

Intensive Care Unit

Orientation Guide

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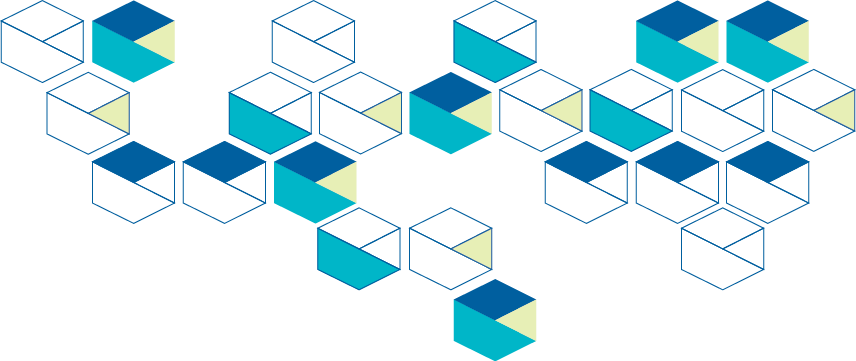


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# Purpose of this Manual

It expected that all medical officers will carefully read this document prior to starting in ICU. You must practice according to the directives, guidelines and principles set forth in this document. It is very important document.

# Introduction

Fiona Stanley Hospital (FSH) is Western Australia’s flagship public hospital. It is the major tertiary hospital for the South Metropolitan Health Service (SMHS) and it integrates with Royal Perth Hospital (RPH) and other SMHS general and specialist hospitals to offer comprehensive health care services to the communities south of Perth and across the State. The ICU supports the acute medical and surgical services at FSH including:

* **State-wide Burns Service**
* **Advanced Heart Failure and Cardiac Transplant Service (AHFCTS)**
* **Advanced Lung Disease Service (ALDS**)
* **Obstetric with major co-morbidities needing tertiary care**

Along with the above, the FSH ICU has a varied case-mix of medical and major surgical patients including cardiothoracic, vascular surgery, general surgery, major ear, nose and throat (ENT) surgery, plastic surgery, bariatric surgery and obstetrics.

The unit also manages patients following **complex cardiac surgery**, including Left Ventricular Assist Device (LVAD) and ECMO insertion. The hospital is the State referral centre for Extracorporeal Membrane Oxygenation (ECMO) and has an ECMO retrieval service.

The Fiona Stanley Hospital Intensive Care Unit (ICU) is centrally located on level one of the main hospital building, adjacent to the Operating Theatres, Coronary Care Unit and directly above the Emergency Department.

It has a modern design with 40 individual patient rooms that are split into 4 pods of 10 beds each. From February 2015 the unit opened with 3 pods (30 beds) and will potentially expand to full capacity as the hospital gets busier.

Some of the unique features of the unit include each individual patient’s room having an external window for natural light, and two courtyards attached to the unit to facilitate taking long term patients outdoors for short periods during their ICU stay. There are several positive (4) and negative pressure (4) rooms for specific patient populations.

The unit has direct access to a dedicated CT scanner and to the Operating Theatres.

The performance of clinical research and participation in local small trials or bigger multicentre trials is supported and encouraged by all clinicians in the ICU.

# The essentials

FSH ICU operates as a Closed Unit, meaning that although patients are admitted under a specialty bed card, governance of the patients during their ICU admission remains with the ICU team. Speciality teams are expected to conduct a daily review of their patients in ICU.

Clinical advice from other specialties is often sought about specific management issues, however any changes to plan of care must be discussed with the Specialist Intensivist or delegate and orders cannot be initiated without approval by ICU staff. These orders include but are not limited to:

* Removal of drains
* Prescribing or ceasing of drugs and fluids
* Ordering investigations
* Ordering blood products

# Pod Allocation

The allocation of patients to the ICU pods and individual bed spaces will depend upon the acuity of the patient, category of patient (short-stay versus long stay) and infection control requirements.

### Pod 1

* Admission of cardiothoracic surgical patients, ECMO patients, heart and lung transplant patients (in the Class P rooms), burns patients (hybrid isolation rooms) and other selected elective surgical cases.

### Pod 2

* Largely houses “clean” major, non-cardiac elective surgical patients of both low and high acuity as well as some short stay lower acuity “clean” medical patients.

### Pod 3

* Any patient requiring Class N isolation precautions is admitted here, along with longer stay, complex cases.
* Patient allocations are made in consultation with the Coordinating Consultant, ICU NUM or Delegate and where appropriate the Infection Prevention and Management Service.

# Getting Started

Prior to your first day of term, you will have been contacted by:

Ms Samantha Thompson - ICU Departmental secretary [Sam.Thompson@health.wa.gov.au](mailto:Sam.Thompson@health.wa.gov.au)

Phone: (08) 6152 6777

She will provide you in advance with the orientation schedule.

### On the day of orientation you will receive

* Departmental Orientation document
* Departmental Orientation Schedule
* A tour of the department
* Face-to-face orientation on the first morning of the term in the ICU seminar room provided by the Head of Department, Cyrus Edibam, or Oonagh Duff, who is in charge of Education or a nominated Consultant.
* Orientation will include an introduction to Metavision ICCIS, the paperless charting, notes and prescribing for ICU.
* Rosters and important Contact lists
* Check you are on the global email list.

### How do we communicate amongst us

* Whats App group-ICU HOD will send important messages via this group
* Hospital Email frequently as important Hospital communications will be sent via this method-You must check this at least twice per week

# Rosters and Leave

### Your Roster

* The FSH ICU Registrars and SRs Roster are managed in-house.
* The consultant in charge of Registrar rostering is Dr Melanie Saw
* FSH medical workforce handles the RMO roster.

### Leave

* SRs and Registrars are eligible for approximately 20 days (4 weeks) of annual leave per year. As a general rule leave is allocated on a pro rata basis (2 weeks per 6 month rotation in ICU).
* The allowance for study leave is 15 days (3 weeks) per year, of which 5 days is accrued each year if unused. Leave will be allocated on a first come first serve basis, with priority given to those taking exams.
* There is a formal policy regarding leave allocation and roster swaps which can be accessed via the ICU admin assistant. Please note that a maximum of 2 SRs and 3 JRs can be away at any point in time.
* For further information on pay and leave refer to WA Health AMA Industrial agreement link below:

[http://www.health.wa.gov.au/awardsandagreements/docs/WA Health System - Medical Practitioners - AMA Industrial Agreement 2016.pdf](http://www.health.wa.gov.au/awardsandagreements/docs/WA%20Health%20System%20-%20Medical%20Practitioners%20-%20AMA%20Industrial%20Agreement%202016.pdf%20)

### Leave requests

* Leave requests will need to be submitted ideally at least 3 months in advance via both electronic form and email to the relevant staff below:
* Please fill in the form and email the completed form to Sam Thompson, ICU Secretary who will pass on to Dr Melanie Saw, the consultant responsible for drawing up the roster and leave allocation for registrars
* RMO’s should contact Medical Workforce.

### Sick leave

* If calling in sick please inform Medical Workforce by phone as well as the Duty Consultant 61521751 and/or SR 61528801 AS SOON AS POSSIBLE.
* If more than 2 days of sick leave are taken, a medical certificate needs to be produced. If you anticipate that you are not going to be well, please inform the Consultant/SR at the earliest feasible time, especially for nights or weekends, so that alternative arrangements can be made.
* Once you return to work please fill out an electronic sick leave form and email this to Sam Thompson. Use the same form as the annual leave form, but instead of annual leave, select sick leave.

### Roster changes

* Swaps need to be cost neutral and if working fortnight hours drop as a result then leave may need to be taken to make up the 80 hours after the swap. Swaps that incur overtime will NOT be approved. Either Dr Melanie Saw or Dr Cyrus Edibam must approve swaps before they take place.
* Filling in the appropriate FSH ICU JMO shift swap form available either in Pod 2 handover room or at the secretary’s desk.(refer to FSH Leave policy for details)
* Emailing and advising Dr Melanie Saw
* Having the form signed by Dr Melanie Saw or the ICU HOS, Dr Cyrus Edibam.

# The ICU Team

Provision of high quality patient care in ICU is critically dependent on healthy respect and good communication between all the multidisciplinary ICU team members as well as the other specialist teams in the hospital.

### Consultants

* Dr Cyrus Edibam\*, Head of Specialty (HOS)
* Dr Chris Allen\*
* Dr Bart De Keulenaer
* Dr Oonagh Duff
* Dr Stephen Edlin
* Dr John Lewis\*
* Dr Edward Litton
* Dr Godfrey Lo\*
* Dr Greg McGrath
* Dr David Morgan
* Dr Bernice Ng\*
* Dr Srinivasa “Krishna” Ponasanapalli
* Dr Peter Pridmore
* Dr Nandkumar “Kumar” Raut
* Dr Adrian Regli
* Dr Melanie Saw
* Dr Simon Towler
* Dr Robyn Wilkinson

\*Participates in the Echo-ECMO roster

### Nursing Staff

* NUM: Luke Dix
* ICU Outreach/MET nurse: Cathy Haddock
* Clinical Educators: Anna Rowe ,Stacey Fuller

### Respiratory and Clinical Technicians

* Mike Das-Gupta (senior Technologist),, Ozan Demir, John Young, Jose Mathew

### Physiotherapy Lead

* Sara Lennon

### Dietetic Lead

* Liliana Sputore (Senior) Dietitian

### Pharmacist Lead

* Breigh Ridley (Senior ICU Pharmacist)

### Social Work

* Kathleen Parker

### Speech Therapy

* Ashleigh Sarris

### Research and Data Manager

* Jenny Thompson

### ICU CIS Team

* Mason Johnstone, Sonya Trewren (App Specialists/Nursing)
* Mike Lovett, , Greg Nicholls, William Rivera (Clinical Engineering)
* Emma Fox, Breigh Ridley (Pharmacy)

# Schedules

### Daily

|  |  |
| --- | --- |
| **Bed Availability round (0600):** | Night SRs and ICU shift coordinator to assess capacity to take elective admissions and place dischargeable pts on EBM |
| **AM Handover Multidisciplinary Team 0800 - 0900** | Handover of all pod 1 and pod 3 ICU pts will occur in the Clinical Workroom (L10614) Pod 2. Pod 2 handover will be in Pod 2 itself, except on Mondays/weekends when a combined handover will take place in the Clinical Workroom Pod 2. |
| **Ward Rounds (0900-1200 onwards)** | Consultant led ward round in each pod |
| **Infectious Disease rounds 1400 Mon and Thurs** | ID physician and ICU team combined round |
| **Consultant-Consultant handover (1700)** | Walk around handover with the evening Consultant/s |
| **PM Handover Junior doctor (2000)** | Day and Night JMOs handover in Clinical Workroom Pod 2 |

### Meetings/ Teaching

|  |  |
| --- | --- |
| **Journal Club (Thursday 1300-1400)** | Clinical Workroom (L10614) Pod 2 |
| **ICU Multidisciplinary Unit Meeting (first Tuesday of every second month 1400)** | ICU medical, nursing staff, Allied Health, pharmacy, resp techs, ward clerks meeting |
| **Monthly Registrar Teaching (Thursday 0800-1200)** | Attendance depends on clinical load. Expectation is attendance of 70% during term.  RMOs are encouraged to attend but it is not compulsory for them |
| **SIM Training (Tuesday 1300-1500)** Twice a month with 3 -4 trainees per session | Trainees will be allocated to attend depending on roster commitments |
| **Radiology Round (Wednesday 1300)** | Clinical Workroom (L10614) Pod 2 |
| **RMO Teaching** | This is self-directed and internet based. |

# Shifts and Staffing

### Day Shift

**Pod 1 (Bed 101-110):** Consultant (0800-1800), JR + SR1 (0800-2030)

**Pod 2 (Bed 111-120):** Consultant (0800-1800), JR + RMO (0800-2030)

**Pod 3 (Bed 121-130):** Consultant (0800-1800), JR + SR2 + RMO (0800-2030)

One of the above Pod 3 SR or JR will be assigned to MET/External duties (0800-2030) supported by the Duty (C) Consultant

### Night Shift

**Pod 1 (Bed 101-110):** Consultant 1 (1700-2400), SR1 + RMO (2000-0830)

**Pod 2 (Bed 111-120):** Consultants 1+2 (1700-2400), JR (2000-0830)

**Pod 3 (Bed 121-130):** Consultant 2 (1700-2400), JR + SR2 + RMO (2000-0830)

MET member will be one of the Pod 3 SR or JR

### Weekends

The Unit is divided into two functional zones for weekend rostering purposes

**Bed 101-115:** Consultant, JR + SR1 + RMO

**Bed 116-130:** Consultant, JR + SR2 + RMO

MET member will be one of the Pod 3 SR or JR

### Meal Breaks

JMOs are allocated a 30-minute meal break per shift. The ability to take this break is variable, particularly during the “day” shifts and the timing needs to flexible and will be dependent on clinical workload on the floor.

While you may not get your full break during a day shift, this will be made up for by longer breaks on night shifts. JMOs are permitted to leave the ICU to buy lunch but should inform the SR or Consultant and relevant nursing staff when leaving the floor.

Make sure you are always contactable.

## Specific JMO Roles

All JMOs are allowed to perform duties according to their level of experience rather than their job title (SR/JR/JMO).

* Examine patients-lay hands on patients during your shift, check on them frequently. We don’t assume that the RMO is the only JMO tasked with typing notes on the round
* Always ask questions if you don’t understand-you will always get an answer/help and this is the best way to learn about the care of the critically ill.

### Senior Registrars

* The role of senior registrar (SR) in the Fiona Stanley ICU is a pivotal one that affords a graded responsibility in a well supervised environment and an excellent opportunity to transition from Registrar to Consultant, by actively participating in a supervisory role for the Registrars and RMOs. There are ten SRs employed per term. There will be two SRs on duty at any one time, the ICU SR1 and the ICU SR 2. Weekends and Public holidays have no impact on SR roster. In general the SR
* Assists the Consultants on the floor and has direct involvement in all aspects of patient care, ongoing management and patient discharge.
* After hours is the most senior doctor in the ICU
* Participates in MET duties and receives all referrals for ICU admissions from the wards, theatres, emergency department and from outside the hospital. The suitability of these referrals for admission is assessed, with assistance from ICU Consultants.
* Provides senior support for the Hospital Out-of-Hours Team (HOOT)
* Provides clinical support for the JRs and RMOs
* Performs all Inter-hospital transfers in hours from the ICU

### Junior Registrars

* The JR will attend handover, Consultant ward rounds and will carry out duties as allocated and supervised by the Consultant or SR. It is expected that JRs will assume some responsibility for supervising RMOs and medical students. Most JRs will also participate on the MET/External shift.
* There are 12 JRs of varying levels of experience, with some very junior and some are almost SR level.
* In addition to ICU trainees (CICM trainee x 5), there are JRs that rotate from anaesthesia (ANZCA trainee x1), medicine (FRACP trainee x1) and ED (ACEM traineex3). We also have service registrars (x2).
* At FSH ICU every JR is able to assume responsibilities commensurate with their experience regardless of job title or roster.

### RMOs

* The RMO will attend handover, Consultant ward rounds and will carry out duties as allocated and supervised by the Consultant or SR/JR.
* RMOs have varying levels of critical care knowledge and experience so always ask questions if you do not understand something. This is the best way to learn who we deliver critical care in the ICU. Didactic teaching is no longer delivered as we provide the BASIC course for this purpose.

# Important Information

## Intensive Care Clinical Information System (ICU CIS)

* FSH ICU has a stand-alone fully paperless ICU documentation system (Metavision).
* Specific training is mandatory before you commence working in the ICU.
* All charting, clinical documentation and drug/fluid prescriptions are made within the ICU CIS
* Although ICU CIS displays common pathology from the labs not all results are displayed. Please continue to check iSoft for all patients. Electronic test ordering is still by hospital iSoft system
* Some forms remain on paper (consent forms, death certificates, cremation forms, NFR forms and a few others)
* iSoft, IMPAX, Bossnet, e-referral, e-diet, GE Muse and Prosolv where needed must still be reviewed for each patient

### Clinical Documentation in ICU CIS

* Medical Admission, Progress Notes and Family Meeting Note documents must be completed. All are accessible from the DOCTORS Menu
* You can **SAVE** as often as you like but you must ALWAYS **SIGN** it when completed (eg. at the end of your shift). This sends the document to Bossnet for the rest of the hospital to view it. It cannot be updated once sent
* Admission Forms: Please enter an **ICU ADMISSION DIAGNOSIS** when you complete the form.
* Progress notes-this where you document the ward round attendees examination findings and management plan**.**
  + **Please update Problem List fields and.** It shows that you can synthesise information about your patient. Move Active Problems to Inactive Problems when resolved.
  + **Please update** **Summary of ICU admission fields each day-** Adding pertinent summary points to the summary fields allows the discharging Dr to have a discharge summary immediatey available. Keep this field brief and succinct.
  + **The last progress note becomes the discharge summary and must be SIGNED**

## Handover

* The Multidisciplinary Handover meeting occurs at 0800 in Clinical workroom L10614 for Pod 1 and Pod 3 and is attended by all the night and day staff. Pod 2 handover is conducted as a walk around bedside handover. On Monday/weekend mornings, and all evenings, all pods handover over together in L10614.
* Please don’t feel intimidated and please speak up so we all can hear! JR and RMOs are strongly encouraged to present patients, rather than leaving it to the SR.
* At the morning sit down handover the night medical staff assigned to the pods (nominated SR for the pods, night registrar and RMO) will present each of their assigned patient’s clinical summaries with the aid of THE METAVISION HANDOVER TAB SUMMARY.
* HANDOVER MUST BE CONCISE (about 2 minutes per patient) and convey the relevant new information between shifts including:
  + Any major status changes during shift
  + Any procedures/investigations/consults/investigations during shift
  + Outstanding tasks that need follow up on next shift
* IT IS UNECESSARY TO RE-ITERATE THE HISTORY IF THE POD CONSULTANT ALREADY KNOWS THE PATIENT. Staff that are unfamiliar with the patient will come up to speed after handover.

## Consultant Ward Rounds

* An in-depth daily pod-based ward round occurs following the morning handover (ideally no later than 0930) and is led by the Consultant. Please focus on what the Consultant is saying. An evening ward round with the night Consultant will usually occur following PM handover.
* Patients should be seen on the basis of priority on the ward round. Please ensure that unwell or deteriorating patients are seen first and then any patients identified for discharge.
* The ward round is attended by the JMOs allocated to the pod and the pharmacist. Other Allied health staff do not routinely attend this round but are always available to be contacted. The patient’s nurse may not be physically present during the ward round so it is important to make sure any changes in current plans are conveyed to them
* Three mobile computers (WOWS) will be required for the ward round-one for the JMO documenting notes, one for the consultant and one for the pharmacist. **It is in your interest to always plug them in when not in use**.
* It is important to concisely document the management plan in the appropriate field of the progress note in Metavision during the round. All other notes can be done later if time is limited

## Admission Procedures

* The ICU pod Consultant must be informed of the expected arrival time of the patient. **For after-hours admissions if the ICU consultant is not present on patient arrival, they should be informed about the admission at the earliest possible opportunity.**
* New admissions that are unstable or at any time when the rostered staff feel unsure-CONSULTANTS EXPECT TO BE INFORMED.
* The consultant/team bed card under which the patient is to be admitted should be clarified prior to admission to the unit.
* There must be handover to the ICU team from the staff accompanying the patient.
* All ‘tubes and lines’ should be assessed as **secured** and their position confirmed clinically or radiologically when appropriate.
* Ensure that family is made aware of the patient’s arrival in the ICU at any hour.

## Ongoing Clinical Reviews

* Please **review your patients at regular intervals during your shift** as condition changes can occur unexpectedly.
* On night shift it is advisable to do a detailed review of your patients around 5am

## Clinical Deterioration

* **Any significant patient deterioration should be immediately communicated to SR and the on duty Consultant.** JMOs should seek advice from the ICU Consultant at any time, especially after hours to discuss or clarify any problems related to the patients, their management and the function of the unit. The onus is on the Consultant staff to be available at all times to provide support to the junior staff.
* **IT IS MANDATORY TO INFORM SENIOR MEDICAL STAFF IF**:
  + Patients has **unexplained tachycardia and/or hypotension. These patients**  MUST have a **bedside echocardiogram** as soon as possible. There is an on-call ICU Consultant that can be called to perform an transthoracic or transoesophageal echocardiogram after hours
  + There is a **significant change in patient’s clinical state** eg: escalating FiO2 requirements, if intubation is anticipated, escalating inotropic and vasopressor requirement, cardio-respiratory arrest, need for renal support etc

## Discharge Procedures

### Discharge Decision

* The decision to discharge patients is the responsibility of the ICU Consultant/SR in consultation with the Specialist team. Early discussion by the ICU NUM/Shift Coordinator with the specialty NUM/ Coordinator is vital for any patient’s discharge to the ward.
* **Discharge tasks (other than printing medication charts) are ideally completed by the night team on the day of discharge where possible**. It is the responsibility of the night team to ensure that the day team is informed that the discharges have been done.

### Discharge Drug Orders

* Drugs and fluids that are not needed for ward discharge **must be ceased** on Metavision prior to discharge.
* Print the **e-NIMC and e-anticoagulation charts** directly from Metavision. Review and then sign them.
* **PCA and regional analgesia** prescriptions that were started before ICU admission will resume on the original paper chart that came with the patient from theatre. These original charts are kept in the blue HIMS file near the ward clerk desk. If started in ICU then a new paper chart must be written by hand
* **Insulin, IV fluids, enteral nutrition and oxygen orders** must be charted onto the specific charts by hand. The e-NIMC will have a **red reminder text** to prompt you to do so for these orders

### Discharge Documentation

* Always sign the latest progress note before signing the medical transfer summary. Always complete and sign the Metavision medical transfer summary before the patient is discharged from the ICU. **This cannot be done after the patient has been discharged from Metavision.**
* Please enter information in the Transfer summary that is **relevant to the ward team.**
* Complete a **NACS summary** for any patient that has **died**, been **discharged home** or **transferred** to another institution. If this is not completed you will be sent a reminder to do so eventually, even if you have left ICU and are working elsewhere.

### Discharge Communication

* Always communicate with home teams, GP, relatives and Coroner where appropriate.
* It is mandatory that the Specialist team Consultant/Registrar is made aware of the discharge as early as possible. The communication should be **both verbal and written**. Out of hours the on call registrar should be notified of any discharges to the ward.
* If practical the receiving team should be notified and attend the ICU to receive handover of all the relevant clinical issues the day before actual discharge.
* Outstanding results, consults and investigations must be highlighted. **(Results Acknowledgement)**

### Specific Death Documentation

* It is the responsibility of the JMO certifying the patient deceased to inform the admitting team and the GP/Community nurse treating the patient or **Coroner** as soon as possible.
* For a death from natural cause the following paperwork needs to be completed prior to moving the deceased to morgue:
* Pronounce time and date of death in notes.
* **Fill out death in hospital form**. Refer to the FSH Document on certifying death.
* Death Certificate.
* Cremation Form.
* Post Mortem Form (if requested).

### Coroners Notification

**What is a reportable death?-use the Death in Hospital Form to guide you**

**Always err on the side of notification if you are unsure-discuss with Coronial Unit**

Under the Coroner’s Act – 1996 – if YES to any of these questions

* Is the cause of death unknown or uncertified by a medical practitioner?
* Has the death or does the death appear to be have occurred in suspicious circumstances?
* Has the death possibly resulted from a criminal act?
* Was the death or does the death appear to have been unexpected or unnatural?
* Complication following administration of a medication, diagnostic, medical or surgical procedure
* Has the death or does the death appear to have occurred, in or following violent circumstance
* Physical or sexual assault, domestic dispute
* Has the death or does the death appear to have resulted, directly or indirectly from injury?
  + Fall, motor vehicle, self harm
* Has the death occurred during anaesthesia? e.g. General anaesthesia
* Did the death possibly occur as a result of, or does it appear to have resulted from, anaesthesia?
* Immediately prior to the death was the deceased a person:
  + Admitted to a centre under the Alcohol and *Other Drugs* Act 1974
  + An involuntary patient, apprehended, detained or absent without leave under the Mental Health Act *2014*
* Is the deceased person’s identity unknown?
* To your knowledge has any one expressed any concerns regarding the cause of the deceased person’s death or medical treatment?
* Coronial cases must be reported to the Coroner’s office-**see FSH hub for mandatory notifications and Coronial Office contact information**. Please do not remove any lines or tubes without consent from the Coroner’s office.

## Drug Prescription Safety

### Check Correct Patient is on Screen

* Please make sure you have the correct patient on the screen when prescribing from a mobile PC.
* Please be very careful when prescribing drugs electronically-some drugs names can look very similar.

### Allergies

* Allergies must be documented in Metavision and also in Bossnet. If you are not familiar with the process then you must learn about it. Pharmacists can assist you with allergy documentation
* Please read the Metavision drug tip field in the drug order for important dosing information

## Electrolyte Replacement

Electrolyte replacement in ICU is very common and you must be very careful. If the need is not urgent then enteral route is preferred.

* Potassium salts (KCl or KH2PO4) must be given in the correct dilution at no more than 20mmol/hr
* Neat KCl infusions must not run at more than 20mmol/hr and must have regular 1-2 hourly blood testing to prevent overshoot
* Always try and give KCl in maintenance infusions or more preferably enterally as this is safer and more likely to correct ongoing losses and deficits

## Antibiotics

* LEVELS: Vancomycin should be prescribed as a regular dose eg BD 0600/1800 or OD 0600. Please take morning drug levels at 0530 and then give the AM dose without waiting for the level. The following dose will be adjusted on the basis of the level.
* DURATION: always put a stop date in the order-if you don’t know-ASK
* CANDIDA PROPHYLAXIS: prescribe oral and NG nystatin 2ml QID (PO/NG) when prescribing a broad spectrum antibiotic (eg meropenem, tazocin etc)
* PROPHYLACTIC ANTBIOTICs FOR CARDIAC SURGERY: please refer to uNit guidelines

## Stress Ulcer Prophylaxis

* All critically unwell and post cardiac surgery patients need stress ulcer prophylaxis with either a H2 antagonist or PPI

## DVT Prophylaxis

* All patient s need to have some form of DVT prophylaxis-either mechanical calf pumps/TEDS and/or heparin/LMWH-please check with your Consultant

## Ordering Investigations

### Routine Tests

* We waste an enormous amount of money on unnecessary blood tests. Routine blood rounds occur at 5:30am. Ask the day Consultant which tests are absolutely necessary and tick only those boxes on the investigation field of the Metavision progress note**. If no boxes are ticked and the patient is stable-do not do any investigations**
* The nursing staff will take the bloods if the tests have been ordered
* **CPOE** MUST BE USED TO ORDER TESTS UNLESS IN EMERGENCY (yellow doentime forms)
* Routine CXR is required on admission to check to check line and tube placement and post procedure CVC/PICC/ICC/ETT/Trach/Bronch) and when chest drains are removed. **Do not do CXR in any other circumstances unless management will change or requested by Consultant**
* **Blood Cultures** must be done if a patient’s temperature exceeds 38C. These must be done prior to antibiotic therapy and performed with aseptic technique and taken from two separate sites (two bottles each site).
* The only other microbiological tests on a routine basis are MRSA/VRE screening swabs. These are done by nursing staff

## External Referrals and MET Duties

An SR or JR is assigned to MET/External duties and carries the designated MET page and ICU drug “bum bag”. This is a busy and often tiring role so please get your share of coffee beforehand. If you are a JR, don’t fret, you will be well supported by Consultants and SRs

### MET Duties

* Attend all adult MET calls as team leader, supported by the C Consultant. Attend all paediatric MET calls (not as team leader).
* Endeavour to handover post MET management plan to home team-they must take responsibility for their patients
* You may have to spend prolonged time with the patient post MET if the patient is still in MET trigger criteria
* Bum Bag must be signed over each shift with a record of content’s recorded in the book
* Familiarise yourself with the **FSH Code Blue SOP** document
* Any issues that you think need investigation by the MET Committee can be done via email to **FSFHGMETClinicalReviewGroup@health.wa.gov.au**

### Referral Requests

* The **C Consultant is available** between 0800-1800 and all admission requests must be discussed with them. After 1800 the nominated night Consultant must be made aware of any admission request. If you are a JR holding the external page please utilise the C Consultant or SR for advice-they are more than happy to help you and will often come and review patients with you.
* **Always document in Bossnet as soon as practicable after any review of patient’s outside ICU**. Any physical review or conversation you have had about the patient’s management, disposition or prognosis needs to be recorded in the **Bossnet medical record**. Many complaints and critical incidents stem from poor/lack of documentation.
* **ED REVIEWS-** It is hospital policy to attend the **ED within 30 minutes** of receiving a call. It is not unreasonable to wait to see if basic resuscitative measures will preclude an ED referral needing HDU. We must however place a time limit on when to judge treatment effect (4 hours). If clinical judgement you feel the patient will be well enough for ward but still with ADDS 4 or more then discuss with ICU Consultant who may have to review in ED along with the ED Consultant-eg prime example is the unstable GI bleeds in ED that are too unwell for ward but not unwell enough to demand urgent endoscopy-the decision on disposition should be made quickly and based on ICU/AMU and ED Consultant input-don’t hesitate to ask the C Consultant for help if there is disagreement about disposition to AMU vs HDU
* **FREMANTLE HOSPITAL REFERRALS:** All referral from the **operating theatres or post op care unit at Fremantle Hospital (PCU)** come to the FSH ICU initially. Fremantle is essentially treated the same as any FSH ward area. If the patient needs HDU/ICU care then they should be a direct admission. If no bed is available in ICU the patient may have to wait in FSH ED. This will require a call to the duty ED Consultant to inform them of the bed issues.
* **EXTERNAL REFERRALS** that do not require further intervention or investigation in the ED should be **transferred directly to the ICU** and not have an unnecessary stop in ED.
* Patients are admitted under a **Speciality team bed card**, and not under the ICU consultant. Please note, mental health never admit under their bedcard
* Unstable patients needing urgent **surgical, endoscopic or radiological intervention** should not be admitted to ICU until definitive treatment has been instigated by the specialist team, unless this is impractical.
* **Patients requiring non-invasive ventilation** can only be accommodated in one of 4 areas-ICU, HACA (High Acuity Care Unit on AMU), CCU or RFU (respiratory failure unit) at FSH. If a patient needs NIV post MET call then the patient cannot stay on the ward for prolonged periods and needs to be referred to the appropriate department.
* HDU level patients should not be admitted to the cardiology telemetry unit. This ward provides standard ward based nursing care only. The patent should either be accommodated in ICU or on CCU.
* If a patient is deemed **inappropriate for ICU admission**, this should be discussed with specialist team and the reason for refusal should be clearly **documented** in the patient’s Bossnet medical record. If in doubt, liaise with the ICU Consultant early so they can communicate to the speciality team Consultant directly if there is any pressure for admission.
* One ICU bed is generally reserved for in-house emergencies/MET calls if possible. If the Unit is full and the possibility of diversion is raised, this MUST be discussed with the on-call Consultant. **It is the job of the ICU Consultant to contact their counterparts to arrange transfers or diversions to other ICU**s
* **All burns, advanced heart-lung/transplant patients** MUST be accommodated at FSH as this is the State quaternary service provider. RPH is the state referral centre for major trauma and. SCGH is the major neurosurgical centre and any patient with major trauma or a neurosurgical problem should be not be accepted to FSH unless discussed with the ICU Consultant
* FSH ICU is **NOT a paediatric ICU**. Patients under the age of 17 years of age are not suitable for admission to FSH ICU except under certain circumstances.
* All hospitals within the SMHS will refer to FSH as the hub tertiary hospital. Country Health services have specific referral pathways to the appropriate tertiary hospital. All transfers must have an admitting Consultant/bedcard team nominated prior to acceptance This **referral map** is available on the WA Health website based on metro postcodes and rural links
* The **Nursing Shift Co-ordinator must be informed** of potential admissions as soon as possible and include urgency of transfer, referring clinicians contact details and special requirements prior to their arrival e.g. requirement for CVVHDF, Micro status.
* Elective booked cases can be found on Theatre List (TMS) or Interventional Scheduling System (ISS). Please note that on occasions **not all elective admissions are listed**.

## Ward Step Up Areas at FSH

* Monitored areas outside of ICU/HDU at FSH have very limited/no capacity to look after HDU level patients
  + CCU/ cardiology ward 4D
  + AMU POD3 (formerly known as HACA)- only flow in from ED or AMU (see Exclusion Criteria on Intranet)
  + RFU (Resp failure Unit)
* These areas all have monitoring capability but they DO NOT cater for unwell multisystem issues because of low nurse staff ratios and inexperienced medical cover. There is usually pressure for ICU/HDU to accommodate certain pts especially if they are at risk of deterioration. If there are disagreements about disposition, please speak with duty ICU Consultant at all hours

## Use of Medical Equipment

All equipment must be handled with care, specifically the ultrasound machines, video-laryngoscopes and bronchoscopes

### Ultrasound Machines

* These devices must be used with care. We have three Sonosite machines, one high end Philips echo machine (Epiq7) and one general ultrasound machine (Philips Sparq).
* The high end echo machine (Epiq7) is not to be used by JMOs unless permission has been obtained from the Consultant. Transoesophageal echo can only be performed by a credentialed practitioner in the ICU.
* Use of ultrasound is mandatory for CVC insertion and advisable for PICC insertion. It can be also be used for drainage of pleural effusions and arterial line insertion.
* A sterile probe sheath must be used for all invasive procedures using US.
* For non-procedural use, contamination of the probe is almost inevitable in ICU patients. You must always protect the probe by placing a freezer bag over it and then use a rubber band to secure it. There are supplies of these on each machine.
* The probes must be cleaned and wiped with **MATRIX** wipes after each use. It I the responsibility of the medical staff to keep these probes safe and clean. The cords and the body of the machine can be cleaned with alcohol wipes or OxyVir-TB wipes **DO NOT USE ALCOHOL WIPES ON THE SCREENS**
* Visible blood staining mandates rinsing with soap and tap water and then high level disinfection. The machines cannot be used until this has occurred. The machines are checked twice a day for blood contamination and will be removed form use until clean

## Procedures

* CVC/PICC/arterial lines and ICC are commonly performed by JMOs
  + All JMOs will be required to complete the CVC insertion competency pathway for ICU before being able to insert CVC lines
  + Insertion of central and PICC lines is prioritised to the registrars and SRs. There is limited opportunity to do these procedures at RMO level and they will only be available to you after completion of all education and observation requirements. Ask the Consultant or SR in advance if they will supervise you inserting a CV line.
  + A competency program must be completed prior to performing CVC procedures.
    - Please complete the online module on learnicuwa [www.learnicuwa.com.au](http://www.learnicuwa.com.au)
    - A practical simulation session is part of the orientation program
    - Practical training consists first by observing the procedure and then supervised insertion
* IABPs, percutaneous tracheostomy, pacing wires and ECMO cannulations, are usually performed by Consultants (or SRs if permitted by Consultants).
* All procedures must be performed with full aseptic technique
* Documentation in the Progress Notes stating the operator, type of line, presence of complications and that position of line has been checked is mandatory.
* **LEGALLY YOU MUST DOCUMENT THE PROCEDURE IN METAVISION**
  + Please fill in the form attached to the inserted line (on the lines and drains tab on Metavision)
* **IMPORTANT POINTS REGARDING INTRAVENOUS DEVICES**
  + Always document the CVC or PICC line tip after review of the Chest X-ray
  + Renal patients-always use wrists unless dire emergency. Do not insert subclavian line in on the side of the AV fistula due to risk of cebtral vein stenosis)

## Infection Control

### Hand Hygiene

* Hand Hygiene is regularly audited in ICU. Medical staffs are the least likely to comply with the 5 moments of hand hygiene and this has very real impacts on patient outcomes. Everyone needs to do it-call people out if they are observed not to have cleaned their hands-this includes Consultants

### Isolation Precautions

* JMOS should familiarise themselves with the various isolation precautions in the unit
* These include
  + Orange Card (contact),
  + Green Card (Droplet) and
  + Blue Card (Airborne) precautions.

### Prevention of Needlestick Injuries

* A recent audit has shown that over the past 2 years we have had 4 reported needlestick injuries by medical staff. Of these, the majority (3) occurred during suturing of lines. The fourth occurred when someone was clearing away drapes and a needle had been left behind.
* Your safety is of the highest importance – ideally our needlestick rate should be ZERO.
* Tips:

1. Be aware that the large curved needles can be tricky to handle. When suturing skin, there can be a “give” which results in the needle jabbing forward – if your fingers are in the way, they will get stuck!
2. When suturing arterial lines leave the guidewire in or place a syringe on the end (this avoids having heavy transducer tubing “pulling” the art line out, and you having to hold it with your fingers in the way).
3. We are in the process of stocking instruments and smaller needles on the procedure trolleys, so you if you prefer you can use a needle holder and forceps instead of the handheld needles.
4. Always use a scalpel or scissors to cut the suture – don’t try and use the cutting edge of the needle.
5. Always cut off the needle before attempting to tie knots.
6. Have a dedicated kidney dish that you can place your used sharps in.
7. Keep a mental checklist of all the sharps you use and make sure they are all disposed of safely at the end in a sharps bin.
8. Always be careful, even if you are tired or in a rush.

The risk of catching a blood borne virus from a needlestick injury is low, but it is still a very stressful and time consuming experience. The best thing is to avoid it in the first place!

## Communication

* Good communication is essential for the ICU to run safely. Keep all members of the team in the loop.
* When orders are written or changed on the ICU CIS it is very important to physically inform the bedside nurse- computerisation is good but it allows us to do things remotely away from the bedside and this can result in communication drop-outs
* Any member of the team can ask questions and query and management decisions of any member of the team including the Consultant
* Always ask questions if you are not sure
* When communicating with families it is very important that a consistent message is delivered from all ICU team members. Please document any family meetings you have in the Family Meeting Note in the IU CIS

## Education and Training

### Senior Registrar’s Education Program

* SR’s and registrars will be expected to prepare and present tutorials and presentations during the term. This includes preparing topics for presentation at the monthly JMO teaching, which will be co-ordinated by the SRs, and at the weekly Thursday lunch time journal club.
* All potential exam candidates should seek counsel about FCICM exam preparation and expectations from the College website and from the Supervisors of training Dr Bernice Ng, Dr Oonagh Duff and Dr Peter Pridmore

### Registrar’s Education Program

Registrars are encouraged to actively participate **in informal bedside discussion during ward rounds**. The ICU Consultants and SRs are usually more than happy to answer questions and teach. More formal teaching occurs through monthly teaching sessions and via the ICU learning platform, learnicuwa.com.au, and the hospital ICU intranet site. The learnicuwa.com.au website has links to the College website to facilitate completion of the College online courses, which are compulsory for all trainees who registered after January 2014. These courses can be found via the [Members portal](https://cicm.org.au/Login) under the Online Learning tab:

|  |
| --- |
| Brain Death and Organ Donation |
| Burns and Inhalational Injury |
| Cultural Awareness |
| Evidence Based Medicine |
| Focused Cardiac Ultrasound in Intensive Care |
| Neuro Intensive Care |
| Safe Patient Transport |
| Spinal Cord Injury |
| \* Tracheostomy |

* Registrar teaching is on Thursday mornings for 4 hours once a month. An ICU consultant always chairs the sessions. ***This teaching is ‘paid time’ and there is an expectation that all designated the Registrars will attend.*** When rostered on the floor attendance to the sessions depends upon clinical workload. The attendance to the teaching forms part of ongoing assessment and **there is a requirement to attend at least 70% of the sessions. Failure to meet this requirement will result in a fail for the term.**
* There are problem-based tutorials on the intranet and internet sites that cover some of the relevant information needed to pass the intensive care fellowship exams and also focus on the day-to-day management of patients in the ICU. They consist of a list of topics with questions to answer and a reference list to read for each teaching session. Once questions have been attempted these can be handed to Oonagh Duff or Robyn Wilkinson for marking.

### Resident Medical Officers (RMOs) Teaching Program

* The RMO teaching program is independent of the ICU Registrar teaching program, although the RMOs are encouraged to attend the registrar teaching when they are free. All of the relevant reading material can be accessed on our Moodle site, where interactive modules can be worked through in your own time. The site can be accessed at learnicuwa.com.au. An email will be sent out at the beginning of the term with details on how to enrol. Many of the PowerPoint presentations from the site are available on the ICU intranet under Education Resources –although these can’t be accessed from home.
* The RMOs will be expected to work through these modules to gain a greater understanding of the common pathologies and treatment modalities in Intensive Care. After completing each module, there will be a short test covering the topic, which can be completed for a module certificate to hand in at the end of term. Any difficulties with the subject material should be discussed with your mentor. Any difficulties with the running of the site should be discussed with Oonagh Duff.

**Advanced Cardiac Life Support after Cardiac Surgery (CALS)**

* Fiona Stanley Hospital has adopted the CALS algorithm for post cardiac surgery resuscitation.
* The CALS algorithm and key positions in CALS can be found at the back of the Manual. The expert consensus document and other information on CALS can be found in the cardiac section of learnicuwa.com.au. You are encouraged to familiarize yourselves with the material. **You will be expected to know it if you work at FSH.**
* We also encourage you to attend a CALS Course wherever it is available, and not just at FSH. There are courses at SCGH and over east.

# Opportunities for Training and Professional Development at FSH ICU:

### CALS and ICE CATS

A modified approach to CPR is required in patients who arrest after cardiac surgery. The CALS and ICE CATS courses address these modifications and include simulations of clinical scenarios so that candidates can get ‘hands on’ experience with the different approaches and with how to perform an emergency sternotomy.

### Basic Course

A 2-day internationally recognised Basic Assessment and Support in Intensive Care (BASIC) Course is provided for the RMOs and junior Registrars new to ICU at the start of each alternate term. It covers all the important areas of basic ICU knowledge. The Intensivists and/or Senior Registrars participate as instructors and lecturers. There is a formal assessment at the completion of the programme.

### **Registrar tutorials**

The Thursday morning ICU teaching is led by the C or D Intensivist on. Registrars will have the opportunity to prepare and present at these sessions.

### **Weekly journal club**

This is attended by all medical staff; attendance by nursing and allied health staff is encouraged.

### **Quarterly Morbidity and Mortality meetings**.

These form part of the quality assurance of the unit and you are encouraged to attend these.

### **Hot Case and Exam Practice**

Mock theory and practical clinical examination practice for trainees sitting either the Primary or the Fellowship component of the CICM exam.

### **Bedside teaching**

Intensivist led day-to-day teaching.

### FSH Medical Grand Round

Attendance for the weekly FSH Medical Grand Round is encouraged and individuals from FSH ICU are expected to present 2 to 3 times per year.

### FSH ICU Weekly Radiology Meetings

These are held on a Wednesday at 1230 to discuss interesting radiology from recent patients admitted to the Unit.

Attendance at educational meetings forms part of the assessment as does presentations at these meetings.

FSH has multiple venues that can be utilised for education and meetings for groups of up to 30 people for teaching and training purposes. There is also access to the Education Building, which has a large lecture theatre with capacity for 350 people and 2 smaller lecture theatres that seat up to 80 people. Bookings for these areas are scheduled via a centralised booking system.

# Assessments and Performance Reviews

* The Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians currently accredit the Fiona Stanley Hospital ICU for unlimited core training and cardiothoracic speciality training
* Time spent working in the Fiona Stanley ICU is frequently accredited towards other training programmes such as anaesthesia, surgical, medical and emergency medicine. Individuals need to check with their own colleges as to the exact requirements. Many colleges require prospective notification of proposed rotations in addition to retrospective term assessment.
* The Fiona Stanley Hospital requires that at the end of each term a formal assessment be produced for all junior medical staff. Assessment differs to most other specialties in that there is little opportunity to develop a close consultant, registrar, and resident relationship. In reality you will only have a brief exposure to most of the consultants. **The term assessments are made by pooling collectively a majority of specialist opinions towards the end of your term.**

While good theoretical knowledge will be appreciated by the senior medical staff, many other factors go into an individual assessment. There will be an expectation that you can clinically examine a patient thoroughly and display practical conversion of theoretical knowledge to the patient who you are caring for.

You must be punctual, display good communication skills and be courteous to relatives, nursing staff, allied staff and even consultants!

Organisation skills are also assessed and include:

* Displaying the ability to achieve set tasks in a streamlined and efficient manner
* Following up the results of ordered tests in a timely manner
* Presenting succinct and accurate morning handovers

# Wellbeing/Mentoring/Term Feedback

* Bullying and harassment is not tolerated and the ICU HOS needs to be informed as soon as possible
* Assigning mentors to every JMO is impractical due to the high turnover especially at RMO level
* A mentor is not the same as the Supervisor of Training
  + The supervisors of training, Dr Bernice Ng, Dr Peter Pridmore and Education co-ordinator, Dr Oonagh Duff, will be available to discuss any training issues and will provide support and supervision throughout the term.
* All Consultants are happy to provide mentorship. If JMOs are comfortable approaching a particular Consultant they can ask them to be their term mentor. For RMOs a Senior Registrar can also be approached to be your mentor as they will often have a close and frequent working relationship.
* Dr Edibam ( ICU HOD) is very happy to meet with any JMO to confidentially discuss any issues that you feel are causing you difficulties or distress.
* If you feel comfortable discussing sensitive issues with a particular Consultant and wish them to provide mentorship please do so, if not please discuss with the HOD who will approach them on your behalf.
* At the end of the term please provide feedback direct to ICU HOD on any aspect positive and negative. The ICU HOD will email you prior to the end of term to discuss any issues generally or confidentially