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E1 Registrar Posts

3-15 months ICU
No more than 4 years in one hospital
At least one consultant per trainee
Access to library, journals, texts, computers

TE3 Supervision of Trainees

Four levels of supervision

- 1 One consultant to one trainee
- 2 One to two
- 3 Consultant available within the hospital
- 4 Consultant exclusively rostered and available from home

General requirements

- Level 1 and 2 for $\geq 25\%$ of work in first four years
- Level 4 for $\leq 30\%$ of work in first four years
- Out of hours work 25-50% of work in first four years
- Supervisor must attend if asked to
- Level 1 supervision in an unfamiliar area

First year

- Level 1 supervision for at least 3 months
- Level 1 or 2 for most in-hours cases
- Supervisor notified of all out-of-hours cases, 25% to be level 1 or 2

Second year

- Level 1 or 2 for about half of in-hours cases
- Level 1 or 2 for at least 20% of out-of-hours cases

Third year

- Level 3 for many in-hours cases
- Level 1 for cardiac, obstetric, major paediatric work

Fourth year

- Level 3 for previously encountered work

PFY

- Consultation and supervision available at all times

E6 The Duties of an Anaesthetist

Clinical

- Providing anaesthesia and other consultative services
- Preoperative assessment and postoperative care
- Supervising trainees and other staff
- Supervising recovery
- Supervising day surgery anaesthesia areas
- Maintaining an acute pain service
- Associating with a pain management service
- Acute resuscitation for emergencies
- Management of ICU patients
- Consultative service in preoperative assessment and management
- Supervising cardiopulmonary bypass

Other

- Administrative duties in the Department and Hospital
- Educational activities for doctors, trainees, nurses, students, the public
- Peer review and quality improvement activities
- Continuing medical education
- Professional associations
- Research and reviews

Contributing to hospital or health committees
Activities to safeguard the wellbeing of colleagues

TE9 Quality Assurance

“An organized process that assesses and evaluates health services to improve practice or quality of care.”

Process

- Planning, implementation, review cycle
- Setting standards

Activities

- Assess Department structure and performance relative to other Departments or ANZCA policies
 - With regard to staff, physical facilities, management and education
- Criteria-based audit
 - Clinical indicators, periop mortality or morbidity, ICU stats, utilization
- Formulation of guidelines or protocols
- Critical incident review
- Risk management
- Peer reviews
- Patient surveys

T1 Minimum Facilities for Safe Anaesthetic Practice in Operating Suites

T2, T5, PS33 (Radiology, Dental, ECT) similar

T6 (Delivery Suite) similar with addition of paediatrician, specifications for delivery room

Principles

- Anaesthesia should be administered by appropriately trained doctors
- Every patient should have a preanaesthetic consultation with a doctor trained in anaesthesia
- Appropriate monitoring must occur during anaesthesia

Staffing

- In addition to surgical staff
- An assistant to the anaesthetist
- Assistance for positioning
- Technical assistance

Anaesthetic equipment

- Anaesthetic machine: O₂, N₂O, volatiles, breathing circuits (adult, paediatric), air if necessary
- Safety devices: indexed gas supply, O₂ reserve, O₂ failure warning, pressure relief valve, O₂ analyzer, antihypoxic device, non-slip CGO
- Separate ventilating device
- Suction, scavenging
- Monitoring, IV, airway, regional equipment
- Difficult intubation equipment, rapid infusion device, warming, chest drain, defib.

Other equipment

- Appropriate lighting, emergency lighting, telephone or intercom, refrigerator, airconditioning, trolleys

Drugs

- Usual anaesthetic drugs
- Drugs required to manage complications

Cleaning and servicing procedures

Recovery area

PS3 Major Regional Anaesthesia

Principles

- Administered only by appropriately trained doctors
- The anaesthetist must not also be the operator
- Informed consent required
- Monitoring requirements as for any anaesthetic
- Anaesthetist must be present until the block is stable or procedure complete

Epidural catheters

- IV access required
- Catheter clearly labelled "Epidural"
- Management as prescribed by anaesthetist
- Protocols for management of complications
- Protocol for monitoring for complications
 - Observations must be charted
- Catheter removal and condition must be documented
- Management may be delegated to a nurse or APS
 - With specific training and experience

P4 Recovery

Principles

- Specific area, close to theatre, trained staff able to contact anaesthetist

Design

- Part of the operating suite, accessible in street clothes
- 9 m² per bed with access to patient's head
- 1.5 spaces per theatre
- Each bay
 - O₂, suction, SpO₂, sphygmomanometer, stethoscope, thermometer, power, lighting, emergency lighting, space for monitors
- Nurses station, drugs, linen, utility room, scrub area, x-ray box
- Clock with second hand
- Telephone and emergency alarm, emergency power

Equipment

Present

- Ventilating device per two spaces, intubation drugs and equipment, resuscitation drugs, IV equipment, analgesics, syringes and needles, ECG per three spaces

Available

- 12-lead ECG, invasive pressure monitor, gas analyzer, defibrillator, nerve stimulator, bronchoscope
- Warming cupboard, refrigerator, procedure light, surgical tray, blood gases, x-ray

Trolleys

- Firm base and mattress, tilt 15° up and down, manoeuvrable, brakes, able to sit patient up, removable side rails, IV pole, mountings for monitors and transport equipment

Staff

- Trained recovery staff present at all times
- Flexible ratio: up to 1 to 3, but 1 to 1 for unconscious patients

Management

- Written protocols for management
- Routine for checking equipment and drugs
- Appropriate recording of consciousness, SpO₂, RR, HR, BP, temp.
- Established criteria for discharge
- Anaesthetist responsibilities
 - Accompany patient until handed over, provide written and verbal

orders, specify O₂ therapy, remain nearby until patient is safe to be left, supervise recovery and authorize discharge or delegate the discharge decision

P6 Minimum Requirements for the Anaesthesia Record

Basic information

- Name, hospital, UR, age, gender, weight
- Date of preop consult and operation
- Anaesthetist's name (also supervisor's name and level of supervision)
- Surgeon's name and procedure planned and performed

Prior to anaesthesia

- Preop assessment and ASA status
- General medical history, drug therapy, allergies
- Previous anaesthesia and surgery
- Airway, dental and reflux assessment
- Investigations
- Premed
- Documentation of anaesthetic plan discussed

Anaesthesia

- Drugs used, including by the surgeon
- Anaesthetic technique and any problems
- Time of events, observations and interventions
- Airway instrumentation and problems
- Details of vascular access and fluids given
- Blood loss
- Position
- Monitoring
- Other interventions

Post anaesthesia

- Observations and events as required in recovery standards
- Plan for pain management, fluid therapy, O₂ therapy
- Clinical indicators and QA markers
- Post-anaesthetic visit

PS7 The Pre-Anaesthesia Consultation

Principles

- Performed by the anaesthetist administering the anaesthetic even if already performed by someone else or questionnaire
- Appropriate time before surgery and in privacy
- Not to be modified except for the welfare of the patient (emergencies)

Including

- Identification and introduction
- Concise medical history and examination, investigations indicated
- Consultation if required
- General discussion of anaesthetic management significant to the patient
- Informed consent
- Ordering premedication
- Written summary

PS8 Assistant for the Anaesthetist

Principles

- A trained assistant is essential
- Present for preparation and induction until no longer required

- Available at short notice during maintenance
- Present for conclusion of anaesthesia
- Required for anaesthesia or sedation
- Equipment as required by other policies
- Deployment
 - Number and status of assistants determined by nature and workload of anaesthesia
 - Assistant is exclusively responsible to the anaesthetist while assisting
 - The assistant is essential: staffing and rostering must allow for one
- Education
 - Must have attended a suitable training course
 - EN or RN in clinical work or VCE required
 - Content
 - Lecture course of at least 150 hours with significant anaesthetic input
 - Practical instruction by anaesthetists with a log book kept
 - Completion of assignments, internal assessment and examinations
 - Duration
 - Three years full-time if no previous hospital experience
 - Two years full-time for EN or equivalent
 - One year full-time for RN
 - May be part-time
 - Regular continuing education

P9 Sedation for Minor Procedures

- Equipment and care must conform to requirements for anaesthesia in other policies
- Consultation, record, monitoring, recovery
- Principles
 - Preanaesthetic assessment required
 - Serious medical condition or possible airway compromise mandates constant presence of the anaesthetist
 - Practitioner administering sedation must understand drugs, potential complications and effect of patient illness on drug action
 - Single operator sedation is permissible only if rational verbal communication is maintained with the patient, otherwise an anaesthetist must be present
- Facilities
 - Tiltable table, space and drugs for resuscitation, suction, lighting, oxygen, ventilation equipment, pulse oximeter, defibrillator

PS10 Handover of responsibility

- Transfer
 - Satisfied of competence of relieving anaesthetist
 - Reliever willing to take over responsibility
 - Patient details: past history, present condition
 - Anaesthetic details: drugs, lines, airway, fluids, events, likely problems
 - Plan for further management if permanent handover
 - Compliant anaesthetic record
 - Check anaesthetic machine, lines and monitoring
 - Notification to surgeon (and supervising anaesthetist if a trainee)
- Relief
 - Patient stable and likely to remain so
 - Facts relevant to safe management explained to reliever
 - Reliever not to substantially change management unless an emergency
 - Anaesthetist available to return at short notice

P11 Cardiopulmonary bypass

Principles

A medical practitioner must take responsibility for CPB

Must be trained in CPB techniques

Should be assisted by a clinical perfusionist or technician

Should assess the patient pre-op and follow post-op

Must communicate with practitioners with overlapping responsibility

PS12 Smoking

Smoking is addictive and can damage the health of smokers and those around them

Benefits of ceasing

↓ COHb $t_{1/2}$ 4 h, so 12 h cessation significantly improves O₂ carriage

Polycythaemia and ↑ viscosity reverse in days

Nicotine ↑ HR, BP, peripheral vasoconstriction, improved within 12-24 h

↑ mucus, ↓ ciliary clearance improve over 6 weeks

Small airway function improves over 1-6 months

Chest infection rate reduced at 2 months, normal at 6 months

Immune response normalizes over 6 months

Increased analgesic requirements normalize over 6-8 weeks

Complication rate higher in plastic and reconstructive surgery

Impaired microcirculation

P13 Autologous blood

Standard label with unique identifier on unit

Signature and name of person collecting blood

Label with patient name, UR, date and time of collection attached

If stored for more than 6 hours, must be stored as for homologous blood

Checking prior to infusion as for homologous blood

PS14 Regional in obstetrics

Epidural or spinal to be performed by practitioner experienced in the techniques

Mother must be under care of an obstetrician

Anaesthetist

Ensures the mother is informed of risks

Is available to supervise management of the blockade

Is competent to deal with complications of block

Provides full instructions for management

Techniques must be recorded in mother's notes

A trained assistant is required for performing a block

Further epidural doses may be given by nurses or other doctors

When prescribed by the anaesthetist with appropriate written instructions

When competent to give the bolus and to monitor the mother and fetus

When skilled staff are available to manage complications

Care during infusion

Monitoring for mother and fetus, assessment of block and adverse effects, management of the labour

Handover as for any anaesthetic

IV cannula must be present throughout

PCEA must be explained to mother and nursing staff

Removal of catheter must be documented

P15 Periop care of day cases

Suitability for day surgery

Surgery

- Minimal risk of postop haemorrhage, airway compromise
- Pain controllable with outpatient techniques
- No special nursing requirements
- Rapid return to normal oral intake

Patients

- Willingness and understanding to follow postop instructions
- ASA I or II, or stable III and IV with anaesthetic consultation
- Term infants over 3 months or ex-prems over 60 weeks PCA

Support

- Responsible person to take the patient home and be present overnight

Decision ultimately rests with the anaesthetist

Preparation

- Preanaesthetic consultation may be assisted by questionnaire or nurse
- Prior referral in case of doubt as to suitability
- Written patient information on process as day case and fasting requirements

Recovery

- Compliant recovery room
- Reclining seating area for after recovery
- Nursing supervision, oxygen, suction, resuscitation equipment

Discharge

- Wheelchair, car and ambulance access

Criteria

- Obs stable for 1 h, orientated, adequate analgesia, able to dress and walk, no nausea or vomiting or dizziness, tolerating oral fluids, minimal bleeding, has voided
- Responsible adult for transport, discharge authorized by surgeon and anaesthetist, written instructions and emergency contact information, 24 hours of analgesic drugs
- Telephone follow up next day

PS17 Endoscopy of the airways

Principles

- Procedure supervised by an experienced practitioner
- Preoperative assessment may indicate the need for a second practitioner
- Informed consent should be obtained
- Equipment must be checked
- Local, sedation or GA may be required
 - Sedation or GA require a second practitioner
- Pulse oximetry and other compliant monitoring
- Reliable venous access
- Supplemental O₂ before, during and after bronchoscopy
- Compliant recovery
- Record of administration of sedation

Facilities

- Tiltable table
- Space and drugs for resuscitation
- Suction, lighting, oxygen, ventilation equipment, pulse oximeter, sphygmomanometer, ECG and defibrillator
- Reversal agents for benzos and opiates

Discharge as for day surgery

P18 Monitoring during anaesthesia

Personnel

- Appropriately trained doctor present from induction to recovery room
- Responsibility only for anaesthesia

Patient monitoring

- Pulse and BP at frequent and clinically appropriate intervals
- Ventilation monitored continuously, directly and indirectly
- Oximetry interpreted with clinical observation
- Adequate lighting to assess colour

Equipment

- Must be in use
 - O₂ failure, O₂ analyzer, pulse oximeter
 - Disconnect alarm if mechanically ventilated
- Must be available
 - ECG, temperature, capnograph, nerve stimulator, agent analysis

P19 Monitored Care

For procedures under local anaesthesia or sedation or in situations such as IV contrast in possibly sensitive patients.

Preanaesthetic consultation, monitoring, sedation, recovery, anaesthetic record, facilities as specified in other policies.

P20 Postoperative responsibilities

Shared responsibility with surgeon for

- Monitoring, analgesia, fluids, respiratory therapy

Responsibilities in recovery

- Handover when stable
- Availability for management of problems, or covered by another anaesthetist
- Safe criteria for discharge to ward
- On-going adequate care after recovery

Suitability for day surgery if discharged home

Quality assurance

- Recognition, management and documentation of adverse events
- On-going audit of anaesthesia care
- Inform patient of any matters relevant to future anaesthetics

P21 Sedation for Dental Procedures

As in [P9](#) plus

Dental practitioners administering sedation must be appropriately trained

- Dosage and administration of drugs
- Management of complications: resuscitation, CPR

Equipment

- Chair able to be laid flat, space for resuscitation, lighting
- Monitoring: BP, SpO₂ for IV sedation
- Resuscitation: suction, oxygen, means of ventilation, drugs

N₂O, O₂ sedation

- Minimum flow of 2.5 l/min O₂, minimum 30% O₂
- Maximum flow 7-10 l/min N₂O
- Flow meters, O₂ failure device, non-return valve, at least 2 cm diameter tubing, nose-piece incorporating air dilution valve, O₂ flush, scavenging to maintain N₂O below 25-50 ppm
- Installation and regular servicing by qualified personnel

IV sedation

SpO₂ required, IV access which will remain patent throughout, reversal drugs
Recovery
Adequately equipped and staffed, plan for transfer to medical care if needed

P22 Patients' Rights and Responsibilities

Rights

- To be treated with skill, consideration and dignity regardless of age, gender, race, religion, disabilities, health and legal status
- To know the identity and status of attending staff and refuse the presence of others during treatment
- To be informed of proposed care and alternatives, side-effects and risks
- To refuse proposed treatment without prejudice to alternative strategies provided the implications are understood by all involved
- To be provided anaesthesia by an anaesthetist after written consent
- To request a second opinion without prejudice
- To know of any involvement in teaching or research and to understand that non-involvement will not prejudice treatment
- To know that all aspects of care will remain confidential
- To know the broad financial implications of therapy
- To the presence and support of next of kin, partner or friend when practicable
- To expect decisions to be made on their behalf after discussion with next of kin should they be unable to communicate
- To be informed of any matters which may affect anaesthesia in the future

Responsibilities

- To inform staff of all relevant medical history including the possibility of infectious disease
- To comply with agreed treatment or inform staff of their intention not to comply
- To consider participation in teaching and research which may improve the care of others in the future
- To consider their ability to meet their financial obligations in relation to care

P23 Transport of the Critically Ill

Administration

- 24-hour coordinated transport by road and aircraft
- Delay minimized by central coordination and communication
- Transfer should not be delayed by waiting to identify a receiving unit
- Reliable communication between sending and receiving hospitals and transfer team
- Clear determination of responsibility and hand-over
- Documentation of condition before and during transport, therapy and history
- On-going quality assurance activities

Classification

- Prehospital, interhospital, intrahospital

Staffing

- Team of staff familiar with transport
 - Ambulance officers
 - Nursing and medical staff
 - Special expertise for neonatal and paediatric transport

Vehicle

- Choice determined by urgency, location, availability, nature of illness

Requirements

- Safety, space, power and gas supply, access, lighting, air-conditioning, restraints, noise and vibration, speed, communication system,

- pressurization
- Equipment
 - Determined by patient condition and expected duration
 - Attention to battery life and restraint in vehicle
- Respiratory equipment
 - Airways, masks, nebulizer, self-inflating bag, suction, ventilator with alarms, sets for intubation, cricothyroidotomy and chest drain
- Circulatory equipment
 - Monitor-defibrillator, oximeter, sphygmomanometer, IV equipment, arterial transducer, pacemaker, MAST
- Other
 - NGT, IDC, dressings, sutures, instruments, splints, blankets, temperature monitor
- Drugs
 - As required to manage resuscitation and likely emergencies as well as sedatives and relaxants
- Ensure all lines and ETT are well-secured prior to transport
- Monitoring
 - Similar to intraoperative requirements

PS26 Providing Information about Anaesthesia

- Principles
 - Information is to be provided in such a way that the patient and relatives are able to understand
 - Where options exist, they should be outlined together with advantages and disadvantages
 - The patient should be made aware of the financial implications of the service
- Presentation
 - Basic information should be provided, even if the patient requests no information. If information is refused it should not be forced on the patient, but the refusal recorded in the notes.
 - Questions should be encouraged and answered
 - An interpreter should be used when necessary
 - Where blood products may be required, their advantages, risks and alternatives should be discussed
- Risks
 - Known risks should be disclosed for common, mild adverse effects and rare but serious ones.
 - Uncertainty in risk and difficulty in applying population risks to an individual should be explained
- Emergencies
 - No discussion of risks may be possible. Attempts should be made to provide information to the family as soon as possible.
- Incompetent patients
 - An explanation appropriate to the patient's understanding should be given.
 - Appropriate consent should be sought from a guardian or next-of-kin.

P28 Infection Control

- Cleaning and disinfection as per AS 4187-1994
- Handwashing
 - Before handling a new patient or equipment for a new patient
 - After leaving a patient
 - Whenever contaminated
 - Gloves to be worn whenever hands may contact blood, saliva or any bodily

- fluid
- Invasive procedures
 - IV
 - Wash hands, wear gloves, disinfect skin, ensure tip and cannula remain sterile
 - CVC
 - Full aseptic technique (mask, gown and gloves), skin preparation, sterile drapes
 - Regional anaesthesia
 - Peripheral blocks: as for IV
 - Axial block or catheter insertion: as for CVC
- Anaesthetic apparatus
 - Disposable items should not be reused
 - ETTs and airways to remain sterile until inserted
 - Face masks and upper airway instruments (laryngoscopes) to be disinfected
 - Circuit to be disinfected or protected with a filter
 - Sampling lines can be reused but returned gas must pass through a viral filter
 - CO₂ absorber and valves to be disinfected regularly and protected with a filter
 - Ventilator to be disinfected regularly
 - Fibreoptics to be cleaned as per AS
- Drugs for injection
 - Multi-dose ampoules only used where all doses drawn up before first is given
 - Single-dose ampoules should be used for only one patient
- For immune-suppressed patients, more stringent practices may be required

PS29 Paediatric Anaesthesia in the Non-specialist Hospital

Non-paediatric centres treating children should have a policy on management of children

Factors

Age (and prematurity), medical and nursing staff experience and familiarity

Equipment

Airway, IV, monitoring, temperature maintenance equipment suitable for children

A separate ward area

Policy

Criteria for transfer to a specialist centre

e.g. neonates, PCA <52 weeks, history of apnoea, ASA 3 or worse

PS37 Regional and Allied Health Practitioners

Practitioners such as dentists, podiatrists and nurses may administer local anaesthetic

Requirements

Training in the use of LA, pharmacology, complications and their management

Certified competence in CPR

Patients should not be denied a GA when indicated

Arrangements for transfer of care if required

PS38 End of Life Decisions

ANZCA's mission statement is *"To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine"*.

ANZCA supports

- Provision of adequate pain relief in terminal illness, even though it may shorten the patient's life, where the intention is relief of pain and not the death of the patient
- Relief of pain in non-terminal illness to restore quality of life and minimize the risk of suicide
- The right of competent patients to refuse treatment, even though it may be life-saving
- The right of Fellows and patients to their individual beliefs
- ANZCA does not support
 - The application of therapies which offer no benefit to the patient
 - The application of therapies in which the primary intent is the death of the patient

PS39 Intrahospital Transport of Critically Ill

Principles

- Hospital must have a protocol for transport
- Benefits of interventions requiring transport must outweigh risks of transport

Equipment

- Dedicated durable trolley capable of fitting in lifts and through doorways
- Suitable for the intervention area (e.g. MRI), gas, suction and electricity available at destination
- No equipment placed on the patient
- Basic monitoring: ECG, HR, BP, SpO₂
- Desirable monitoring: ET/CO₂, MV,
- Basic equipment: defibrillator, suction, self-inflating bag if on ventilator, spare batteries, airway equipment
- Basic drugs: analgesics, sedatives, relaxants, resuscitation drugs

Policy

- Checking of transport equipment
- QA process for evaluation of transport

Staff

- Designated nurse, orderly and doctor familiar with equipment and emergency management

Departure check

- Notify destination
- Check monitors and alarm limits, ventilator and alarms, self-inflating bag, suction, gas cylinders and spare cylinder, batteries and spare battery, emergency equipment and drugs, patient films and notes
- Check patient: paralyze and sedate if indicated, replace near-empty infusions, check airway, ventilation, alarms, drains, lines, monitors, security on trolley, haemodynamic stability

In transit

- Best route planned, lifts held in advance, communication facilities in transit
- Vigilance in monitoring, documentation of interventions

Arrival

- Check fixed gas, suction, electrical and monitoring equipment
- Transfer to fixed equipment and recheck patient
- Formal handover of care if required

IC1 Minimum Standards for Intensive Care Units

Level 1

- Provides immediate resuscitation, short-term cardiorespiratory support, and monitor and prevent complications in "at risk" patients
- Suitable for uncomplicated myocardial ischaemia, post-surgical, unstable

medical and short-term ventilated patients

Should have

Access to emergency, theatre, imaging, laboratory and physiotherapy services

Policies for admission, discharge and referral

Supervision by a suitably qualified doctor, consultant support always available and 24-hour resident cover

1:1 nurse:patient ratio for critically ill patients

Programs for education, orientation and audit

Technical and clerical support with adequate office space

Level 2

In addition

Ventilatory support, invasive monitoring and dialysis support

Designated medical director who is an intensivist

Medical staff present at all times

Nursing staff to have ICU certification

Access to a nurse educator

Isolation

Formal audit

Level 3

In addition

The widest level of care: all aspects of intensive care medicine

Greater than 1:1 nurse:patient ratio for complex patients

Formal nursing education program and nurse educator

Medical education programs

Research program

Physical facilities

20 m² per bed

One washbasin per two beds

One single room per seven beds with own washbasin

Adequate service outlets

Level 3: 3 O₂, 2 air, 3 suction, 16 power per bed, compliant with standards

Lighting, air-conditioning, windows, privacy