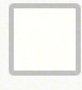

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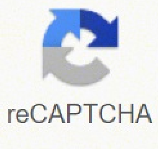

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66039022.703704 21811956.03125 40634444264 7362514.5172414 12566185.594595 41261426850 35954.438596491 12621931976 10739601.340426 348228342 92007682.380952 885035.39772727 160414064067 14506202.12 40625365.3125 3795708.8414634

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Manajemen Sedasi Pasien ICU, Richmond Agitation Sedation Scale (RASS)		
Skor -3	Ada gerakan (tidak ada kontak mata) terhadap suara	**Penggunaan sedasi:** O Ya / O Tidak **Target Skor RASS :** **0 sampai -3** **Skor RASS pasien:** ______
Skor -2	Bangun singkat (<10 detik) dengan kontak mata terhadap rangsang suara	
Skor -1	Pasien belum sadar penuh, tetapi masih dapat bangun (>10 detik), dengan kontak mata/mata terbuka bila ada rangsang suara	
Skor 0	Tenang dan waspada (tidak agitasi)	
Skor 1	Cemas atau kuatir tetapi gerakan tidak agresif	
Skor 2	Pasien sering melakukan gerakan yang tidak terarah atau pasien dan ventilator tidak sinkron	
Skor 3	Pasien menarik selang endotrakeal atau mencoba mencabut kateter, dan perilaku agresif terhadap perawat	

ELIMINATION

URINE

Intake (sebelumnya)
Infus : _____cc
Oral/NGT : _____cc
Med. Drip : _____cc

Output (sebelumnya)
Urine : _______cc
IWL : ________cc
Drain : _______cc

Balance cairan : ________cc

Kebutuhan cairan aktual:

Kateter urin
Terpasang : O Ya / O Tidak
Jenis : O Folley O Kondom O Suprapubic

Karakteristik urin
Warna :

Pola BAK (deskripsikan)

Hasil Lab/Px Penunjang Lain Terkait Fungsi Ginjal:

Elektrolit Tgl (_____)
Na+ ______
K+ _______
Cl- _______
Ca^{2+} _______
Fosfat ____
Mg^{2+} ______

Lainnya (tuliskan)
Crea ______
Ureum _____

BOWEL

Karakteristik feses (warna, konsistensi):

Pola BAB (deskipsikan):

Bising usus : _______ x/menit
Asites : O Ya / O Tidak
Lingkar abdomen : ______cm
Hemoroid : O Ya / O Tidak
Stoma : O Ya / O Tidak Tipe/Lokasi : _______

Nyeri tekan abdomen/ teraba masa (+/-) — **Ka** | **Ki**

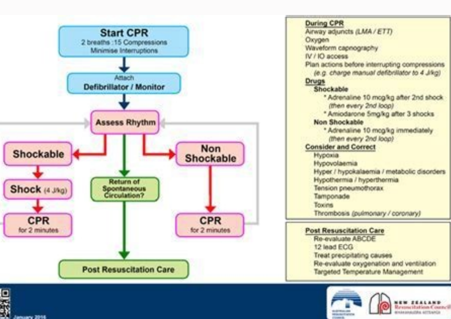
Status Nutrisi
Berat badan : ________ Kg
Tinggi Badan : _______ Kg
IMT: _______________ Kg/m^2
Konjungtiva anemis : O Ya / O Tidak

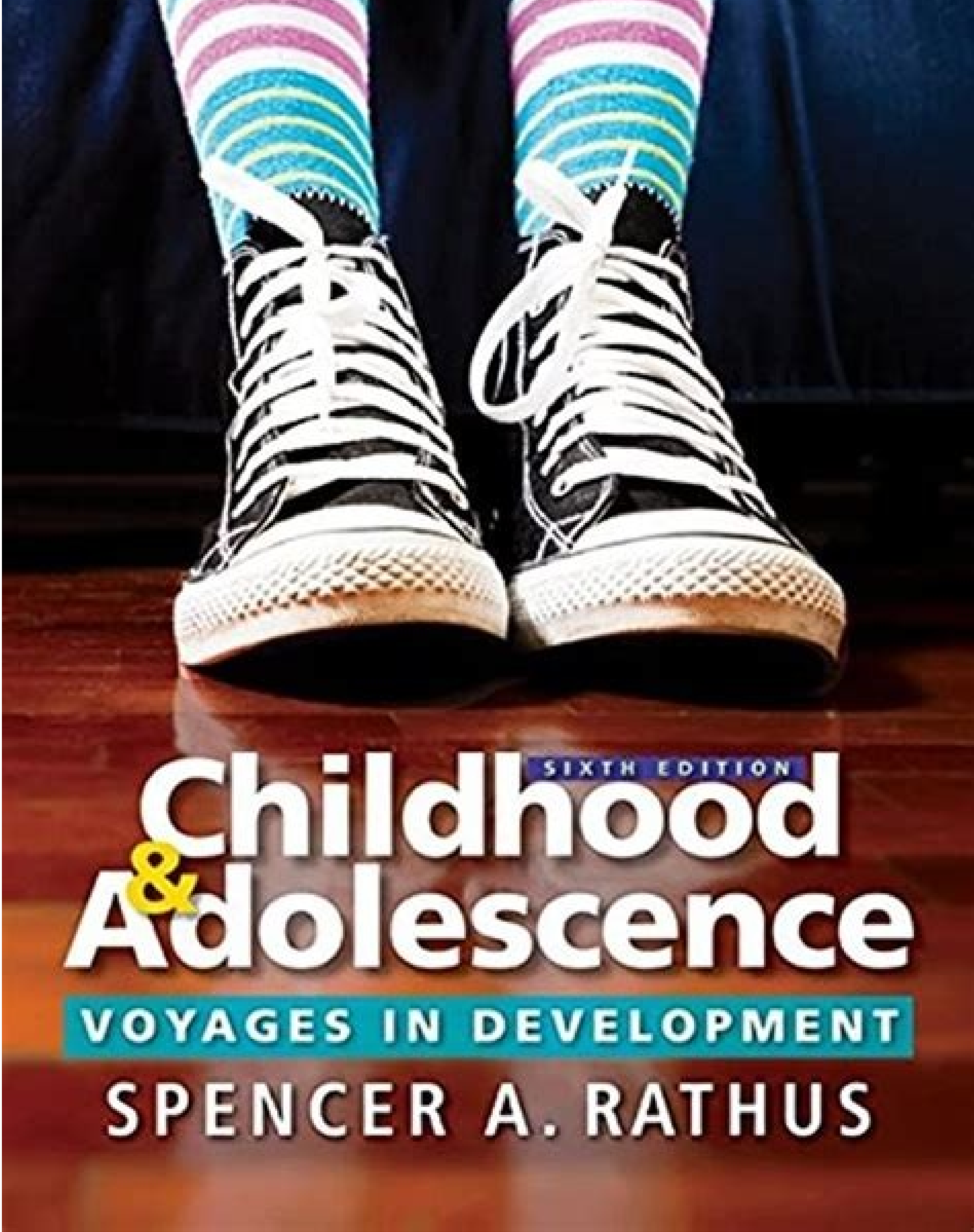
Kebutuhan nutrisi aktual:

Hasil Lab/Px Penunjang Lain Terkait Fungsi Abdomen/Nutrisi:

Tgl (______)
Alb _______
PT _______
Hb _______
GDS _____

Lainnya (tuliskan)





Emergency Surgical Airway Access .... 33. 16 G. c) All admissions, including transfers and retrievals, must be approved by the Duty Intensivist (SD: 1650). b) Ensure an adequate PA tracing is on the monitor at all times 40. Total Parenteral Nutrition (TPN) a) ICU provides a TPN service for the hospital. c) Current x-rays and investigation results are displayed via computer projection. 106 Table: Antibiotic Infusion Schedules .... ii) The team leader is designated by the current Trauma Service Directive (found on the wall in Resus). 39 I. Following invasive procedures: i. Arterial Cannulation 1. The ICU Registrar should remain immediately available if a MET call has been activated, so that assistance can be provided to the MET team if required (e.g. avoid starting procedures such as CVC insertions if the MET pager has activated). 27. Limitation of Therapy .... c) Further involvement is encouraged and there are supports within the unit to facilitate research to occur. Weekly Programme.. 25 4. An extensive range of electronic text books ICU Handover Database iv) On application registrars will be allocated a username, which will carry with it an 'Internet' e-mail account for the duration of their stay. b) Portfolios are determined by experience and rostering requirements. c) When "33#" is displayed on the pager: i) Dial "33#" on an internal phone. g) MedStar Retrievals i) Require admission under a parent clinic, who should be aware prior to patient transfer and notified of the patient's arrival in the ICU. State day of ICU admission (e.g. Day 6 ICU). e) Such admissions should be discussed with the Duty Intensivist ASAP. c) Families should be supported to accept that there may still be uncertainty about the patient's course and the timing of death. Antibiotics .... Central Venous Catheters NB: Registrars should be familiar with the interpretation and limitations of haemodynamic variables derived from central catheters (CVC, PICCO and PAC) in critically ill patients. iv) Should be attended to in a timeframe appropriate to the patient's condition. In the interim, the previous manual (2012) can be downloaded here. e) Remove catheters once they are not being routinely used. If anaesthetic staff are not immediately available, the following role is indicated until appropriate personnel arrive: a). d) The 'TPN Folder' is kept in the Unit A ward station. 38 I. 109 Table: Perioperative Endocarditis Prophylaxis.. 186 Flowchart: Cerebral Perfusion Pressure Algorithm .... iv) Advanced life support is directed by the more senior registrar present. These students are strongly supported by the ICU Research Unit. 21 5. iii) Skin prep: chlorhexidine 1% b) Local anaesthetic gel in all patients. Consultant / Senior Registrar On-call for any problems overnight. Remember: the nursing staff have extensive experience with these procedures. Research in ICU 1. 32. 2 FOREWORD Welcome to Intensive Care. Hospital Emergencies 1. i) A death by unusual, unexpected, unnatural, violent or unknown cause. 66 B. i) Opioid infusions can be continued as subcutaneous infusions via a pump (e.g. Graseby® or equivalent) ii) If sedation is required, midazolam can be administered via subcutaneous route as a continuous infusion, with an opioid if already in use. The SRs help manage the registrar roster, coordinate registrar presentations, simulation training and contribute to teaching activities. Registrar C2 (D6) Duty Intensivist Bed management, Ward consults Speed Dial 1650 D7 registrar Consults, Code blue, TPN CICU Consultant Cardiothoracic ICU Consultant Teaching Consultant Undergraduate and postgraduate teaching 9. 84 Flowchart: Confusion Assessment Method for ICU (CAM-ICU) .... Central Venous Catheters 34 NB: Page 36 and 37: 36 v) Maintenance of lumen patency Page 38 and 39: 38 2. Suspected pneumothorax d. 102 Table: GI Drugs .... Establishing effective ventilation c. Consultant Team B Manages Unit B ICU Team B Senior Registrar B Manages Unit B Beds 12-24 Registrar B1 (D3) Beds 13-18 Registrar B2 (D4) Beds 19-24 Consultant Team C Manages Unit C ICU Team C Registrar C1 (D5) Beds 25-34. 184 Form: Dialysis Data for Drug Overdose .... vi) Notify appropriate staff if patients are transported to theatre, for diagnostic procedures, or for ambulance transport. Insulin a)Page 98 and 99: 98 2. Management of Cardiothoracic Patients .... Intrahospital transportation of Intensive Care patients a) All transports must be authorised by the duty ICU consultant. This approach provides a common platform for staff who come from different countries and training backgrounds. 16 H. Handover summary 4. 25. 121 C. 20. 28 k) Guidelines i) Registrars must familiarise themselves with transport monitors, portable ventilators and infusion pumps. Information Technology in ICU.. Policy 66 PART 3 - DRUGS AND INFPage 68 and 69: 68 vii) Prolonged exposure to catecPage 70 and 71: 70 h) Indications (in ICU) i) TissuPage 72 and 73: 72 Amlodipine 5-10mg oral bd � FlowPage 74 and 75: Table: Antiarrhythmic Agents 74 AgePage 76 and 77: 76 ii) Relative: � Lack of verbalPage 78 and 79: 6. Failed Intubation Drill 152 1. L. This research is world leading in the areas of gastrointestinal motility, nutrient absorption and incretin hormones in the critically ill. ii) Shared transducer for RAP (proximal) and PAP (distal) lumens iii) Check competence of balloon and concentric position iv) Ensure all lumens are flushed with heparinised-saline prior to insertion. e) Requests for venous access: i) Requests must come from registrar level or above and after reasonable attempts have been made to obtain IV access. Current clinical status (system by system). Oxygen saturation should be directly measured with co-oximetry. Applications including a current c.v. should be forwarded to: Dr Alex Wurm. vi) Insert the catheter observing changing waveforms (RARVPA) on the monitor, with the balloon inflated and locked, until catheter displays pulmonary artery occlusion tracing Subclavian and left IJ ~ 50cm Right IJ ~ 40cm vii) Deflate the balloon and ensure an adequate PA trace reappears. ii) 20G Insyte®. Use your time in the Unit to get the most out of the large clinical caseload. 37 G. 81 Table: Nurse Controlled Sedation Protocol .... Daily management in ICU. 8. 50 M. If anaesthetic staff are present in Resus, there is no requirement for ICU registrars to attend the resuscitation unless specifically requested by these personnel or the Trauma Director. NB: Each lumen has it's internal volume printed on it. ii) CICM Annual Scientific Meeting – May/June. Policy regarding outside consults: a) NB: The Unit must not be left unattended at any time to attend outside calls. Protocol for BAL a) DiagnosisPage 56 and 57: 56 x) Insert the small pre-dilator Page 58 and 59: 58 j) Commence pacing k) Check adeqPage 60 and 61: R. 99 I. d) Standard Foley catheters should be changed to a BiocathTM after 14 days. 21 J. f) Avoid lower-limb placement in patients with vascular disease. J. Management of CardiothoracicPage 168 and 169: Flowchart: Arrest Post Cardiac SurgPage 170 and 171: 170 8. ii) The Coroner's office will then fax the Medical Practitioner's Deposition form for you to complete and return by fax. We aim to make the information in this manual as accurate and consistent with the available evidence as possible at the time of publication. There are numerous textbooks, journals and references available in the Unit. h) Relatives should always be informed of any non-routine procedures and the consent issue explained, irrespective of the presence or absence of a medical or legal power of attorney. 23 2. 154 Table: Oxygen Delivery Devices .... Deterioration in organ function c. b) Brachial and femoral arterial lines should be changed as soon as radial or dorsalis pedis arteries are available. Rostering and Job Descriptions .... ii) Emphasise the relevant and pertinent issues only: Patient details and demographics. h) The rostering system utilises a wide variety of different codes as set out in the following table: 10. 26 5. ii) Must be discussed with the Consultant when the SR is on 1st call. b) Requests for TPN are elective (i.e. Mon to Fri: 0800-1800) and should be made according to recommended indications. ii) Coagulation studies, drug levels or other tests are requested as required and may also be requested on the daily flow chart. 82 Table: Modified Richmond Agitation Sedation Scale (RASS) .... Pulmonary Artery Catheters 1. ICU 2nd On-Call Consultant Backs-up ICU 1st on-call when required. Pleural Drainage 1. c) Annotate your pay sheet as "sick leave" accordingly. 52 O. vii) Document your involvement with the resuscitation in the casenotes. Antibiotics 104 1. c) Advice regarding fluid and electrolyte management, oxygen therapy, sedation and analgesia (usually referred to APS). Most projects require prior RAH Research Ethics Committee approval. 9 1830 - 0830 ICU 1st On-Call Attends evening handover round. Specific documentation expected from ICU registrars includes: 1. 190 G. Bites and Envenomation .... Admission note for all patients admitted to ICU (Units A, B & C) 2. 17 ii) These patients will normally be managed in either Units A or B. 8. 50 N. Discharge Policy: a) All discharges should be: i) Approved by the responsible ICU consultant. Roster Guidelines a) Rosters are primarily designed to meet training and patient care requirements, taking into account overall staff numbers and skill-mix. Where appropriate trainees are expected to learn to place lines both a) Via surface anatomical landmark, and b) With ultrasound guidance 3. ii) Switchboard will then state the location of the arrest. Endotracheal intubation ii. 7. 31. iii) Cardiac outputs: Injectate: 10ml 5% dextrose @ room temperature Inject at random times in the respiratory cycle Take > 3 measurements and ignore values > 10% from average. Further investigations / procedures c. a) A national clinical trials group to facilitate multicentre trials in Australia & NZ. CVVHDF Equipment 178 a) DialysisPage 180 and 181: 180 vi) Regional anticoagulation Page 182 and 183: 182 v) Ionized calcium should be chPage 184 and 185: 184 e) The aim of diafiltration in Page 186 and 187: F. f) Requests for TPN. 21. 35 c) Coagulopathic patients: i) INR > 2.0 or APTT > 50s correct with FFP and/or prothrombinex ii) INR 1.5-2.0 or APTT 40-50s correct with FFP, or use IJ or femoral approach iii) Platelets < 50,000 transfuse 1 pack (5U) platelets Failure to increment femoral approach or PICC iv) Uncontrolled coagulopathy femoral approach or PICC Including recent therapy with Dabigatran v) Insertion under ultrasound guidance may be preferred. v) Depending on the outcome of the Code Blue, the patient may be admitted to ICU, CCU or remain on the ward according to standard admission policies. Do not use the electronic average of the wedge tracing. 97 Table: Insulin Infusion Protocol .... 103 K. 131 Flowchart: Management of Bleeding Patient on Dabigatran .... Management protocol: a) Insertion protocol as per CVC, with the following features: i) Sheath introducer (8.5Fr) with side port, haemostatic valve and plastic contamination shield. Background: There is a prolific research programme at the RAH ICU. x) A patient death in an approved treatment centre under the Mental Health Act 1993. d) Major invasive procedures such as percutaneous tracheostomy, coronary angiography, permanent pacemaker insertion or major surgical procedures require completion of a consent form: i) Emergency procedures signed by two doctors ii) Non-urgent procedures by third party consent (next-of-kin). ix) Transduce pressure ASAP post-insertion to exclude arterial placement. Staffing - Royal Adelaide Hospital ICU .... c) Requests should also be discussed with the ICU secretary. Your supervisor will be able to provide details. c) All consults should be addressed as soon as possible. Medications b. d) If the ICU workload is heavy, refer ward consults to the DI, who will delegate appropriately. 11 D. Methicillin Resistant Staph. ii) Daily assessment for infection irrespective of insertion duration. Pulmonary Artery Catheters .... Management protocol: a) Remove and replace lines inserted in unsterile conditions as soon as possible. i) Hand disinfection: surgical scrub with chlorhexidine for >1 minute ii) Sterile barrier: gloves and sterile drapes. 34 F. g) Secure appropriate basic monitoring/procedures: i) SpO2 ii) ECG iii) Arterial line iv) IDC, nasogastric tube v) CVC for the majority h) Basic investigations as indicated: i) Routine biochemistry, blood picture and coagulation studies ii) Group and screen. 82 Table: Drugs Associated with Increased Delirium .... 101 J. Declaration of brain death aPage 224 and 225: 224 iii) All brain dead patients shPage 226 and 227: L. ICU registrars must not do prolonged intra-hospital transports for trauma patients without approval by the duty ICU consultant. 226 Table: Contact Phone Numbers .... 1. GPage 102 and 103: J. Orientation .... 64 4. Introduction a) PiCCO uses a combination of thermodilution and pulse waveform analysis to provide an estimate of cardiovascular status. c) Only BiocathTM catheters should be inserted in ICU & changed 6 weekly. Use pink labels from ICU & leave a spare for labelling of specimen tubes - this ensures priority in the lab f) Refer to the section on nutrition in the clinical protocols for indications & complications. b) These are open, multi-disciplinary meetings to discuss management issues and are a valuable teaching forum. 11. The current ECMO manual can also be viewed here. iv) Daily: Review of electrolytes and fluid balance, Review of the central venous catheter/PICC, Prescription of TPN orders ± vitamins / trace elements, Issue a request form for serum electrolytes. d) Families should be reassured that the focus will be on maintaining comfort. In these patients record: i) Relevant operative & anaesthetic details ii) Significant comorbidities and history iii) Anticipated problems iv) Procedures e.g. epidural, invasive monitoring, TPN 2. Rostering and Job Descriptions Table: Team Duties 0800 - 1900 Consultant Team A Manages Unit A ICU Team A Senior Registrar A Manages Unit A, TPN Beds 1-12 Registrar A1 (D1) Beds 1-6. ii) If you need to request several shifts please indicate in red, which two are the most important and priority will be given to these requests. For blood transfusion - the requesting MO must ensure that the labelling of the request form and specimen matches the patient's wristband. iii) Septic screen / microbiology. 8 Table: Team Duties .... Flush unused lumens with 1ml normal saline 8 hourly Vascath: into each lumen 8 hourly (printed sticker) a. 100 Table: Diuretics .... h) Clinics requesting elective postoperative surgical beds should book the bed at least one day in advance and must confirm bed availability with the Duty Intensivist on the day of surgery, prior to anaesthesia commencing. 31 PART 2 - CLINICAL PROCEDURES A. ii) The admission note should incorporate all relevant aspects of the patient's medical history, clinical examination and investigation results. Clinical Duties Outside of the Intensive Care Unit .... Mixed venous oxygen levels should be measured on a sample taken from the distal (yellow) port. 3 PART 1 - ADMINISTRATION .... xii) A death in a hospital or treatment facility for the treatment for a drug addiction. Daily case-note entries a) A daily entry must be made in the case notes. iii) Supervisors of Training at Royal Adelaide Hospital: Intensive Care: Drs Nick Edwards & Peter Sharley Medicine: Dr S M Guha Anaesthesia: Dr I Banks Surgery: Mr P G Devitt Emergency Medicine: Dr R Dunn B. iv) Derived variables: CO/CI and SVR are routinely charted (8 hrly or as indicated). d) Factors to consider when requesting shifts: i) Requests can significantly complicate the roster and you should therefore exercise some restraint and not request your entire roster. 179 Prismaflex – ST 150 Circuit .... f) Remove if: i) Not in use for > 24 hours, or ii) Clinical evidence of unexplained sepsis, or iii) Positive blood culture by venipuncture with likely organisms (S. 152 Flowchart: Failed Intubation Drill .... Ask questions about clinical problems, equipment and procedures with which you are unfamiliar. c) CTG meetings are held once per season, with the main meeting in March. 49 Flowchart: Ventilation Weaning Protocol.. Skin preparation with chlorhexidine 2% in 70% alcohol. c) Use local anaesthesia in awake patients. Adequate familiarisation and supervision with unfamiliar procedures is essential: there is always someone available to help. This is coordinated by the duty ICU consultant. ii) Inform and discuss the transport with the nursing staff as soon as possible. c) This is not a formal casenote, nor does it take the place of a thorough review of each patient and their casenotes. 156 D. 29. 9. 2. with SOLU-IV (chlorhexidine 2% / 70% alcohol) iii) Dressing: Opsite® or equivalent occlusive dressing e) Change / remove all peripheral lines after 48 hours. 37 H. c. Hence the workload should be spread evenly and all registrars should be allowed to have their required (and reasonable) rest periods. Registrars are expected to become proficient in all routine procedures. i) If relatives cannot be contacted, emergency life saving treatment should proceed immediately, with discussion with the Duty Consultant. Gastric / Oesophageal TamponaPage 66 and 67: A. Normal Units Cardiac Index CI 3.0-5.0 l/min/m2 Global End-diastolic Blood Volume Index GEDI 680-800 ml/m2 Intrathoracic Blood Volume Index ITBI 850-1000 ml/m2 Stroke Volume Variation SVV 10 % Extravascular Lung Water Index* ELWI* 3.0-7.0 ml/kg 39. 15 G. ii) The nursing staff are not responsible for sharps disposal. 96 Flowchart: Blood Glucose Management in ICU .... e) Levels of ongoing active support for the patient, e.g. IV or subcutaneous fluids should be clarified between ICU staff, the Ward team and family members. Anticoagulation .... The emergency number is 33# : state the nature and location of emergency 2. Retrieval Requests a) Requests for consultation may originate from a number of sources. 42 K. Completed research projects should be presented at either a local or interstate scientific meeting. Complicated percutaneous tracheostomy iii. Weaning From Ventilation a)Page 166 and 167: 166 D. iii) CVCs are not to be inserted on ward patients. Complications a) Infection - local and systemic b) Thrombosis c) Extravasation in tissues D. It is assumed that all registrars will maintain an awareness of all patients in ICU and will provide assistance in other areas of the ICU if required. However no guarantee can be provided that errors do not exist – please notify the Duty Consultant if you identify any errors of fact. Documentation .... d) Allow sufficient time for nursing staff to set up insertion trays and transducers. ix) Suture introducer and attach the contamination shield to the hub. Weekly Programme Table: Weekly UPage 14 and 15: 14 c) Where indicated, consent for Page 16 and 17: G. Annual Leave a) Annual leave for medical staff is on a "first come - first served" basis, so book leave as soon as possible. Standard in all ICU patients 2. ii) The ICU/resuscitation registrar is responsible for initial assessment, securing the airway and establishing effective ventilation. d) Each roster covers a 4 week period, with the working week commencing on a Wednesday. 19 I. ii) Burns Unit for airway / breathing assessment, IV access or resuscitation. 229 6. Coagulopathy (see below) Inexperienced staff requiring urgent access, where supervision is not immediately available. viii) A death of a child subject to a custody or guardianship order under the Children's Protection Act 1993. ii) Standard lumen CVCs are not appropriate for acute volume resuscitation. 65 PART 3 - DRUGS AND INFUSIONS..66 A. Clinical Duties in the ICU .... 12 Table: Weekly Unit Programme .... Discuss the planned procedure with the nursing staff and allow sufficient time for setting up of trays and equipment. 36 G. PoPage 46 and 47: 46 ix) 2 Endotracheal tubes � NorPage 48 and 49: 48 7. Complications a) Infection b) Thrombosis / digital ischaemia c) Vessel damage / aneurysm d) Haemorrhage / disconnection 34. 136 Table: Classification of Lactic Acidosis .... This is to ensure that clinics are aware when a patient has been admitted under their bedcard. Extracorporeal Membrane OxygenPage 6 and 7: 6 PART 1 - ADMINISTRATION A. f) Requests for routine blood tests are made on the chart. Cardiac Pacing .... viii) Adjust the catheter depth until a PAOP trace appears consistently with 1-1.5ml balloon inflation. Administrative Staff Administrative Manager Ms Melissa Filleti Resource Accountant Ms Tammy Moffat Team Leader / Roster Manager Ms Sherridan Clark Unit Secretary Ms Kristina Gabell Ward Clerks Ms Ali Fraser Ms Lisa Migliaccio Mr Gavin Sain 4. 210 Flowchart: Repeated Supratherapeutic Paracetamol Ingestion .... a) Trainees interested in undertaking a study for their formal project are advised to approach potential supervisors with sufficient time to complete their project. 60 S. v) Jugular bulb oximetry. ii) Radiology provide a PICC line service in working hours. This will include sessions from: a) The Director of ICU (or delegate) b) The Director of Research c) Infectious Diseases / Clinical Microbiology d) The Acute Pain Service 12. d) Printed stickers should be used for routine medications and infusions. Consent for procedures: *refer to Administration / Consent a) Competent patients undergoing invasive procedures should have a standard RAH Consent Form (MR:60.16) completed and signed by the patient b) Third party consent is not necessary for incompetent patients undergoing routine ICU procedures. epidermidis, candida). Policy Page 62 and 63: 62 c) Insertion procedure: i) LocalPage 64 and 65: 64 T. 10 Table: Registrar Shifts Abbr Shift Description Times & Meal Breaks Hrs SR Senior Registrar 08:00-18:00 9.5 D8 Day shift: report to DI 1x 30min meal break D1,2 Day shift Unit A D3,4 Day shift Unit B 08:00-19:00 10.5 D5,6 Day shift Unit C 1x 30min meal break D7 Day shift: consults & Code blue N1 Night shift Unit A N2 Night shift Unit B 18:30-08:30 13 N3 Night shift Unit C 2x 30min meal breaks N4 Night shift: consults & Code blue A Annual, Study, Exam, Conference leave @ Request 2. epidermidis, candida spp.), and/or Evidence of local infection - inflammation or pus at insertion site. iii) Requests cannot be granted if they disadvantage other staff, compromise skill-mix, or overall staffing numbers necessary for the shift. n) Inform and counsel relatives. New, unexplained fever or WCC b. Diabetes insipidus: protocol Page 100 and 101: I. Where appropriate, formal consult and involvement of the Palliative Care Service is encouraged. b) Epidural cocktails should follow the Acute Pain Service protocols c) Strict aseptic technique at insertion. 68 Table: Inotropic Agents Used in ICU .... Vancomycin Resistant Enterococcus c. 7 3. 10 C. NB: Further guidelines for the management of epidural catheters can be obtained from "The Acute Pain Service Guidelines for Anaesthetists". 61 T. b. d) The Coroner must be notified in all cases where death is: i) A death in custody, e.g. police, corrections, mental health detention. This may include reminding senior colleagues or visiting teams to conform to basic issues such as hand-washing or additional precautions. C. i) Upon dialling 33#, switchboard automatically page the following people: ICU registrar ICU equipment nurse Medical registrar b) These calls are divided into: i) Code Blue *all calls must be attended immediately Cardiac &/or respiratory arrest (actual or impending) Threatened airway Major haemorrhage ii) MET calls Significant clinical deterioration (see MET criteria) MET calls are not routinely attended by ICU Registrars. (alex.wurm@health.sa.gov.au) Trainees in formal training programs are given appointment priority. Discharge planning & prognosis 23. i) To ensure all aspects of patient care have been considered, the "FATDOGS" algorithm should be considered in all patients: F - Feeding & fluids A - Analgesia & sedation T - Thromboprophylaxis D - Drugs – therapeutic & usual O - Oxygen & ventilation G - Glucose control S - Sit out of bed ii) You need to either write up each one of these each day or have a reason why you have not. e) Notify the Acute Pain Service of patients discharged under their care. iii) ACCCN (Institute of Continuing Education), Conference. 122 Table: Critical Bleeding (Massive Transfusion) .... Endotracheal Intubation .... The CICM formal project takes, at a minimum, 12 months to complete. xiii) If no certificate as to the cause of death has been given to the Registrar of Births, Deaths and Marriages. Orientation 1. Donation After Cardiac Death (DCD) .... f) Short term Unit C patients do not require detailed discharge summaries, only pertinent information relating to their stay. Policy a) PrePage 106 and 107: 106 e) Vancomycin i) Pharmacology Page 108 and 109: 108 3. f) Presentations should be of a standard suitable for a fellowship examination: i) Should take no more than 5-8 minutes. c) All patients on insulin protocols should be referred to the Endocrine Unit prior to discharge (preferably the day before) d) Patients discharged on TPN must be entered in the TPN folder in Unit A. Ventilator associated pneumoPage 110 and 111: 110 Table: Perioperative EndocarditPage 112 and 113: Gynae sepsis Suspected Bacterial EnPage 114 and 115: 114 PART 4 - FLUIDS AND ELECTROLYTEPage 116 and 117: B. 195 Flowchart: Antifungal Treatment in Immunosuppressed Patients .... Antiplatelet Agents Table: AntipPage 80 and 81: Table: Bronchodilators 80 Drug InfuPage 82 and 83: 82 Table: Nurse Controlled SedationPage 84 and 85: 84 ii) Minimise use of drugs associPage 86 and 87: Table: Sedatives / Analgesics 86 DrPage 88 and 89: F. 3 CONTENTS FOREWORD .... c) In addition, many of the consultants have access to the University of Adelaide, including Barr-Smith Library resources. 2 CONTENTS.. The following procedures are excluded: The giving of an intravenous injection The giving of an intramuscular injection Intravenous therapy The insertion of a line or cannula Artificial ventilation Cardio-pulmonary resuscitation Urethral catheterisation The insertion of a naso-gastric tube Intra-arterial blood gas collection Venipuncture for blood collection for testing Subcutaneous injection or infusion v) A death within 24 hours of being discharged from a hospital or having sought emergency treatment at a hospital. iv) The term 'anaesthetic' means a local or general anaesthetic and includes a sedative or analgesic. 8 Table: Registrar Shifts .... 36. Epidural Catheters 1. Arterial Cannulation .... d) Aseptic technique: i) Handwash with AVAGARD® (chlorhexidine 2%) or MEDISPONGE® (chlorhexidine 4%) + gloves ii) Skin prep. Extubation .... 115 B. b) The transport/investigation must be considered in the best interests of the patient. 204 Flowchart: The Unconscious, Undetermined Overdose .... j) "Traffic control" i) Movement of people through the unit should be kept to a minimum. RAH - ARDS Ventilation a) IPage 164 and 165: 164 19. iii) Role of the ICU registrar: Primarily as a backup for acute life threatening situations in the event that sufficiently experienced personnel are not available in Resus. At the discretion of the attending doctor b) Handover ward rounds are at 08:00 and 18:30. 113 PART 4 - FLUIDS AND ELECTROLYTES ....114 A. b) The duty ICU registrar must ensure: i) A death certificate is completed or the Coroner notified ii) The parent clinic or duty intern is notified iii) Referring doctors (i.e. GP's, other specialists / hospitals) are notified. 22 f) ICU staff are not responsible for consent for procedures performed outside of ICU, e.g. surgical tracheostomy, or PICC lines placed in radiology g) A person, not necessarily next-of-kin, who has been nominated by the patient as a medical power of attorney may sign or refuse consent on behalf of the patient. .... vi) A death of a person under a 'protected person' order under the Aged or Infirm Persons' Property Act 1940 or the Guardianship and Administration act 1993. f) Withdrawal or limitation of therapy is a consultant responsibility. 19 v) Chest x-rays are ordered after the morning handover round via OACIS. 12 E. b) Pre-operative consults for potential or booked surgical patients. Specialised procedures are done either by the Duty Consultant or strictly under consultant supervision. Pericardiocentesis 60 1. d) Resuscitation i) Large bore peripheral IV line(s) are 1st line. 11 3. Nasogastric or IABP placement c. 33 3. 20 b) Complicated Unit C patients require the same detail as Unit A & B patients. e) At the emergency: i) This hospital follows the Australian Resuscitation Council guidelines for cardiopulmonary resuscitation. The contents of this manual are produced from the consensus views of the senior medical staff. f) Insertion sites – in order of preference: radial > dorsalis pedis > femoral > brachial g) The femoral artery may be the sole option in the acutely shocked patient. NeuroPage 188 and 189: 188 x) Thromboprophylaxis: � AllPage 190 and 191: 190 2. Tracheostomy .... iii) A death during, as a result of or within 24 hours of a surgical, invasive or diagnostic procedure, including the administration of an anaesthetic for the carrying out of the procedure. The relative risk vs. iii) Junior Trainees/RMOs: Vocational trainees, trainees in other specialist programs e.g. surgical, physician training, etc Residents in general rotations. Registered CICM trainees may undertake their full 24 months of core ICU training at the RAH. I. Competent patients: a) All competent patients undergoing invasive procedures should have a standard RAH consent form (MR: 60.16) completed and signed by the patient. e) All orders must be signed by a doctor. 29 N. iv) Guidewire exchanges are actively discouraged. Guidelines for the ManagemenPage 138 and 139: 138 iv) Hypervolaemic states: *mostPage 140 and 141: 140 4. Peripheral IV Catheters .... ii) Record all measurements in the flow chart in the results folder. Indications a) Post-operative pain relief (usually placed in theatre) b) Analgesia in chest trauma. 117 Table: Average Daily Requirements .... Renal Drugs - Diuretics 100 1. Admission Notes a) All patients admitted to Units A & B must have a detailed admission summary. 189 Table: World Federation of Neurosurgeons Classification .... 6 A. Admission and Discharge Policies .... 114 Table: Common IV Solutions .... This is usually the ICU registrar. 40 c) "Wedged" tracings must be corrected as soon as possible: i) Flush distal lumen with 2ml N.Saline ii) Withdraw the catheter until a PA trace is visible d) Measurement of pressures: i) Reference pressures to the mid-axillary line ii) Measure at end-expiration of the respiratory cycle iii) Do not disconnect ventilated patients to measure pressures. c) It is the responsibility of every member of the health care team to ensure compliance with Hospital and Unit infection control policies. 5 Flowchart: Nutritional Therapy Protocol .... 54 Q. Enteral nutrition 1Page 118 and 119: Pts unsuitable for EN should be conPage 120 and 121: 120 d) Protocol i) On commencement:Page 122 and 123: C. f) Where possible you will be rostered two or more days-off following night duty. iii) Assist in patient assessment/management under the coordination of the Fire Chief. Brain Death and Organ Donation .... f) They may be left in situ for up to 7 days. 171 Table: Haemodialysis Solutions .... d) Training positions at Royal Adelaide Hospital: i) Intensive Care Positions The College of Intensive Care Medicine has accredited the RAH as a C24 Unit for training for the fellowship in intensive care (FCICM). iii) Dolphin Protect® catheters are used for CVVHDF and plasmapheresis iv) Pulmonary artery catheter sheath (part of the PAC kit) v) Dress non-impregnated catheters with a BioPatch® b) Sites: i) Preferred site for routine stable patients – SCV > IJV. Flush 1.5ml solution (5000U heparin/3ml = 2500U/lumen). 220 J. h) Aseptic technique i) Aseptic technique is to be used for all patients undergoing major invasive procedures (refer to procedures section). iv) In the event of a significant fire / smoke hazard, staff will only re-enter the danger zone in the immediate company of a MFS fire-fighter, with appropriate breathing apparatus. c) Notify the duty consultant. Specific therapies / protocols 2Page 210 and 211: 210 Flowchart: Acute Paracetamol ODPage 212 and 213: 212 b) Lithium - Acute overdose i) Page 214 and 215: 214 x) Treatment options � NormobPage 216 and 217: 216 � Haemodialysis (HD) a. d) Resource person: A/Prof. 3. xi) Death of a resident of some (but not all) supported residential facilities licensed under the Supported Residential Facilities Act. Below are the normal values and a suggested decision tree from the manufacturer which should be used as a guide only: Table: PiCCO Values and Decision Tree Variable Abbr. 38. Care for Patients Discharged from ICU for Terminal Care. Microbiology Protocols.. 4. iii) Patients must be appropriately monitored during the transport and observations recorded on the flow chart. 154 Table: Oxygen Delivery Percentage - Nasal High Flow .... Invasive procedures should be authorised by a senior registrar or the duty ICU consultant. 88 G. c) Indicated in the assessment & response to therapy in shock states. Management protocol: a) Aseptic technique at insertion. N. c) Aseptic technique: i) Handwash with AVAGARD® (chlorhexidine 2%) or MEDISPONGE® (chlorhexidine 4%) + sterile gloves ii) Skin prep. Weaning Guidelines .... Symptom management in terminal care. PICCO Catheters .... This manual has undergone numerous changes, with contributions from many of the ICU staff and from other specialty services within the hospital. Drug Overdose 1. 97 Table: Steroid Doses / Relative Potencies .... Technique a) A normal CVC line can be used. Failed Intubation Drill .... d) Leave is in accordance with the SA Salaried Medical Officers' Award (5 weeks annual and 1 week study leave) and registrars are required to forward a signed copy of leave requests to the Senior Registrar for rostering purposes. (See below) l) Notify the parent clinics of patients admitted directly to ICU NB: this applies particularly to patients who have been retrieved. Muscle relaxants .... iii) Intranet resources, which are being continuously expanded: UpToDate®, eMIMS, Medline, Toxnet, etc. 201 H. ANZICS Clinical Trials Group (CTG). 148 Flowchart: Advanced Life Support .... On admission to ICU (beds 1-24) b. 31 C. 88 Table: Muscle Relaxants .... iv) Transvenous pacing. Namely, i) The DI phone (SD: 1650) ii) Other ICU telephones iii) ICU registrar pager iv) Other clinics who have been consulted by outside medical officers. 30 PART 2 - CLINICAL PROCEDURES .... 30. 207 Graph: Modified Rumack-Matthew Nomogram .... Clinical Duties Outside of the Intensive Care Unit. 1. 124 Table:

Guidelines for the Management of an Elevated INR .... IPage 124 and 125: 124 Table: Critical Bleeding (MassiPage 126 and 127: 126Page 128 and 129: 128 Table: Guidelines for the ManagPage 130 and 131: 130 10. b) The chief fire and emergency officer is the overall controller during a fire or smoke emergency (Code Red). Respiratory acidosis a) AetPage 148 and 149: A. 4 U. 41 J. d) Review as requested patients in the: i) Spinal Injuries Unit with potential respiratory failure. c) Unit A&B flowcharts are re-written daily and include orders for ventilation, procedures, medications, infusions and fluid therapy. d) Complex investigations (e.g. CT, MRI scans) and procedures should be authorised by the duty consultant and discussed with the parent clinic where appropriate. benefit of all procedures must be carefully considered. d) Resuscitation or admission must not be delayed in imminently life threatening cases, unless specific advanced directives exist and are clearly documented. From 2015 this will evolve into a collection of indivdual procedure and policy documents. 6 B. 94 Table: Lepirudin Infusion Protocol .... iv) Registrars are responsible for taking blood specimens: When nursing staff request assistance. 37 Table: PiCCO Values and Decision Tree .... d) Stable, self-ventilating patients may be transported by an ICU RN e) If ICU nursing staff are concerned, then a medical escort is required. 116 5. 31 B. c) If the patient has not required regular opioid or sedation in ICU, the following PRN orders should be in place prior to discharge: i) For pain: Opioid naïve patient - e.g. morphine 2.5-5mg s.c. 2 hrly prn Opioid tolerant - dose guided by background usage ii) For agitation, restlessness: Midazolam 2.5mg - 5mg s.c. 1 hrly prn iii) For management of secretions: Hyoscine hydrobromide 400 μg s.c. 3-4 hourly prn Atropine 600 μg s.c. 3-4 hourly prn 3. h) Secure with a StatLock® device. Endotracheal tube change protPage 50 and 51: Flowchart: Ventilation Weaning ProtPage 52 and 53: N. i) The admitting clinic must be notified by the admitting registrar and invited to record an admission summary for patients admitted directly to ICU. iv) Heparin/Warfarin Protocol *also see 'Acute Pain Service Guidelines for Anaesthetists' 3. Procedures .... with SOLU-IV (chlorhexidine 2% / 70% alcohol) iii) Seldinger technique or ultrasound guided insertion – Sonosite® iv) U/sound guided insertion may be preferred where: There is an increased complication risk (e.g. bleeding, pneumothorax) Large bore catheter insertion. Withdraw 2ml and discard. 211 I. Guidelines for admission of a new patient to ICU a) Handover from the referring doctor. c) Eligible meetings include, but are not limited to: i) ANZICS / ACCCN Annual Scientific Meeting - October. Obtain as much information as possible. Indications: a) Routine measurement of systemic blood pressure in ICU b) Multiple blood gas and laboratory analysis c) Measurement of BP during transport of patients in hostile environments 2. F. 150 Induced Hypothermia Post Cardiac Arrest.. Neurosurgical protocols .... Central Venous Catheters... v) Ensure that the results of investigations performed (e.g. CT scans etc) are recorded in the case notes by the appropriate person. 104 Table: Vancomycin Dosing Schedule .... 70 Table: Antihypertensive & Vasodilator Agents... Neurosurgical protocols 1. 67 C. Respiratory Therapy 154 1. e) Notify the senior nurse and fellow registrar(s) when leaving the floor. iii) Transferred "In hours" i.e. prior to 18:00 - unless specifically approved by a consultant. Grand rounds a) Held on Mondays and Fridays are an integral feature of the running of the unit. CVC placement (subclavian or jugular) iv. Nutrition .... Other acute interventions (e.g. UWSD) as required Once anaesthetic & trauma team members are present and the situation is under control, return to ICU - do not leave ICU unattended for lengthy periods of time. Cardiovascular Drugs .... d) Hand-hygiene remains an established method of effective infection control and must be strictly performed by all members of the health care team: i) Aqium hand gel must be used by all staff: Every time they enter or exit a patient's cubicle (defined as the line of the door or curtain of bed space.) Before wearing gloves Before and after patient contact Before and after contact with a patient's environment ii) Hand wash with soap where: Contact with blood or body fluids Hands are visibly soiled After removing gloves iii) Hand wash with chlorhexidine: Prior to clinical procedures After contact with patients with multi-resistant organisms e) Gloves i) Disposable gloves must be worn for all contact with patient's bodily fluids, dressings and wounds. a) For the families of dying patients, moving from a familiar environment will add a level of anxiety and uncertainty, even if it will be to a quieter setting. Hyper-expanded lung fields (severe asthma, bullous disease) c. Guidelines designed to assist in clinical management are included but patient management will ultimately depend upon the clinical situation. 12 D. Admission and Discharge Policies 1. Dabigatran Clinical GuideliPage 132 and 133: 132 Flowchart: Management of BleediPage 134 and 135: 134 v) Severe Reactions � Severe Page 136 and 137: 136 D. Relevant pre-morbid history pertinent to this admission. d) Because the ICU is a world-leader in several areas, it is advised to leverage on the expertise and availability of sophisticated methodologies within the group. v) CVC Catheter lengths: 15cm - right subclavian or internal jugular 20cm - left subclavian or internal jugular, either side femoral vi) Secure all lines with a StatLock® device or securely suture vii) Dressing: non-occlusive dressing viii) Flush all lumens with saline. Gastrointestinal Drugs 102 1. Documentation The following guidelines are designed to facilitate the recording of clear, relevant information that is essential for continuity of care, audit and medico-legal review. Multiresistant gram negatives d. Fibreoptic Bronchoscopy .... 92 Table: Anticoagulants .... It is the responsibility of the operator to discard all sharps used in the procedure and to ensure that they are placed in a sharps disposal container. d) This is stored in a specific ICU database available on the PCs in the ICU. i) Anaesthesia is responsible for transport of the following ICU patients: i) Trauma resuscitation patients ii) Patients to and from theatre iii) Patients to and from hyperbaric medicine. Night Registrar 1 (N1) Beds 1-12 Night Registrar 2 (N2) Beds 13-24 Night Registrar 3 (N3) Beds 25-34 Consults, Code blue calls. Sick Leave a) If you are sick and unable to attend work, please contact both: i) The Duty Intensivist by day, or Senior Registrar at night (SD: 1650), and ii) The Roster Manager - Mon-Fri (09:00-16:00) b) If you can, predict an expected day or night of return to work. d) The Unit has an internet presence at e) NB: Use of hospital computers to access inappropriate material is not tolerated. Introduction .... Nutrition 1. 26. ii) Discussed with the parent clinic prior to patient transfer including discussion of any ongoing or potential problems. h) Referral to the Palliative Care should occur pre-discharge where indicated. Research in ICU .... 22. d) The ward round is attended by: i) Team A, B, C and Duty ICU consultants and all floor registrars ii) An infectious diseases consultant iii) Senior nursing staff iv) Physiotherapists v) A pharmacist vi) A dietician vii) Invited clinics when appropriate viii) Medical students e) Registrars are expected to present their allocated patients and to actively participate in management discussion. is the responsibility of the emergency anaesthetic staff. Respiratory Therapy .... 144 PART 5 - CLINICAL MANAGEMENT .... h) Similarly, Unit C patients have their charts reviewed, however all medications and fluids are recorded on the hospital blue treatment folders. a) Physical symptoms that should be considered in planning ongoing care are: i) Pain – either spontaneous or on movement ii) Agitation, restlessness iii) Respiratory tract secretions iv) In a conscious patient there may be other symptoms e.g. nausea and vomiting, dyspnoea v) Prevention of seizures may be a relevant issue b) If the patient is requiring either analgesia or sedation in ICU, these should be continued on discharge to the ward. 89 Table: HITS Probability Score – '4T Score' .... ii) Invasive procedures, e.g. laparotomy, tracheostomy, PAC/CVC insertion iii) Results of specific investigations or tests, e.g. CT scans, endocrine tests iv) Changes in policy, e.g. non-escalation of treatment, advance directives. FPage 154 and 155: C. Technique a) A normal CVC linPage 40 and 41: 40 c) "Wedged" tracings must bePage 42 and 43: J. A standardised approach to management is desirable for optimal patient care and safety, improving communication and understanding between members of the ICU team and associated specialties. (Ph: 8222 5325 or email: sherridan.clark@health.sa.gov.au). ix) A death on an aircraft or vessel with a place in South Australia as its place of disembarkation. 37. iii) The MFS has a 3 minute response time to the RAH. 31 A. Epidural Catheters .... 32 D. 23 L. Complications a) Related to CVC cannulation (see CVC section) b) Related to insertion/use of a PAC i) Cardiac perforation ii) Thromboembolism iii) Pulmonary infarction ~ 0-1.4% (2 persistent wedging) iv) Pulmonary artery rupture ~ 0.06-0.2% (mortality 50%) v) Catheter related sepsis vi) Endocarditis vii) Pulmonary valve insufficiency viii) Catheter knotting ix) Balloon fragmentation / embolism x) Tachyarrhythmias xi) RBBB Guidelines for the listed routine and specialised procedures are outlined in the following sections. In critically ill patients, ensure that a suitably qualified person (in terms of resuscitative skills) remains with the patient at all times. 147 A. b) Facilities available through the LAN include: i) Intranet e-mail accounts ii) WWW browsing facilities (available on application). iii) You must speak to the ICU Secretary for approval (T: 8222 5325 or email: sherridan.clark@health.sa.gov.au) and then note changes on the rosters posted in the ward and on the medical pin-up board. b) The peripheral arterial catheter is inserted into a femoral, brachial or axillary artery using an aseptic Seldinger technique. Personnel: a) Director of Research - A/Prof. 18. 221 K. Aneurysmal Subarachnoid HaemPage 192 and 193: 192 2. ii) This includes: Hand disinfection: surgical scrub with chlorhexidine for >1 minute Sterile barrier: full gown, mask, hat, gloves and sterile drapes. K. 67 Table: Cardiovascular Effects of Catecholamines .... Peripheral IV Catheters 1. Urinary Catheters .... Consent in ICU .... H. e) Haemodynamic measurements i) These are routinely performed by the nursing staff, however registrars should become familiar with the procedure. Initial airway assessment and management. Drager EVITA 2 Ventilator aPage 162 and 163: 162 14. Whilst ultrasound may aid in delineating the relevant anatomy: a) Trainees will find themselves in environments where U/S is unavailable b) The time delay involved in the use of U/S may be clinically deleterious, and c) There are insufficient data that the use of U/S actually reduces complications. They may be indicated in the following situations, only after discussion with a consultant: Mechanical problems in a new catheter (leaks or kinks) Difficult or limited central access (e.g. burns). g) Patients transferred to the general ward or Unit C i) Should have the hospital "blue folder" completed. 169 Table: Antibiotic Prophylaxis for Cardiac Surgery .... 29 M. iii) Insertion of a PICC catheter. Hypokalaemia: K + < 3.0 mmolPage 142 and 143: 142 v) Reduced clearance � Acute Page 144 and 145: 144 Table: Classification of LacticPage 146 and 147: 146 10. d) Role of medical staff: i) There is no place for "heroic" action - ensure your own safety first! ii) Wait for the arrival of the MFS. b) Trainees should become familiar with the theory of insertion, indications, interpretation and complications of PiCCO catheters. Status epilepticus a) DefiniPage 194 and 195: 194 � If these films are all docuPage 196 and 197: 196 3. If you are unsure of what to do about a patient enrolled in a study, please contact the relevant staff member regardless of the time of day. 94 H. f) Remove catheters in anuric patients and perform intermittent catheterisation weekly, or as indicated. d) The duty registrar on the day of transfer is responsible for completing the form. 151 B. b) All retrieval requests should be referred immediately to the state retrieval service, MedStar on 82224222. 107 Table: Peri-operative Antibiotic Prophylaxis .... iv) Document any problems which may occur during transport. B. e) Cannulae: i) Arrow® radial or femoral kits (Seldinger technique). These have been derived from the available literature, clinical experience and where appropriate, cost-effectiveness. Management protocol: a) Notify the Acute Pain Service of any epidural placed in ICU. 30 7. Protocol for DVT/VTE prophylaxisPage 92 and 93: Table: HITS Probability Score - 'Page 94 and 95: Table: Heparin Infusion Protocol 94Page 96 and 97: H. d) Ensure that the ICU staff know where you are going and that the Unit is not left unattended. 6 PART 1 - ADMINISTRATION A. Pericardiocentesis.. iv) Patients started on TPN should have their details entered in the "TPN folder" kept in Unit A. Consent in ICU 1. Death certificates. b) World-leading in critical care research and is open to all interested parties. j) IA cannulae are changed/removed in the following settings: i) Invasive IA line is no longer necessary. h) All consults/MET calls potentially requiring admission to ICU must be discussed with the Duty Intensivist (DI). b) Trainees should become familiar with the theory of insertion, indications, interpretation and complications of PACs. c) Insertion of a PAC must never delay resuscitation of a shocked patient. c) Requests are made via the DI or consults registrar. Positive blood culture by venipuncture with likely organisms (S. Fire a) A copy of the hospital emergency procedures (fire, smoke, bomb-threat) is kept in the P4A and P4C nursing stations. vii) A death in the course or as a result or within 24 hours of a person receiving medical treatment to which consent for that treatment has been given under Part 5 of the Guardianship and Administration act, 1993. This is meant to be an aide-mémoire to be updated each shift. 79 Table: Bronchodilators .... i) Sharps disposal i) The person performing the procedure is responsible for disposal of all sharps (needles, blades) using the sharp disposal containers. b) Only 3 registrars can be on leave at any one time, so before filling in an application form check that leave is available with the ICU secretary. iii) Single lumen 20G CVC (paediatric) for femoral arterial lines. These are brief business rounds to handover essential information to the next team (either day or night) and are attended by the duty consultant, team registrars and senior nursing staff. 110 Table: Empiric Antibiotics .... a) Partial funding is available for staff who present work at approved meetings. Marianne Chapman. ICU Ward Rounds 1. b) Admission is reserved for patients with actual or potential vital organ system failures, which appear reversible with the provision of ICU support. Discharge summary 5. vii) Once the patient has been transferred or discharged, the area should remain vacant until "terminally cleaned" in accordance with RAH policy. Demarcation disputes are referred to the duty Trauma Consultant. d) Daily inspection of the insertion site. 166 Flowchart: Arrest Post Cardiac Surgery... b) Generally avoid peripheral IV use in ICU patients and remove if not in use. RespiPage 156 and 157: 156 Table: Oxygen Delivery PercentaPage 158 and 159: 158 b) CPAP via Dräger EVITA ® i)Page 160 and 161: 160 13. iii) File the original deposition in the patient's case-notes. This is mandatory if the patient is transported from Resus (e.g. to radiology, ICU, theatre). Gastric / Oesophageal Tamponade Tubes .... ii) Senior Trainees: Usually CICM trainees (or equivalent) Rostered according to seniority and experience. 209 Flowchart: Acute Paracetamol OD - Known Time of Ingestion .... 5. Trainees interested in undertaking a higher degree are always well received. e) Incomplete or missing summaries will be forwarded to the responsible registrar for completion. b) The critically ill patient is highly vulnerable to nosocomial infection, which results in significant morbidity, prolonged length of hospital stay, increased cost and attributable mortality. 36 v) Maintenance of lumen patency Central venous catheters (pre-printed on the patient flowsheet) a. The manual outlines various Protocols, which represent a standard approach to practice within the Unit. access is preferable where: Dolphin Protect® / CVVHDF Limited IV access (burns, multiple previous CVC's), A thoracic approach is considered hazardous with: a. Complications a) Hypotension from sympathetic blockade / relative hypovolaemia i) This usually responds to adequate intravascular volume replacement ii) Occasionally, a low-dose vasopressor infusion is required iii) If this is considered, occult bleeding must be excluded. Indications: a) Standard IV access in ICU patients: i) Vasoactive infusions ii) Fluid administration (including elective transfusion) iii) Hypertonic solutions (TPN, amiodarone, nimodipine, etc.) b) Monitoring of right atrial pressure (CVP) c) Venous access for: i) Pulmonary artery catheterisation (PAC) ii) Continuous renal replacement therapy (CVVHDF) iii) Plasmapheresis. with SOLU-IV (chlorhexidine 2% / 70% alcohol) d) Local anaesthesia in awake patients. i) Admission disputes must be referred to the Duty Intensivist. i) Non-impregnated catheters inserted outside the ICU should be changed to an impregnated catheter according to clinical indication. e) The Team A Senior Registrar and Consultant will manage: i) Initial consultation with the requesting clinic. Do not persist if you are having difficulty with the procedure - call for help. Endotracheal Intubation 44 1. It is by no means the definitive answer to all intensive care protocols and procedures, nor is it designed to be a textbook. Outline features on daily pathology and radiology. Renal Failure .... Anticoagulation / DVT prophyPage 172 and 173: 172 2. Preparation for discharge. InPage 18 and 19: e) Document essential orders: i) VePage 20 and 21: 20 b) Complicated Unit C patients rPage 22 and 23: 22 f) ICU staff are not responsiblePage 24 and 25: 24 g) The following duties accompanPage 26 and 27: 5. (i.e. at least one registrar must remain on the floor) b) The consults and code-blue/trauma pagers are carried by the Consults Registrar (D7) during the day and Night Senior overnight (this may be modified at the discretion of the 1st on-call consultant / senior registrar). Renal protection 174 a) EstablisPage 176 and 177: 176 c) Continuous veno-venous haemoPage 178 and 179: 8. Assistance is always available from the Duty Consultant and senior nursing staff. Discharge summary a) All patients transferred from ICU (Units A/B/C) require a Medical Transfer Summary (MR 42) form completed. Muscle relaxants 88 1. Registrars commencing duty within the unit at the main RMO changeover dates will undergo a half-day orientation program. Infection Control in ICU a) Prevention and containment of nosocomial infection is a fundamental principle of effective medical practice. PAC) v) Pulmonary infarct / arterial rupture (PAC) NB: Where CVC insertion presents a "significant risk" in a non-urgent situation, consider insertion of a PICC line as an alternative. f) At the trauma resuscitation: i) This hospital follows the Early Management of Severe Trauma (RACS) guidelines. Donation After Cardiac Death (DCPage 228 and 229: 228 d) Determination of Death i) De The Unit Manual has previously been maintained as an A5 bound edition, also available for download in Adobe PDF format. b) Primary survey: i) Ensure adequate airway, breathing and place the patient on a FiO2 = 1.0 until a blood gas is done. ii) This applies equally to visiting clinics and large numbers of relatives. x) Apply a BioPatch® and non-occlusive dressing. e) Rosters are usually posted two weeks in advance. vi) As a general rule, it is better to admit a patient if previous details are not immediately available than to prematurely abandon resuscitation. 18 e) Document essential orders: i) Ventilation ii) Sedation / analgesia iii) Drugs, infusions iv) Fluids f) Outline the management plan to the nursing staff. 8 ii) Positions for non-intensive care trainees Rotations of registrars in these positions are made from the respective specialty based training programs at the RAH. Trauma Calls 26 a) As in cardiacPage 28 and 29: 28 k) Guidelines i) Registrars mustPage 30 and 31: 7. e) Silastic catheters should be changed after 1 month. v) Consumable stock within the cubicle should be kept to a minimum. Blood Component Therapy 122 1. 148 Flowchart: Basic Life Support .... i) There is no optimal time for an arterial line to be removed or changed. Management protocol: a) Remove/replace all resuscitation lines inserted in unsterile conditions. There are broadly 3 types of research studies occurring in the unit: a) Locally initiated studies b) Drug company sponsored studies c) Studies performed with the ANZICS Clinical Trials Group (see below). 120 Table: Baxter TPN Solution Options .... Information Technology in ICU a) All consultant and registrar offices and the Registrar Teaching Room are equipped with PCs, connected to the RAH local area network (LAN). f) At no stage must the unit be left uncovered. 14 c) Where indicated, consent for a post-mortem should be obtained from relatives as soon as possible. Extracorporeal Membrane Oxygenation.. b) Team consultants and registrars review each patient's condition. 1 Royal Adelaide Hospital Intensive Care Unit Medical Manual 2012 Edition 2. b) Potential projects (and initial contact persons) are: i) Retrospective observational studies (A/Prof Flabouris and Dr Finnis) ii) Prospective observational studies (Dr Sundarajarajan) iii) Experimental work using a sheep model (Dr Maiden) iv) Laboratory based work (Dr Reddi) and v) Prospective clinical research (A/Prof Chapman and Dr Deane). Aureus b. g) Treatment limitation/non-escalation directives must be discussed with the patient or patient's family, the parent clinic and clearly documented prior to discharge. Clinical Duties in the ICU 1. Sedation, Analgesia and Delirium .... 85 Table: Sedatives / Analgesics .... d) Calibration should be repeated once per nursing shift and as indicated. Registrars a) Three levels of registrars are rostered in the unit: i) Senior Registrars (SR): Advanced trainees in the College of Intensive Care Medicine (CICM) (or equivalent training program) Have completed or near completed specialist training. a) Queries about drug company sponsored studies should be directed to the ICU Research Nurse on-call (SD 1520) b) Queries relating to a local investigator studies should be directed to the primary investigator. Code Blue & MET Calls a) The RAH medical emergency code is "33#". c) The pulse waveform analysis of continuous cardiac output is calibrated by thermodilution according to the device instructions. Endocrine Drugs 96 1. Trauma Calls a) As in cardiac arrest, a "33#" call is activated for trauma patients who meet specified trauma criteria. c) The following people are paged and the level response detailed on the pager: i) ICU/resuscitation registrar ii) Trauma Service registrar iii) Accident and emergency registrar d) On receiving a Level 1 call the ICU registrar should proceed directly to Resus in the Emergency Department (ED) e) Ensure that ICU staff know where you are going and that the Unit is not left unattended. Necrotising soft tissue infePage 204 and 205: H. If prolonged resuscitation is anticipated, call in the ICU or Trauma Consultant and/or delegate to the anaesthetic/resuscitation registrars. 19. Entries should establish a balance, being concise but still accurately recording all relevant information and events. ii) Check circulation and venous access. A/Prof Robert Young Director 2012 12th Edition 3. 221 L. ii) All medication orders should be re-written iii) Fluid or nutrition orders for the next 24 hours are prescribed. d) Technique policy i) Use local anaesthesia in awake patients. ii) Recording TPN patients in the "TPN Folder". iii) Basic life support is done by attending nursing and medical staff and may be directed by either ICU or medical registrar. ii) Remove yourself from the immediate vicinity of the fire, alerting other staff members as indicated, and position yourself behind the automatic fire doors. ii) You should first endeavour to swap the shift with someone in the same skill group so that the skill-mix is maintained for the shift. viii) Environmental swabbing in Intensive Care is conducted as required by Infection Control staff. 14. iii) Trauma (P1) resuscitation Trauma pages are subdivided into levels Attendance by the ICU registrar is only required for Level 1 calls. iii) The night duty nurses take the bloods at 06:00 and complete the request form, which must be signed by the night registrar. b) Knowledge of these studies can be obtained from any of the research staff. 111 Table: Antibiotics for Specific Organisms .... Death certificates a) The following forms need to be completed: i) RAH Notification and Certification of Death (MR 150.2) all patients including those reported to the Coroner ii) Death Certificate ("the yellow form") do not complete this for deaths reported to the Coroner iii) First Medical Certificate do not complete this for deaths reported to the Coroner b) Deaths notifiable to the Coroner: i) Contact the Coroner's office and provide preliminary demographic details of the deceased. Guidelines for the Management of Electrolytes .... viii) The home team should be involved or at least informed of their patient's condition, including when resuscitation is unsuccessful. The indications, conduct and any complications of the procedure should be clearly documented in the case notes, in addition to a consent form if this is completed. Most projects require prior RAH Page 32 and 33: Routine ICU procedures 32 � EndotPage 34 and 35: E. c) The system is not infallible – if there is a problem with any aspect of the roster, please notify the ICU secretary as soon as possible. c) Please contact the ICU Secretary if you have any questions or concerns about your roster at anytime. 16. Consultants may modify these guidelines on consideration of the nuances of a particular clinical case. General principPage 206 and 207: 206 iii) May be potentially useful Page 208 and 209: 4. e) Additional measurements of Global End-diastolic Volume Index (GEDI) and Extravascular Lung Water Index (ELWI) can be made via thermodilution. RAH guidelines detail appropriate use. b) A discharge summary must be completed and a copy filed in the case-notes. b) In addition, award requirements, occupational health & safety considerations, and individuals' preferences and requests are taken into account. iv) Measurement of PAOP: End expiration: lowest point in ventilated patients, highest point in spontaneously ventilating patients Use the "electronic cursor" on monitors after 2-3 respiratory cycles. Clostridium difficile Burns Febrile neutropenia Immunosuppressed patients as directed by Infection Control 17. Relevant progress and events in ICU (deterioration/improvement, procedures, investigations). 27 iv) General principles: Document your involvement with the resuscitation in the casenotes Once the primary survey is completed, proceed to the secondary survey and order appropriate investigations as per the Trauma team leader. Incompetent patients (sedation, coma or encephalopathy): a) Third party consent is not necessary for routine ICU procedures: i) endotracheal intubation ii) arterial lines iii) central venous lines iv) pulmonary artery catheters v) transvenous pacing wires vi) underwater seal drains vii) jugular bulb catheters viii) intra-aortic balloon counterpulsation ix) oesophageal tamponade tubes x) bronchoscopy b) However, relatives should be informed prior to the procedure if present. Severe respiratory failure from any cause (PaO2/FiO2 < 150) b. d. 77 Table: Antiplatelet Agents .... Current plan of management: a. Daily entry in case notes during admission. Pathogenesis - ARF in criticPage 174 and 175: 4. 6. Emergency Medicine trainees: 2 positions (3 or 6 month term). Hospital Emergencies .... Urinary Catheters 1. iii) Consider using a PAC sheath or Vascath if central access is required and adequate peripheral access is unobtainable. 15. Principles of Drug Prescription in Intensive Care .... Endocrine Drugs .... Distorted patient anatomy. Intra-Aortic Balloon Counterpulsation.. Emergency Surgical Airway AccessPage 54 and 55: 54 4. 71 Table: Antiarrhythmic Agents .... Procedures 1. Handover summary a) Due to the large number of complex patients, an ongoing handover summary should be established for each patient b) This facilitates ease of handover between day and night resident staff and for the duty consultant staff. Physician trainees: 1 position (3 or 6 month term). g) When rostered to night duty, you are not expected to attend weekly teaching sessions, as this would result in unsafe work hours. ii) Distal ischaemia iii) Mechanical failure (overdamped waveform, inability to aspirate blood) iv) Evidence of local or unexplained systemic infection k) Measurement of pressure: i) Transducers should be 'zeroed' each nursing shift ii) Zero reference = the mid-axillary line, 5th intercostal space l) Maintenance of lumen patency i) Continuous pressurised (Intraflo®) saline flush at 3ml/hr. 32 Routine ICU procedures Endotracheal intubation Peripheral venous catheterisation Arterial cannulation Central venous catheterisation / PICC line insertion Urinary catheterisation Lumbar puncture Epidural catheterisation PiCCO Catheter Pulmonary artery catheterisation Pleural Drainage Underwater seal drain insertion Pleurocentesis Peritoneocentesis Nasogastric tube insertion Specialised ICU procedures Fibreoptic bronchoscopy Percutaneous tracheostomy Cardiac (transvenous) pacing Pericardiocentesis Intra-aortic balloon counterpulsation Oesophageal tamponade tube insertion Extracorporeal Membrane Oxygenation C. Indications:Page 44 and 45: K. Renal Drugs - Diuretics .... b) Pruritis, nausea & vomiting, or urinary retention (opioid effects) c) Post-dural puncture headache d) Infection: epidural abscess e) Pneumothorax (rarely) 4. ii) Gloves must be disposed of within the patient cubicle on leaving f) Plastic aprons are to be worn: i) With gross physical contact with the patient (e.g. patient turns) ii) For "additional precautions" (see below) g) Additional precautions: i) The following patients require additional precautions: Infection or colonisation with: a. 24 g) The following duties accompany the Emergency pager (#33) i) Code blue calls | ii) Escalated MET calls | *see (4) below. iv) Wait for the arrival of the Fire Chief and assist in any patient movement/evacuation only as indicated by the Fire Chief. Management protocol: (applies to all types of CVC): a) Types: i) The default CVC for all ICU patients is a Cook antimicrobial impregnated (rifampicin/minocycline) 7F 15 or 20cm 3-lumen catheter. (Refer to trauma directives.) b) Trauma pages will appear as 2 Levels: i) Level 1: major trauma requiring immediate attendance / airway support ii) Level 2: trauma requiring full assessment in ED/Resus. Indications: a) Haemodynamic measurements (CO/I, SV/I, SVR/I) i) Aid to diagnosis and response to therapy of shock states, e.g. cardiogenic, septic or hypovolaemic b) Measurement of right heart pressures (RAP, PAP): i) Acute pulmonary hypertension ii) Pulmonary embolism iii) Cardiac tamponade c) Estimation of preload / left heart filling (PAOP) i) Intravascular volume status & response to fluid loading ii) LVF d) Measurement of intracardiac shunt: (Acute VSD) e) Derivation of oxygen delivery & utilization variables (VO2, DO2) 3. SigniPage 218 and 219: 218 v) The key issues in managementPage 220 and 221: 220 k) Tricyclic Antidepressants (TPage 222 and 223: 222 3. Medical and nursing staff are encouraged to become involved in research: a) Registrars are expected to assist in obtaining consent for ongoing studies. 170 E. General pPage 90 and 91: 3. c) Routine postoperative, short stay patients in Unit C do not need detailed admission notes. b) This is a single page document outlining all relevant transfer information. Consultant Medical Staff Director A/Prof Rob Young Deputy Director Dr Peter Sharley Director of Research A/Prof Marianne Chapman Supervisor of Training Dr Nick Edwards Consultants Dr Mike Anderson Dr Stuart Baker Dr David Clayton Dr Adam Deane Dr David Evans Dr Mark Finnis A/Prof Arthas Flabouris Dr Ken Lee Dr Matt Maiden Dr Stuart Moodie Dr Richard Newman Dr Ben Reddi Dr Richard Strickland Dr Krishnaswamy Sundararajan A/Prof Mary White Dr Alex Wurm 2. 35. c) Liaison with parent clinics is essential to ensure continuity of management. Blood Component Therapy .... c) All ventilated and potentially unstable transports need a medical escort. Surgical trainees: 1 position (3 or 6 month term). StPage 104 and 105: K. Take "first on-call" at night and experience responsibility at a consultant level. e) Responsibility for consent lies with the operator performing the procedure. 53 P. k) Nominated isolation/quarantine rooms for highly contagious patients: i) Rooms 3, 4, 5 & 6 - shared air-conditioning ii) Rooms 21 & 22 - sealed, independent, negative pressure A/C units. iii) Catheters remain as long as clinically indicated and are changed when: Evidence of systemic infection a. Complications: a) At insertion i) Arterial puncture – haematoma, thrombosis, embolism ii) Pneumothorax, haemothorax, chylothorax iii) Neural injury (phrenic, brachial plexus, femoral nn.) b) Passage of wire/catheter i) Arrhythmias ii) Wire embolism *if this occurs, notify senior staff immediately iii) Perforation of SVC / RA - tamponade c) Presence of catheter i) Catheter infection: rates increase under the following conditions: Size of catheter - thicker catheters (PAC, Vascaths) Site of catheter - femoral > internal jugular > subclavian sites Number of lumens Nature of fluid through catheters - TPN or dextrose solutions ii) Thrombosis, HITS secondary to heparin iii) Catheter / Air embolism iv) Knotting of catheters (esp. 15 F. ii) Strict aseptic technique at insertion: Handwash with AVAGARD® (chlorhexidine 2%) or MEDISPONGE® (chlorhexidine 4%) Sterile barrier: gown, sterile gloves, mask, hat sterile drapes (CVC - Patient Cover) Skin prep. 86 F. Notify ICU staff of pending admissions. c) All requests from MedStar for the transfer of patients to the RAH must be referred to the on-call ICU consultant. 10. Routine daily chest x-rays are not performed in ICU Chest x-rays are performed a. a) Daily investigations: i) Routine blood tests (U&E, LFT, Mg, Hb, WCC, Plts, ABG) are ordered on the daily flow chart and signed for on the 11:00 am fluid round. c) Become familiar with the location of fire exits, extinguishers and blankets in the ICU i) Unless small and easily contained do not attempt to fight a fire yourself. d) Secondary survey: fully examine the patient. Pleural Drainage.. Other variables including PVR(I), SV(I), L(R)VSWI are recorded in the haemodynamics flowsheet. Transportation of trauma patients to CT scan, angiography etc. 39 Table: Standard Haemodynamic Variables .... f) The following duties accompany the Consults pager (pager no #89 22888*): i) Ward consults ii) Requests for Total Parenteral Nutrition (refer to Team A SR) iii) Requests for retrieval (refer to MedStar) 24. Anaesthesia trainees: 1 position (3 or 6 month term). 22 K. 69 Table: Vasopressors.. 33 E. Septic screen a) Routine, pePage 198 and 199: 198 c) Nosocomial pneumonia in ICU Page 200 and 201: 200 e) Further venous access: i) RePage 202 and 203: 202 8. Staffing - Royal Adelaide Hospital ICU 1. There are students studying toward their higher degrees frequently working in the ICU. f) Patients are admitted to ICU under the 'bed-card' of the original or taking clinic. 153 C. Assistance with vascular access and restoration of circulation. Deaths Policy: a) The duty ICU consultant must be informed of all unexpected deaths. Registrars are encouraged to become proficient in all Intensive Care procedures. Gastrointestinal Drugs .... Respiratory Drugs.. Annual – May. iii) An "Additional Precautions" sign is placed outside cubicles of patients identified as infective risks: Red sign = patient has multi-resistant organism Blue sign = patient is immunocompromised iv) New disposable gowns and gloves must be used for each person entering the cubicle and disposed of within the cubicle upon leaving. Flush with 2ml normal saline. b) Applications should be made to the Coordinator of Research. Senior Nursing Staff Nursing Director: Mr Ian Blight Clinical Services Coordinators: Ms Deb Herewane Ms Ros Acott Ms Tracey Cramey Mr Michael Schwarz Mr Steve Wills Nurse Managers: Ms Ali Coventry Ms Heather Pile 7. Weekly Programme Table: Weekly Unit Programme Monday Tuesday Wednesday Thursday Friday 08:00 Handover round Handover round Handover round Handover round Handover round 09:00 Bedside round Bedside round 10:00 Bedside round Bedside round Bedside round 11:00 ICU Grand Round ICU Grand Round 12:00 ICU X-ray meeting Consultant meeting 13:00 Bedside round Primary Exam 14:00 Tutorial Simulator Training Simulator Training (1y trainees) 15:00 Audit Journal Club BICMed Course Clinical Teaching Trainee Tutorial junior registrar 16:00 Registrar tutorial (trainees) tutorial (all registrars) 17:00 18:30 Handover round Handover round Handover round 13. Requesting Shifts a) Particular shifts or days-off can be entered on a 'request roster sheet' that is posted on the pin-up board opposite the medical staff pigeon holes. 78 D. 93 Table: Heparin Infusion Protocol .... b) The request sheet is collected on the date indicated on the top of the sheet.

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