Fellows/CMOs are expected to familiarise themselves and be involved in obtaining consent for research studies that require a prospective consent within the unit.
- If you have a quality assurance activity or research idea, or want to undertake a project (FCICM requirement), please contact A/Prof. Shehabi or any other Consultant. We are more than happy to facilitate. All projects must obtain approval from the POW Research Ethics Committee prior to commencement. Completed research projects should be presented either at a local or interstate scientific meeting. Some funding is available for both nurses and medical staff who present work at any meeting.

INFORMATION TECHNOLOGY AND CONFIDENTIALITY

All senior and junior medical staff offices are equipped with personal computers connected to the POW Local Area Network (LAN). Facilities available through the LAN include –

- Hospital email account.
- Intranet resources, including:
    - ICU Sub-Intranet containing some valuable resources.
    - Clinical Governance.
    - Hospital protocols and policies.
    - Internal Staff Contact Directory.
    - Clinical Information Access Program (CIAP) with access to Medline, MIMS, UpToDate, and electronic textbooks.
- Internet browsing.

Use of hospital computers to access inappropriate material is not tolerated. POWH guidelines detail appropriate use.

Patient confidentiality must be maintained at all times. Consent must be sought prior to obtaining any photographic (including radiology) material. Material must not be used on social media without prior arrangement. Please refer to NSW Health guidelines regarding social media usage and your Code of Conduct.

ATTACHMENTS

- ✓ Campus map
- ✓ Rosters (as available)
- ✓ ICU Shift Swap Form
- ✓ Pay period calendar
- ✓ Teaching Timetable (as available)
- ✓ Cardiothoracic Admission Example
- ✓ Cardiothoracic ALS Algorithm
- ✓ eMR Quick Reference Guides for patient handover – also located at each computer station;
    - JMO Handover Tool – POW and SGH Only CTL without actions Setting Preferences
    - JMO Handover Tool – POW and SGH Only – Ad-Hoc without actions
    - JMO Handover Tool – POW and SGH Only- CTL (Census Task List) without actions
- ✓ IIMS Cheat Sheet - How to lodge an IIMS report
- ✓ Organ Donation Information