ADMINISTRATIVE STRUCTURE AND GUIDELINES
PRINCE OF WALES HOSPITAL INTENSIVE CARE UNIT

Administration

1. The ICU has an administration and budget which falls under the Department of Anaesthesia and Intensive Care.

2. Medical, nursing and minor staff are employed and supervised by the Department of Anaesthesia and Intensive Care.

3. The ICU provides a specialist service to other departments, and as such encourages co-operation with the primary user specialties. In this regard the ICU is in the process of establishing an ICU users committee to discuss utilization of ICU resources and considerations for improvement of day to day function.

Unit Staffing - Medical

1. The Director of the unit has final responsibility for all matters relating to the function of the ICU and is appointed by the Chief of Service of the Department of Anaesthesia and Intensive Care.

2. Clinically the unit is under the direction of a nominated intensive care specialist 24h a day for periods of one week (call consultant). The consultants change over every Wednesday.

3. On a day to day basis, the unit is managed by the on-call consultant and under their supervision an additional two senior medical officers and two medical officers are responsible for the clinical management of patients within the ICU. Other duties include consultations, retrievals and resuscitation outside the ICU.

4. At night the ICU is staffed by one senior medical officer and one medical officer with the call consultant available when needed on a 24h basis. An additional doctor is available in the ICU until 21:30h.

Unit Staffing - Nursing

1. The DOM and two Ward Managers are responsible for the (nursing) administration of the unit. Nurse staffing is 1:1(nurse-to-patient ratio) during the day. At night, the ratio is 17:22 on weekdays when there are cardiac cases and 15:20 on weekends. One to three nursing officers supervise registered nurses during each 8h nursing shift. There is one Nurse Specialist who is responsible for the teaching and training of nurses.

Clinical decision making in the ICU

1. The care of the ICU patient involves multiple specialties and is usually complicated. While routine management is by the ICU team, difficult management decisions are made by consensus between doctors from the primary referring team and ICU medical staff.

2. To avoid confusion and ensure clinical responsibility there is only one route for *management actions* taken ie. *all actions* must be ordered and where reasonable carried out by ICU staff.

3. Decisions obviously in the realm of expertise of the referring team are deferred to the senior doctor responsible for the referring team after discussion eg: decisions on re-look laparotomy, specific clinical imaging etc.

4. Organ support and general ICU management eg; use of inotropes, ventilation, renal support, antibiotics etc. is usually managed by the ICU team, where desirable with consensus eg. the use of inotropes in a cardiac case.

5. Given the usual adherence to the above principles, conflict is uncommon, but when it does occur, to avoid confusion and ensure consistency of orders to junior doctors and nurses, the final responsibility for clinical decisions rests with the ICU director.

6. Please refer to the ICU Organization Chart for a schematic representation of the primary administrative and clinical responsibilities.