Dartford and Gravesham NHS
NHS Trust

DARENT VALLEY HOSPITAL

Critical Care Directorate

The Ideal Anaesthetic Induction Project

The ICU Induction Pack

Dr. Mansoor Sange / CT/ August 2020

Dear Trainees,

A warm welcome to all the trainees to the Intensive care Unit at Darent Valley Hospital! We look forward to working with you over the next year and in the future.

Training Recognition

The intensive Care Unit (ICU) at DVH is fully recognised for all stages of Intensive Care Medicine Training for a CCT in Anaesthetics. The only stage it is not recognized is for the Advanced Year for a CCT in ICM. Training in ICM can only take place in minimum blocks of 3 months. *To ensure that all competencies are achieved during a training module, no more that 5 working days of any leave can be during a 3-month block of training in ICU.* If any of this leave is taken it will delay the sign off of the module. Please plan for this especially if you are doing the module at the end of your placement. This is not applicable to foundation year doctors.

Consultants

Name	***Role***
Dr. M. Protopapas	*Lead Clinician for Intensive Care*
Dr. Islam Abdo	*ICU / Anaesthesia / Echo*
Dr. Dhiraj Ail	*ICU / Regional Anaesthesia / Ultrasound*
Dr. Z. Belagodu	*ICU / Trust Simulation Lead / FICE trainer*
Dr. M. Sange	*ICU / FICM and RCoA Tutor*
Dr. R. Suleman	*Emergency Medicine Consultant / ICU*
Dr. David Tyl	*ICU / ICU follow-up Clinics/ Neurology*

Matron:	Maria Crowley	
Senior Practice Development Nurse:	Charlotte Coates,	extn 4762
Senior ICU Audit Nurse:	Katy Collins / Laura King	extn 4932
Lead Physiotherapist:	Ashley Quinn,	Bleep 139
Senior Pharmacist:	Kevin Day	Bleep 174
ICU lead for Nutrition and Dietetics:	Jessica Feldon	

The Unit

We currently have six level 3 (ICU) and four level 2 (HDU) beds. We currently use these flexibly depending on patient need. We admit about 650 patients per year and approximately 50-60% are ventilated. Our Standardised Mortality Rate is compatible with units of similar size and patient mix.

Admissions

The final decision to admit or refuse a patient rests with the ICU consultant.

All admissions to ICU /HDU should be discussed with the ICU consultant in charge of the unit for the day and out of hours with the consultant on call. As soon as a decision to admit is made, it is very important that this is documented clearly in the patient's notes. This time is then used to audit any delays in admitting the patient to ICU.

Similarly, a referral should also be discussed with the ICU consultant before the patient is refused admission unless the decision is straightforward and agreed by both ICU doctors and the referring team.

Discharges

Though it is appreciated that sometimes this may be unavoidable we aim not to discharge patients out of hours (after 10 pm) as this is associated with increased morbidity and a higher re-admission rate.

Limiting / Withdrawing Therapy

The decision to limit or withdraw treatment is always made at a consultant level. The patient (if this is appropriate) and the family of the patient should always be kept informed in an honest and sensitive manner. It is important that a comprehensive record of the conversation is recorded in the ICU notes.

All withdrawals of treatment must be discussed with the SNOD (specialist Nurse for Organ Donation) as per organ donation guidelines.

If active treatment in a patient is considered futile and is withdrawn, then the patient is entered into End of Life Care Pathway. There is a section in this that needs to be filled in by the ICU doctor. This is printed out from PAS by the nurse at the bed side.

Discussions with Relatives

All discussions with relatives should be undertaken by consultants and it is expected that juniors will attend these as they are educationally very valuable. Occasionally particularly out of hours senior trainees / SAS may undertake these discussions if the consultant covering the ICU is happy.

Staffing in the unit

There are currently seven Intensive Care Consultants that provide cover for the unit during the day 8am to 6pm Monday to and 8am to 1 pm Friday.

We operate a block system where each consultant covers the unit for 4.5 days each. There are invariably 3 doctors on the unit daily - the consultant and 2 more junior doctors.

One of them (non-trainee) sometimes does a block of 5 days. There is also a supernumerary FY2 who will be on ICU for most of their 4-month rotation.

Handovers take place at 8am in the ICU seminar room. The incoming and outgoing teams and the ICU consultant attend them in the morning.

Out of Hours Cover

Out of hours, the unit is covered by the ICU consultant on call rota. On weekdays the consultant intensivist on call covers the unit from 6 pm till 8 am the next morning. On weekends the consultant intensivist covers the unit from Friday 1 pm to Monday 8 am.

The ICU consultants can be contacted for advice out of hrs for all the patients on the unit, any sick patients on the wards / ED and for any potential transfers out of the hospital. **For all paediatric sick patients and airway advice (except on ICU) please initially contact the Anaesthetic consultant on call via switchboard.**

Referrals / Outreach

The day to day running of the ICU is the responsibility of the ICU team. Referral teams review their patients and provide input as required. A dedicated section in the ICU sheets is provided to record their input.

Patients are referred to ICU by medicine, surgery or A & E. The referral may come from the consultant, a junior or often from the outreach team who have previously assessed the patient.

The outreach team consists of experienced outreach nurses that review patients on the wards and follow up patients for three days after ICU discharge. They also have an educational role (ALERT courses). They are present in the hospital seven days a week both during the day and also at night. They are supported by the ICU doctor and consultant intensivist.

We have a system of managing deteriorating patients in the hospital. There is the outreach team, the medical emergency team, a NEWS scoring system, amalgamated DNR / TEP Treatment Escalation Plan Forms and hospital at night handovers all of which are utilised for this purpose. The operation of this will be discussed more fully at induction.

Medical Emergency Team (MET) Calls

If a patient triggers a MET call or is reviewed by the ICU team this must be recorded in the notes. MET calls must be attended within 15 minutes. Till recently, all MET calls used to be attended by the ICU bleep 230. After a review of the workload of the ICU on call anaesthetist the following has been agreed from August 2017.

- All MET calls will be attended by Outreach 24/7
- All MET calls will be attended by the medical registrar 24/7
- The ICU anaesthetist will attend MET calls **24/7 originating from ED, Cypress ward, Palm ward, Laurel ward, Chestnut ward and AMU**. This is because these are the areas where most calls originate from and more importantly ED will be operating MET calls in line with sepsis screening and the emergency laparotomy pathway.

We have generally agreed that ED will be calling the MET team if:

- They are seriously worried about a patient.
- If after an initial period of review of 2 hours by the ED doctor the patient NEWS score warrants a MET team review as per protocol
- Once the patient has been reviewed and a decision has been made to refer to a specialty for admission a NEWS score should be done prior to the patient going to the ward. This will prevent patients going to the ward only to MET call on arrival

The above will be subject to the following conditions:

- The ICU anaesthetist will be available to attend any MET call if requested to do so by the outreach team or the medical registrar
- The ICU anaesthetist will be available to attend MET calls if the outreach nurse is in recovery looking after an ICU patient or outreach is unavailable for that particular shift. This should be highlighted at the night hospital handover.
- If a patient in ED is clearly a surgical patient, then the outreach and Anaesthetic team will take over and expedite further treatment in conjunction with the surgical team. This will be part of the emergency laparotomy pathway.

Nursing Care on the ICU

We aim to have one ICU nurse per level 3 patient and one ICU nurse per two level 2 patients. This is flexible depending on circumstances and decided by the sister in charge and the ICU matron Maria Crowley.

The decision of how workload is distributed among nursing staff is the decision of the nurse in charge and ultimately the ICU matron.

Although senior nurses will often request beds on the wards early in the morning in order to maximise the chances of discharging the patient, the patient must not be discharged without medical review and appropriate documentation completed.

Ward Rounds

According to the FICM standards, twice-daily consultant ward rounds and its documentation is mandatory.

We have a morning ward round on ICU, which is the main business round of the day. The idea is that the ICU doctor sees the patients after their handover at 8 am and then a formal ward round takes place with the consultant. The timing of the ward round varies depending on the consultants. *It is very important that the trainee doctor is meticulous in history taking, physical examination, investigations review and documentation for each of the patients that they see.* A formal management plan is made for the day by the consultant on the morning ward round.

There is also a second ward round before or at evening handover. This is to be recorded in the notes as the **Second Ward round**. We are not doing well in documenting this ward round as per a recent audit.

Please maintain a **jobs list** in the jobs register that can be populated on the morning ward round. This list can then be used to guide the team and each job is "ticked off" as it's done. This ensures that no jobs are missed. It also allows you to safely handover any unfinished jobs to the night team. This may include a list of patients to see on Laurel ward or outside ICU.

Teaching takes place on Thursday mornings starting at 8:15 am. This represents protected teaching time and will be discussed in detail by Dr Sange who is in charge of this.

'Routine' blood samples are sent off by the nurses in the morning and the results are normally back by 8 am. This allows the blood results to be available for the morning ward round. If patients need a phlebotomy, then this needs to be done by the night ICU doctor early in the morning to avoid delays receiving the results. All peripheral blood cultures are also performed by an ICU doctor using a dedicated pack for this.

Documentation

There are dedicated admission pack, continuation pack and discharge forms on PAS that need to be filled in for each patient. These have recently been updated. When the patient leaves the unit, they are filed in the main hospital notes by the ward clerk. Documentation is absolutely vital in ICU and this needs to be legible, signed and dated each time. Please remember that **"if it is not documented - it did not happen".**

All clinical input relating to patient care (except for nursing care) is recorded in these sheets. This includes input from referring teams, physiotherapists, dieticians, pharmacists etc. We take this opportunity to remind you that these are important documents both clinically and medico-legally. Please do remember to fill in the Venous Thromboembolism Risk assessment that forms a part of the admission notes.

When the patient is discharged to the ward a discharge summary should be filled in electronically and

should be attached to the front of the main hospital notes. The discharge documents can be initiated early (on day 2 or 3 of admission) by the daytime staff and can be saved up to 2 times on the PAS system. It is then easier for the ICU team to discharge the patients if a bed becomes available at a short notice. It is very important to avoid discharge delays. The ward team that will be looking after the patient should be contacted and informed. Out of hours the medical / surgical registrar should be informed. This should be then documented in the relevant section of the discharge summary. The section on cardiac arrest and re-admission on the discharge sheets should be discussed with the consultant covering the unit. The medical team on the weekend now have an e-handover on patient services (on PAS) which asks the weekend team to review the patient and you can choose who reviews (i.e. F1, SHO or Reg).

There is a dedicated 'ICU drug chart' incorporating additional medications relevant to our patients. When the patient is discharged to the ward a 'ward drug chart' should be filled in by the ICU doctor. Please ensure that prescriptions are legible otherwise the nurses will not administer the medication.

If the patient is to be transferred to another hospital, then an appropriate referral letter should be prepared both form the ICU team and also from the referring medical / surgical specialty.

It is really important that the junior doctors complete all the patient documentation daily before they finish their shift. Any conversations between teams (especially outside the ICU or the hospital) need to be documented meticulously. Please also document any change in plans and the reasoning behind it as the day progresses. If for any reason the documentation is incomplete, then they should hand this over to the incoming doctor. Leaving incomplete notes is clinically and medicolegally not acceptable.

Renal Replacement Therapy / Cardiac Output Monitoring / Lines

We have the facilities to provide renal support for four patients and employ Flotrac systems from Edward Lifesciences for cardiac output monitoring. Consultants also perform bedside transthoracic echos to assess the patient's cardiac and haemodynamic state.

Percutaneous tracheostomies are done on ICU including adjustable flange tracheostomies for larger patients.

Central lines (preferably using the internal jugular approach) must be placed in an aseptic technique using ultrasound. All lines, including vascaths, are silver coated and are 16cms in length. We also have dedicated 16cm silver coated single lumen TPN lines. As a general guide, in the average patient, please insert the lines all the way in.

All vascaths have an additional lumen that can be used for vasoactive infusions. If possible, generally avoid left sided vascaths as they tend to be less reliable that right sided vascaths or femoral vein vascaths.

If a line is to be inserted de novo purely for the purposes of TPN then a single line should be used. If a multi- lumen line is in-situ, then the blue port should be reserved for TPN if appropriate. We now have a guideline for the use of PICC and Midlines on ICU.

Airway Management / NG tubes

Airway adjuncts such as the video scope and the bronchoscope are available. These must be correctly handled / maintained to avoid damage.

There is a difficult airway trolley on the unit. Please familiarise yourselves with its contents.

Capnography should be used for all airway manipulations and in all ventilated patients. There are integrated capnographs in the monitors for each patient.

All patients with potentially difficult airways should be identified at the handovers. A 'Difficult Airway' label should be placed above the bed.

Nasogastric tubes are 'harnessed' to avoid 'accidental' removal. There is a protocol for the verification of the position of nasogastric tubes and this must be followed in all circumstances. All NG tubes have to be confirmed by a consultant and a second doctor must sign a confirmation sticker.

Endotracheal tubes are also fixed with Anchor Fast to avoid 'accidental' extubation.

LocSSIPs

We have an established practice of using Local Safety Standards for Invasive Procedures (LocSSIPs) Checklists for 6 procedures on ICU. This include Emergency Intubation, Insertion of CVP / vascath, Bronchoscopy, insertion of Chest Drain, Percutaneous Tracheostomy and insertion of NG tube. Please see the training videos available on ADAGIO in the ITU section. The checklists can be printed of PAS and must be used for all patients on ICU. A new LOCSSIP for proning patients has recently been added.

Use of Theatre Recovery / Transfers

We often use a dedicated area in the main theatre recovery to look after critically ill patients prior to admission to our ICU or transfer out. This is because we are in more 'familiar' surroundings, have the help of an ODP and very often an outreach nurse and can use one of the ICU ventilators. It also happens to be next to the ICU. The senior nurse in charge of theatres and the recovery sister should always be informed beforehand.

We sometimes have to transfer patients out of the hospital either for clinical reasons or because of limited resources. These patients are invariably level 3 and are fully monitored throughout their journey.

Level 3 patients require the presence of a suitably experienced nurse and an anaesthetist. Level 2 patients from ICU or other parts of the hospital do not on the whole require anaesthetic escort. This will obviously have to be assessed on a case-to-case basis.

If a patient is referred to ICU by another specialty but there are no available beds to admit them, then a decision needs to be taken by the consultant covering the ICU as to the most stable patient to transfer out. We aim to transfer the new patient if possible, as this causes less disruption to the patients / families that are already in our ICU. If that is not possible then our most stable patient is transferred out after a full explanation is given to the family and patient if appropriate.

Recently, an adult critical care patient transfer service has started (called SPRINT 02081265725) of which we are a part. Any critical care patient who needs a transfer to another hospital for any reason can be transferred using this service where a team will come and transfer the patient for us. This service is available 7 days a week, 08:00 to 22:00

After transfer, please note that it is the responsibility of the ICU doctor and nurse to ensure that all the transfer equipment is returned to ICU intact and not left around in other parts of the hospital

Deceased Patients

The Medical examiner office has been operational at DGH for the last couple of months. Every death on the unit will need discussion either with the Coroner or the Medical examiner before the final Medical certificate of the cause of Death is issued (MCCD).
The Summary of death certification form needs to be filled out as soon as there is a death on the unit. This form can be found under patient documents in the PAS system . Please discuss with the Consultant in charge or the parent consultant regarding the provisional cause of death. The medical examiner will either meet or have a telephonic conversation with you regarding the circumstances of death, the cause of death as well if there were any concerns with care during the present admission. Once this is done, then you will be asked to fill in the MCCD and if required a Cremation form 4 in the bereavement office. If the cause of death is unknown or there is a clear criterion to refer the death to the coroner, then can be done without consulting the Medical examiner. The Medical examiner is always happy to discuss any case and we encourage trainees to use this as a learning opportunity to gain insight into the process which follows the death of a patient.

Microbiology and allied medical staff

There is dedicated consultant microbiological input to the unit with a consultant ward round Mon – Sat in the afternoon. All the microbiology is discussed and decisions regarding antibiotics are taken. **The microbiology round needs to be attended by an ICU doctor and the nurse in charge.** The microbiologists can also be contacted out of hours for advice. We have agreed some general antibiotic guidelines and have a trust antibiotic protocol on the Microguide app that can be downloaded for free.

There is a dedicated pharmacist, dietician and physiotherapist that visit the ICU on a daily basis. Their input is important in the daily management of the patient.

There is a dedicated ICU audit coordinator who collects data on a daily basis. A general outline of the data collected is included in the folder. As this data is based on information recorded in the notes it is imperative that these are as accurate and complete as possible.

Guidelines

ICU information / guidelines are found on ADAGIO the hospital's intranet in a dedicated ICU section.

Shifts / Handover

ICU junior shifts are 13 hours long and run between 8am and 9pm / 8pm to 9am. The FY2 is present 0800-2000 on Monday, 0800 – 1700 Tues to Thurs and 0800 – 1300 on Friday. ICU handovers therefore take place twice a day.

Multidisciplinary Meetings

The ICU MDT takes place either on a Wednesday or a Thursday in the ICU seminar room. It is attended by the ICU doctors, the nurse in charge, dietician, physiotherapy and the pharmacists. It may also be attended by the parent team involved in the patient's care. Please document the MDT

discussion on the MDT sheets (that can be printed of PAS) and complete the attendance register in the folder.

Echo-cardiography / Ultrasound

We have two hi resolution ultrasound machines on ICU that can be used for vascular access, lung / abdominal ultrasound and echocardiography. If a trainee is interested in gaining competencies for the FICE accreditation, please contact Dr. Zak Belagodu at the earliest. Dr. Ail and Dr. Abdo also have a special interest in lung and heart ultrasound.

Critical Incidents

If the trainees are involved or witness any harmful or potentially harmful practice or near misses on ICU then they are strongly encouraged to report it via the DATIX critical incident reporting system that is available on the Trust intranet system ADAGIO. Then please drop a line via email to Dr. Parmar (lead for clinical governance) with the DATIX number. This will enable the trainee to receive written feedback on the outcome of this form. We would also encourage you to present and clinical case reports with learning points at the Monthly Clinical Governance meetings and / or the Thursday Teaching sessions.

The ICU at Darent Valley is remarkably busy for a DGH its size. It has its challenges, but we are striving hard to improve the care that we provide to our patients. We like to think that we are an open, progressive department that cares for both our patients and our staff. If you have any clinical or non-clinical issues relating to any aspect of the management of the ICU, please feel free to contact Dr. Protopapas at any time. For any training issues please contact Dr. Sange.

COVID 19 Section

The ICU at Darent Valley was exceptionally busy in the first COVID 19 surge where at one point we were looking after 28 intubated patients in ICU, theatres and recovery. There were many more on the respiratory wards on CPAP / NIV. All trainees and consultants were on a shift system and all elective work was stopped. QMH Sidcup was closed and all the staff joined teams at DVH. There was a lot of staff (nurses and doctors) redeployed to help on the ICU. A MERIT intubation team was in place. The response from the trainees was exceptional. They worked extremely hard without any complaints and saved a lot of lives. The camaraderie on display was simply brilliant. I am sure that all the members of this department will remember their contribution for a very long time. Slowly, over time the numbers have decreased although we still have to have two sections to the ICU – a COVID area and a Non-COVID area. Elective work is slowly gathering pace.

The non COVID area in the main ICU and the COVID area is Theatre one and two. If the numbers increase again there is a planned escalation strategy to deal with this. The redeployed staff has gone back to their original jobs and the consultants and trainees have gone back to their original rotas. But since there is an extra ICU area in theatres, there is extra staffing in the form of an Outreach consultant during the day time, 7 days a week and an extra ICU floater trainee / SAS doctor (that is paid extracontractual rates) for normal days (0800-1700) and nights (2000- 0900). This will be in place for the foreseeable future depending on the patient load.

Working in these circumstances (especially long hours in PPE) is stressful. It’s very important to work as a team and look after each other. Ensuring adequate breaks is essential. Effective communication between team members goes a long way to prevent critical incidents and to keep

patients and staff safe. We will get through this as a team.

We wish you all the best for your time here and hope you enjoy working in the ICU at Darent Valley Hospital!

Dr M Protopapas
Lead for ICM

Dr. Mansoor Sange
RCoA / FICM Tutor

On behalf of the ICU Consultants
August 2020

The Ideal Anaesthetic Induction Project

By Dr. Megan Thomas, Dr. James Jackson, Dr. Shamini Sivakumaran, Dr. Rajin Maahi

ICU Bleep 230 0800-2100 (Night 2000 – 0900)

- ICU covered by consultant and 2 anaesthetists +/- FY2 doctor in the daytime.
- The second doctor on the unit has to carry the 699 bleep. This can be returned to the ICU desk drawer at the end of your shift.
- Theatre changing room code 5689.
- Storeroom code 1357
- Handover in ICU seminar room, night doctor to print 5 handover sheets.
- Ward round as per consultant preference usually around 10 am. Dr. Sange usually starts WR at 8am sharp.
- Review all investigations for patients (bloods, radiology, micro) daily. DartPortal is useful for this.
- Admission proforma and daily notes printed from Patient Centre via clinical documents.
- Discharge forms to be typed and saved on Patient Centre and to be updated on discharge. To be done in the daytime so that its easy to discharge patients at night in case the anaesthetist gats busy.
- Ward drug card will also have to be updated / re-written.

- Bleep holder to attend MET calls (selected)/ trauma calls/ cardiac arrests/ Maternal collapse or emergency.
- Review ward patients as requested.
- Attend micro ward round and document.
- Document evening ward round in notes.
- Night doctor encouraged to attend medical handover on AMU at 2100 (not mandatory) or liaise with outreach nurse (bleep 476) RE sick patients on ward.
- Offer support to SHO covering theatre.
- Review patients and document in notes in appropriate section.

- Avoid metaraminol infusions, insert CVC line and use noradrenaline.
- Edward Lifesciences Flotrac (invasive and non-invasive) monitors for cardiac output are available.
- Discuss all admissions with consultant.
- The first port of call for Airway assessment for transfer to Medway for airway pathologies is bleep 242. If it's a relatively junior anaesthetist, then you may have to help – **refer to Anaesthetic Consultant – not ICU**
- Utilise guidelines on ADAGIO system.
- Encourage theatre colleagues to admit patient if planned ITU admission.
- Transfer difficult airway cases to theatre from resus if concerned regarding intubation.
- Please ensure you contact the lab if sending a CSF sample or a vasculitis screen. If you can please hand the specimen over to the lab personally as this avoids processing delays for these types of samples.
- Room to rest on chestnut ward (if locked the key is in the "green keys" with ICU nurse in charge. Please return key as soon as you have unlocked the door) or ITU corridor (code C3469XZ)

James Jackson June 2017 Updated Aug 2020 – Dr. Sange, Dr. Dan Lake

Referrals in ICU

Most referrals in ICU can be done via bleeping the respective registrar on their bleeps, but there are some exceptions to this.

1. **Cardiology, Gastroenterology, Respiratory, Nephrology and Ageing health** needs a referral via patient centre (select the patient, then go into order entry and there is a tab for specialty referrals and the appropriate one can be selected and filled in). Once filled in, the urgent ones can be discussed with the registrar on the teams.
2. **Neurology** – referrals need to be done via an email to dvhneurology on nhs.net mail. The neurology registrar's bleep number is 101.
3. **Neurophysiology tests** – these are carried out by Kings neurophysiology team. There is a form to fill in which then needs to be scanned and then emailed to the king's neurophysiology team. They will send someone to do the testing here. If the tests are urgent, please contact the team at Kings to try and arrange a slot sooner rather than later.
4. **ENT referrals** – ENT is based at Medway Hospital and out of hours, we need to go via switchboard to Medway and speak to the ENT registrar on call. In hours 9-5 Monday to Friday there is a clinic held in outpatients and you can go down and speak to them directly.
5. **GUM referrals** – clinics are based at Gravesend Community Hospital and referrals can be done via the phone. They are usually very good about giving advice on the phone even if they cannot come and see the patients.
6. **Hepato-biliary surgery referrals** – these should be done by the home team but if in the rare case we are involved. The HPB team is based at Kings. It is useful to sign up to the inter-hospital transfer system on the Kings Hospital Website. The referral system is used for HPB and neurosurgery referrals. If you aren't already signed up, all you need is an nhs.net email address to get a password. The website is https://nww.ihtl.nhs.uk/thubreferrals .
7. **Neurosurgery referrals** – Our tertiary centre for neurosurgery is Kings. The images need to be linked to Kings. The referrals are again via the website https://nww.ihtl.nhs.uk/thubreferrals/. Once the online referral is done, you can ring and speak to a neurosurgical registrar at Kings on 020 3299 9000.
8. **Poisons Helpline** – Toxbase website has all the information needed. You can request a registration on the website or in severe cases it useful to ring and speak to someone for advice on 0344 892 0111.
9. **Severe respiratory/cardiac failure referrals** – There is an online referral form for St Thomas ECMO unit. To make a referral for ECMO/Complex Respiratory advice please use this SignPost® link: https://www.signpost.healthcare/ecmo-referral-pathway . The phone number for GSTT Intensive Care Unit is 02071882511.
10. **Lane Fox Referral** – Some of our patients need to be transferred to Lane Fox Unit to be weaned off ventilators. Referrals are done via email to gst-tr.lfureferrals@nhs.net .
11. **Coroners Referral** – online system with link on ADAGIO. See note on Medical Examiner in ICU induction pack.
12. Dermatology is based at St Thomas Hospital and can be contacted via switchboard.

Discharges on ICU

All of our paperwork is online, and we try and do the discharge paperwork in hours so that the on-call members at night-time do not have fill in paperwork when they are also in the process of admitting patients. Most of the information is filled and saved as incomplete and unverified so that it can be edited by the discharging person who needs to fill in the date and also the information about whom the patient has been handed over to.

For surgical patients, please verbally hand over in-hours to the relevant team members and out of hours to the on call FY1 or SHO.

For medical patients, out of hours please verbally hand over to the on-call team members. In hours Monday to Friday, the teams are ward based and you can ring the ward to which the patient is going to and ask to speak to junior doctor on that ward and hand over to them. It's very important that the doctor's name to whom the patient has been handed over is documented on the discharge summary.

Once the relevant information has been filled in, you can print the discharge summary and save the document as complete/verified so that it can no longer be edited and printed. This remains on PAS. So, there is both an electronic and a paper copy. If unsure which consultant they need to be discharged under, please discuss with ICM consultant

Shamini Sivakumaran -August 2019 Updated Aug 2020 – Dr. Sange

FY2 INTENSIVE CARE / ANAESTHETICS INDUCTION

Most of the information required regarding the daily activities and running of the ward can be found in the "The Ideal Anaesthetic Induction Project - The ICU Induction Pack" which should be made available to you before you start. As the FY2 you will be based in primarily on ICU. There is an option for you to spend the last month on Anaesthetics. This can be discussed with the clinical tutor.

GENERAL: The FY2 will be posted on ICU with 2 additional doctors (2 registrars' or 1 registrar + 1 core trainee). There is one hot week consultant who will cover ITU per week. Handover starts at 0800 and takes place in the seminar room which is located outside the ITU entrance. This lasts for about an hour, and all patients are thoroughly discussed. Following this, all patients will need to be reviewed by the team prior to the consultant led ward round which typically starts around 10:30 (approximately). The reviews are completed on a set proforma (pink daily review sheets; can be accessed/printed via PAS). The daily reviews are done by the FY2, the CT and the SpR. After completion of this, the consultant would join the team and preform the ward round and finalise the management plan for the day. All outstanding jobs will need to be completed following this (i.e requesting imaging, speciality referrals, discharge summaries). A second ward round takes place either late afternoon or in the evening. The FY2 will generally not be present for this.

ROTA: The anaesthetic/ICU rota can be accessed via the CLWRota app (to gain access to the app, get in touch with Dr Zaheer). The shifts for the FY2 are as follows:

Monday: 0800 – 2000
Tuesdays – Thursdays: 0800 – 1700
Fridays: 0800 – 1300
Saturdays – Sundays: 0800-1600

You will be required to do weekend shift once every 4 weeks, you will have the Friday off and work the weekend. You then continue and work the following week as usual. There are no night shifts. Please note that these shifts do not match those of the other trainees as they generally finish an hour later. **Leave:** As you are supernumerary you should be able to take your 9 days leave whenever required – let Dr Baber Zaheer know via email (Anaesthetic Consultant, rota lead) and then request leave via the CLWRota app.

LEARNING OPPORTUNITIES:

- Please discuss with your supervisor if you have any particular aims or skills you would like to gain during either part of the placement. This applies even if you are not considering a career in ICU or Anaesthetics as there will always be applicable skills to gain and the consultants/trainees are happy to help with this. If you have a particular medical or surgical specialty interest, then you can also ask to see particular patients before the ward round and look after during the day.
- You will be working close with a team who have a vast amount of knowledge on basic and advanced physiology and pathology. The trainees based on ICU have either passed their membership exams or are currently studying for it. Therefore, they are a key resource to utilise and engaging in informal discussion with them will be of extreme value. Also, weekly anaesthetic teaching takes place in the education centre every Thursday (0830 to 1300). You are required to attend these. They are consultant led therefore are very beneficial. There is a half-day departmental Audit meeting once a month, during these weeks, no Thursday teaching is held.
- Multiple opportunities to undertake practical procedures such as central lines and arterial lines, and there are also likely to be other opportunities such as ascitic and chest taps/drains. Airway opportunities are readily available in theatres but limited in ICU itself. Take opportunities to attend MET calls and A&E reviews with the bleep holder when you can as these are valuable learning opportunities – you should not be holding the bleep yourself. There is an second bleep (#137) which can be found on ITU and is option for you to carry. The bleep will notify you when a MET call is made.

Dr Rajin Maahi, Foundation Year 2 - Doctor --- April 2019