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1.0 GENERAL INTRODUCTION

1.1 Critical Care Service

Critical care is provided by a multidisciplinary team of healthcare professionals who are organized by qualified critical care physicians to:

- 1.1.1 Coordinate total care of the patient
- 1.1.2 Ensure that treatment is appropriate for all organ systems
- 1.1.3 Honor patient's preferences regarding medical treatment
- 1.1.4 Respect the patient's religions and cultural beliefs

1.2 Critical Care Physicians

Critical care physicians – or intensivists – are usually certified in a medical specialty such as surgery, internal medicine, pediatrics, or anesthesiology and also have received extra education and training in critical care. Intensivists are normally assigned to the ICU on a full-time basis and work with other critical care team members to provide ongoing and consistent care to all patients in the ICU.


1.3 Critical Care Nurses

- 1.3.1 Critical care nurses are registered nurses who have received specialized education in critical care nursing.
- 1.3.2 Critical care nurses provide high levels of skilled nursing for continuous and total patient care as members of the ICU team.

1.4 Respiratory therapists

- 1.4.1 Respiratory therapists are licensed professionals who provide technical expertise with ventilatory care and work with the critical

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care team to monitor and adjust ventilators and give other respiratory care – including aspects of chest physiotherapy – as needed.

- 1.4.2 Respiratory therapists are highly educated and skilled professionals who provide invaluable expertise to many of the ICU patients.

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1.5 Clinical Pharmacists

- 1.5.1 Clinical pharmacists are highly educated and skilled professionals who provide invaluable expertise to many of the ICU patients.

1.5.2 Clinical pharmacists have extensive training and knowledge of the effects of drugs and their interactions. They give valuable advice about choice of drugs and help minimize complications related to their use – especially with patients with multi-organ dysfunction. They also play a valuable role in cost containment, and avoidance of inappropriate therapy.

1.6 Other important members of the critical care team include nutritionists, physiotherapists, social workers and others.


2.0 SCOPE OF SERVICE IN THE ADULT ICU

2.1 The adult ICU is for all patients over the age of 12 years who may benefit from the skills provided by the ICU team and from the special resources available in the unit.

2.2 ICU patients include:

- 2.2.1 Patients who are critically ill and require intense and continuous care with sophisticated equipment to support failing organ systems.

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2.2.2 Patients who are admitted for close monitoring to help prevent or minimize the risk of serious complications.

2.23 Particularly emphasis is given to the support of patients with cardio-respiratory insufficiency or failure. Nearly all adult patients requiring ventilatory support are cared for in the ICU.

1.7 Tertiary Care

1.7.1 As one of the few tertiary care ICUs in the region, the acuity of illness is high and there are significant number of critically ill patients who are transferred from other hospitals in the Kingdom.

1.7.2 Ethical Care and Family Support


1.7.3 High ethical standards have to be maintained at all times – especially when dealing with end of life situations. Emphasis is given to appropriate and ongoing discussion with, and support for, the families of patients in the ICU.

1.8 Teaching

1.8.1 As a tertiary care unit, supervising and teaching resident staff and other paramedical groups occupies an important part of the function of the unit. This role is clearly recognized and is supported by all members of the ICU staff.

1.9 Continuous Quality Improvement

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1.9.1 Provision of care is recorded and monitored in a manner to allow careful review of the quality of care and to aid in improving the delivery of care as newer and better methods become available.

1.10 Research

1.10.1 Clinical research is part of the ongoing responsibility of the unit and is supported by all members of the ICU team.

2 MEDICAL TEAM MEMBERS

The ICU medical team is composed of specially trained physicians, nurses and other paramedical staff, including respiratory technicians, physical therapists, nutritionists and clinical pharmacists. They work as a coordinated team to provide ongoing care on a continuous basis using any or all of the resources available in the hospital, as required, to provide the highest quality of care possible.

They are involved in ongoing self-education as well as the education of residents and other health care workers who rotate through the ICU.


Clinical research is an integral part of their work in the unit.

2.1 Chairman of the ICU

The Chairman of the ICU has overall responsibility for the quality of care provided in the ICU. He is supported by a team of Consultants, Associate Consultants and Assistants and by other medical staff, who, working as a team, provide continuous and closely coordinated medical coverage in the ICU.

The Chairman supervises, reviews and evaluates the quality of care given by means of regular patients' rounds and quality assurance reviews.

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He is also the administrative head of the ICU and works closely with the hospital administration to ensure a sound organization structure and efficient use of resources.

He is involved in reviewing and updating equipment to ensure that a high quality of care can be provided at all times.

He is also responsible for the medical education within the unit and for research.

2.2 Deputy Chairman of the ICU

The Deputy Chairman of the ICU assists the Chairman in all the abovementioned responsibilities and he replaces him in his absence.

2.3 Privileges

The Credentialing and Promotions Committee must grant privileges to any physician wishing to perform any particular procedures in the ICU.


Nursing staff and other personnel involved in these procedures must adhere rigidly to their respective department procedures and protocols.

2.4 ICU Medical Staff Responsibilities

All patients are admitted to the ICU under the care of on-call ICU consultant. The ICU staff indicates that they have accepted responsibility of the patient while in the unit by the written admitting note.

Upon completion of on-call service, the outgoing team will transfer the care of all patients in the unit to the incoming staff team. Hand-over should include a brief review of the patient's condition and progress that has been made. The incoming staff will then accept the responsibility.

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The ICU most responsible physician will be the ICU consultant who was on-call at the time of the patient's admission. However, on completion of his/her on-call duties, the next ICU consultant coming on-call will assume these responsibilities.

3.0 DOCUMENTATION

3.1 Admission

An appropriate history and physical examination will be completed and recorded by a member of the on-call ICU team and recorded in the chart.

3.2 Ongoing care

3.2.1 Regular and contemporaneous notes will be recorded in the chart as needed to document the changes in the patient's condition.

3.2.2 Appropriate details of any procedure that has taken place and of any complications that may occur must be clearly documented in the medical notes.


3.2.3 Details and the consequence of any conference involving decisions about patient management should also be documented on the chart.

3.3 Discharge from the Unit

3.3.1 Patients will customarily be discharged from the unit when they fulfill the discharge criteria for the unit. (*See Admission and Discharge Policy*)

3.3.2 At the time of discharge the accepting team will be contacted and review the status of the patient, write orders for the transfer of the patient, and accept responsibility before the patient leaves the unit

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for the floor.

- 3.3.3 In exceptional circumstances, if the accepting team is unavailable and requests help from the ICU staff, the ICU staff may complete the discharge summary and write transfer orders for the accepting team. The MRP will then assume responsibility for the patient upon transfer from the ICU.

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3.4 ORDERS

- 3.4.1 Patients transferred from the wards for admission to the ICU will have all their orders reviewed and re-written by the admitting ICU staff in consultation with the referral service.

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- 3.4.2 Direct admissions from the Operating Room (OR) will have their orders written by the ICU staff on-call in consultation with the appropriate service.

- 3.4.3 All orders must be written on the patient's order sheet. These should include date, time, medical record number and signature. All orders must be written clearly and with a ballpoint pen.

- 3.4.4 Orders must be reviewed and revised as necessary in light of changes in the condition of the patient. The nurse in charge of the patient should be informed of the written orders, and if necessary, the orders explained.

- 3.4.5 As a general rule, the ICU physicians will write all patient care orders. Orders written by other medical and surgical services should be reviewed by the ICU physicians and countersigned by them before implementation.

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4.0 EMERGENCY ADMISSION FOLLOWING THE SUCCESSFUL RESUSCITATION OF A CARDIAC ARREST OR CARDIO-RESPIRATORY COLLAPSE OUTSIDE UNIT

- 4.1 The Intensivists on duty should see these patients as soon as possible and discuss further management with the primary team and, in the event of a cardiac arrest,
- 4.2 The code statues will b e decided with the discussion with primary team.
- 4.3 The patient should be transferred to the ICU as soon as a bed is available and the patient stable enough to be moved.
- 4.4 There should be no delay in the transfer of post arrest patients to a critical care area.


5.0 ROLE OF THE ADMITTING SERVICE

5.1 Surgical and Trauma Patients

- 5.11 The surgical admitting service is expected to be involved on a daily basis with the management of surgical-related issues and other major decisions pertaining to post-operative patient care – this includes that family discussions. It is the responsibility of the admitting service to ensure all surgical related matters are dealt with in a timely fashion.
- 5.12 The surgical Team should be responsible for the handling of surgical trauma related issues on a daily basis and, for example, in conjunction with Neurosurgery should be responsible for confirming that there is no neck injury and coordinating between other surgical specialties the timing of different surgical procedures.

6.0 Medical Patients

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The medical admitting service is expected to be involved on a regular basis with the management of medical related issues pertaining to patient care – this includes family discussions.

7.0 ROLE OF THE CONSULTING SERVICE

- 7.1 The Intensive Care Team may request specialty services to provide opinions. The consulted teams are expected to respond in a timely fashion, and give consideration to the fact that the patient is in the ICU. Daily follow-ups by these specialty teams are often necessary as dictated by clinical condition of the patient. E.g. Ophthalmology consults for corneal abrasions, neurosurgical consults for ICP care.
- 7.2 Clear and adequate documentation of the initial consultation as well as of all follow up assessments is expected.

8.0 MEDICAL CONFERENCES

- 8.1 When there is no need to coordinate and prioritize care of cases with multiple problems involving different care teams, consideration should be given to organizing multi-disciplinary conferences with all involved physicians. The results of such conferences should be documented.

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