Intensive Care Unit - Operating Procedure

Effective: 3 February 2016

1. GUIDING PRINCIPLES

South West Health Campus is committed to providing safe and appropriate healthcare.

The following document defines the role of the Level 1 Intensive Care Unit (L1 ICU) in patient management and outlines the pathways to access the unit. The intention is to improve the interdisciplinary communications, management and care of patients requiring admission to the ICU. The process will provide a framework for balancing the competing demands of clinicians for admissions of patients to the ICU.

For the purposes of the following Operating Procedure, the term "ICU" is defined as all beds contained in the combined unit of four (4) ICU and four (4) HDU beds, in the interim phase until such time as level 2 status is reached, or otherwise advised.

2. PROCEDURE

ICU provides the highest degree of monitoring and nursing care within Bunbury Hospital. The unit has 8 beds and was planned to offer 4 ICU beds and 4 HDU beds during 2012 and 2013. Due to nursing shortages it is currently staffed for 4 ICU and 2 HDU beds. There is a plan to have staff for 100%occupancy in future.

The ICU operates as a closed unit, i.e. patients admitted to ICU will be primarily under the care of the Duty Intensivist and the ICU team.

When any patient is accepted for admission to the ICU/HDU Bunbury hospital by the ICU Consultant or his delegate, the Duty of Care is to rest with the treating ICU Consultant for the duration of the ICU/HDU admission. This is to be reflected in patient's notes and management component of the discharge summary.

The ICU patient will also have a nominated Home Unit.(Medical/ Surgical/Orthopedics/Obstetrics & Gynaecology and Paediatrics) While the primary responsibility for patients in ICU will be with the Duty Intensivist, members of the Home Unit are welcome to be involved with the care of their patients but all changes in treatment must be relayed through the Duty Intensivist. Upon discharge from the ICU the patient is to return to the care of the Home Unit, after appropriate liaison (unless discharged directly or when a different discharge location is more suitable).

The Home team or Consultant component of the computer screen and discharge summary is to reflect patient to be under the home team. It is important that this occurs for continuity of care in patient's management before admission to ICU/HDU and at the time of intra hospital and inter hospital transfers.

3. DEFINITIONS

ED	Emergency Department
ICU	Intensive Care Unit
HDU	High Dependency Unit
NUM	Nurse Unit Manager
MER	Medical Emergency Response

4. ROLES AND RESPONSIBILITIES

4.1 The Home Unit Consultant (or acting on their behalf, the home unit Duty Registrar) responsible for the patient requiring admission to ICU is to contact the Duty Intensivist or the Duty ICU Registrar via Bunbury Hospital switchboard, to discuss the patient's requirement for ICU care. If the referral is made to the duty ICU registrar, he / she must then refer the request for admission to the ICU (including the HDU beds) with the duty Intensivist. Only patients who have been accepted by the Duty Intensivist may be admitted to ICU.

4.2 Note that this policy applies to all sources of referral, whether they be from the Emergency Department, an inpatient ward, the operating theatres or the St. John of God hospital.

4.3 The Duty Intensivist or Duty Registrar must liaise with the ICU Shift Co-ordinator on 1217 regarding unit capacity and bed availability prior to finalising acceptance of the patient and prior to the transfer of the patient to the ICU.

4.4 The Home Unit Registrar for the patient is to liaise with the Duty Registrar for ICU and provide a comprehensive handover including written documentation of continuing care requirements.

4.5 The ward/ ED Shift Co-ordinator is to liaise with the ICU Shift Co-ordinator (1217) prior to initiation of patient transfer.

4.6 Any perceived issues around access are to be discussed between the ICU NUM, ICU CNS, the Home Unit Consultant and the Duty Intensivist if indicated

4.7 Patients referred from ED to ICU for possible ICU/HDU admissions are to be reviewed by the duty ICU Registrar/ ICU Consultant within 45 min of referral. In the case of ICU review delay secondary to other workload the ED team is to be informed and is to be responsible for ongoing care until ICU review.

4.8 Patients requiring tertiary level care (including Intensive Care) are to be referred directly by the ED medical team to the most appropriate tertiary facility. If the patient requires intensive care medical input prior to transfer (or if there will be significant delays to patient transport) ED are to refer to the ICU team. In the case of significant delays to interhospital transport the ICU will admit the patient to the Bunbury ICU (where appropriate capacity exists). If ICU/HDU is full or not able to accept patients and patient needs ICU care then ED to refer patients to Perth directly and manage them in ED. ICU Consultant/ Registrar would be happy to help in management, if need arise, but it should primarily be ED responsibility to manage and arrange for transfer.

4.9 If patients referred to the ICU cannot be accommodated due to capacity constraints the issue is to be escalated to the duty ICU Specialist and ICU nurse coordinator to ensure that all local solutions for patient care have been considered. If it is decided that tertiary referral is the only solution (this is to be made by the ED medical staff) Ongoing care of the patient is to then follow the principles outlined in point 8 above.

4.10 The ICU medical team are responsible for the care of patients once they have been reviewed and accepted for admission to the ICU (irrespective of their location within the hospital). If there are delays in admitting patients to the ICU the responsibility of ongoing care of the patient still rests with the ICU team. The Emergency Department team should only become involved in an emergency situation or after discussion with the ICU team. There is to be clear communication between ICU and ED regarding care of patients. The ED medical staff are to assist in the care of any ICU patients in ED when the ICU workload prevents prompt attendance by the ICU registrar.

4.11 ICU team is responsible for management of patients admitted under their care. ICU is to liaise with the Home team if they need input from the home team in patient’s management in ICU/HDU.ICU is open to have input and suggestions from the Home team in patients care. ICU team is responsible from a medico legal perspective for the management of patients admitted under their care in ICU/HDU.

4.12 When a patient is ready to be discharged from ICU/HDU, ICU registrar is to inform the Home team registrar about the transfer. ICU registrar is expected to give a detailed hand over along with the Discharge summary in patients file.

4.13 ICU Consultant is responsible for the decision making for the Admission/Discharge process of all the patients admitted / discharged from ICU. ICU Consultant on call is to provide outreach support for patients care after discharge from ICU. If there is any concerns regarding patient’s condition or care after ICU discharge, it is expected that the Home team registrar/consultant will directly discuss with ICU Consultant on call for any urgent review/ discussions required

4.14 Patients referred to ICU for possible ICU/HDU admissions from ED and other wards are to be reviewed by ICU team in a timely fashion. The decision to admit or refuse admission to ICU is entirely with ICU team (ICU Consultant on Call) the decision to be documented and communicated to the primary team. The ICU Consultant on call is to make the final call for admission/discharge of patients to/from ICU/HDU and will be medico legally responsible for the decision. In case of disagreement, it is expected that a Consultant to Consultant discussion occurs in the best interest of the patients care.

4.15 The decision to effect an unanticipated, out of hours, discharge of a patient from the ICU to a general ward must be made by the Duty Intensivist in conjunction with the Home Unit Consultant managing that patient (or their registrars acting on their behalf where they may delegate this function). An appropriate level of care must be maintained.

5. PLANNED ICU ADMISSION POST ELECTIVE SURGERY

5.1 The Duty Anaesthetist or Surgeon is to contact the ICU Shift Coordinator on ext.1217 and the Duty Intensivist at least 24 hours prior to the planned admission and provide relevant details e.g. patient identification, clinical indications and potential Length of stay.

5.2 On the day of the planned admission to ICU the Anaesthetist must contact the ICU Shift Co-ordinator to confirm bed availability prior to the commencement of the anaesthetic.

5.3 If admission to ICU is not possible due to occupancy/ acuity the procedure may need to be postponed.

5.4 ICU is to keep a Folder for ICU/HDU admissions, where we keep all the elective booking forms. ICU Coordinator in the morning is to check the folder and update about elective bookings.

6. UNPLANNED /EMERGENCY ADMISSIONS POST ELECTIVE SURGERY/ EMERGENCY SURGERY

6.1 The Duty Intensivist/ICU Registrar and the ICU Shift Co-ordinator is to be contacted in the first instance to confirm bed availability and appropriate clinical resource. The timing of the transfer from Recovery is to be in full consultation with the ICU Shift Coordinator (1217) to ensure a smooth transfer of care while maintaining comprehensive monitoring and interventions as clinical appropriate.

6.2 A comprehensive handover must be provided by the patient's Home Unit Registrar to the ICU Registrar and documented in the medical record.

6.3 The Anaesthetist/ Surgical Team to Contact ICU registrar (2717) and inform about the possible ICU/DHU admission. If the request is for a HDU bed, it is expected that the ICU registrar will review the patient in recovery and discuss the case with the on call ICU Consultant and takes a decision regarding ICU/HDU admission. The decision to be documented and communicated to the Anaesthetist and home team.

6.4 In cases, where patient needs emergency unplanned admission to ICU, it is expected that the Anaesthetist looking after the patient will liaise with the ICU registrar and request for a ICU bed. ICU registrar will discuss with ICU consultant and ICU Nurse Coordinator and accepts the ICU admission. If the bed is available, patient to be transferred to ICU in a timely fashion with minimal possible delay. If a bed is not available in ICU, then, the patient to be managed in recovery by the anaesthetist looking after the patient and the recovery nurses till the bed is available in ICU. All efforts will be made to expedite the process to take patient to ICU/HDU.

7. EMERGENCY TRANSFERS (including post MER events)

7.1 Unplanned admissions/transfers from other clinical areas across the SW Health campus to ICU must be referred to the Duty Intensivist in the first instance by the Home Unit.

7.2 The ward Shift Co-ordinator is to simultaneously advise the ICU Shift Coordinator (ext.1217) of a pending admission/transfer and to confirm availability of a bed.

7.3 Resuscitation or admission to the Unit must not be delayed in imminently life threatening cases, unless specific advanced directives exist and are clearly documented.

8. COMPLIANCE

It is a requirement of the WA Health Code of Conduct that employees “comply with all state government policies, standards and Australian laws and understand and comply with all WA Health business, administration and operational directives and policies”. Failure to comply may constitute suspected misconduct under the WA Health Misconduct and Discipline Policy.

9. EVALUATION

Adverse events related to the instruction target zero.

10. REFERENCES

Royal Adelaide Hospital ICU protocols and guidelines: 2012.

This document can be made available in alternative formats on request for a person with a disability

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