Anaesthetics/ICU Handover Document

What is this job?

Anaesthetics/ICU is a pretty good rotation to have at any point in your training. You are ultimately supernumerary and therefore **this is the best time to develop your portfolios** or go on a nice, long holiday. The whole team, from consultants to senior trainees and even allied health professionals, are very supportive. You will not feel unsupervised, and you won't be left to manage patients on your own.

Your rotation will consist of ward days in ICU, days in theatres, and long days. Usually, you'll rotate between theatres and ICU each week, with long days interspersed every 1 in 4/5 weekends. There are **no twilight or night shifts in this job!** There is no stable number of patients in ICU; some weeks you'll be very busy and some weeks there won't be much to do after lunch. In the last rotation, December 2022 to April 2023 it ranges between 3-14 patients at any given time.

Shift times

ICU normal days – 8:30am till 4:30pm

Theatres – 8:00am till 4:00pm

Long day & Weekends – 9:00 till 9:30pm. Usually long days will be on ICU; therefore, you need to report for handover at 8:30am and will remain in ICU till 9:30pm. If your long day's in theatres, then you will be in theatres from 8:00am till 4:00pm and then report to ICU for 5:00pm till 9:30pm.

What should you bring?

A pen.

Each patient has a stethoscope by their bed so you will be required to use that and not take yours around (infection control). Aside from a pen, there's nothing you are expected/need to bring.

Regarding scrubs, they can be found in the staff room (It says Senior nurse on the sign and is used by the pharmacists) closest to the ward doors and opposite the male changing room. However, the ward never seems to have the middle or smaller sizes stocked. Your best bet is to grab blue scrubs from the linen room (lower ground floor, opposite Dixon ward). Remember to grab extra pairs if you're working the weekend as the linen room is not open then.

Bring a lock if you want to store valuables in the changing rooms as the key card locks are currently not working.

Daily Schedule

You are expected to arrive for your shift, starting at 8:30 am with the morning handover. The male's changing room is closest to the ward doors and opposite the Senior nurse's room. The female's changing room is one door down from the Outreach teams' room, closer to the ward exit doors. Get changed into scrubs before the start of your shift and head into the coffee room. The handover will take place promptly at 8:30 am (sometimes a bit earlier depending on the consultant and if all the relevant staff are already present, **Consultants are strict on arriving by 8:30am so be there**). Handover usually goes for forty-five minutes or so, depending on patient load. Take note of jobs mentioned for

ALL patients. As the most junior doctors on the team, we usually get first dibs on the patients we'd like to see. Most of the time, patients picked are patients that they find interesting educationally or they have seen the patients throughout the week for continuity of care. As the ward is quite well-staffed (usually two consultants, two junior doctors, a registrar, two senior trainees, and an ACP), you can see 1 or 2 patients, **at first it is best to see one patient properly and then more when you get more confident.** It depends on the staffing on the day itself. **As FY1s, you may be asked to prioritize Level 1 or Level 2 patients as these patients are more stable and most likely to be discharged from ICU to the wards**. Normally this is discussed during the morning handover. If there are many senior doctors staffed, they might split the juniors to assist instead of reviewing a patient on our own.

If you walk into the coffee room for handover and no one is there by 8:30 am, wander on to the ward as there might be a new admission requiring assistance from the whole team.

After handover, you'll disperse onto the ward and start seeing your patient/s. As you walk onto the ward, you'll notice the trolleys on the left and the ward desk station after that. The ward round sheets are green and can be found at the closer end of the ward desk station top (the area above the paper shredder).

The ward round sheets are green and can be found at the closer end of the ward desk station top (the area above the paper shredder). The ward round sheet requires you to list the presenting complaint of the patient, the main problems, a respiratory examination (including ABG results), a cardiovascular and gastrointestinal examination, a renal and neurological examination (include U&Es and fluid balance), and a management plan. **ALL** examination components must be done for each patient, not just focused examinations. **Make sure to turn the lights on when examining, one consultant is extremely particularly about this. Towards the end of the daily review sheet, there are tick boxes of suggested components you should have gone through (drug chart review, sedation hold review etc), make sure to tick them once you've completed as some consultants are quite specific on this. Always sign your name or stamp.**

You will have a fair amount of time to review your patient before the ward round begins; between 1-2 hours depending on the Consultant and if no new patients are being admitted. It is always a good idea to ask the nurse looking after the patient today to see if they have been handed over anything and if they have any concerns regarding the patient. Ward rounds usually start at 12pm or later, sometimes even at 3pm. If you've reviewed your patient and there's nothing else to do before ward round, you can grab yourself a quick coffee but make sure it is announced. There will be days where you are unable to grab canteen lunch due to the ward round timings so be prepared for this.

In the beginning, you are not expected to come up with a management plan independently so focus on the examination of the patient and documenting this and review the previous day and night management plan to help understand what is going on with the patient.

As time passes, you will learn what are the usual management plans here are a few examples of common plans:

- **OOHCA** (out-of-hospital cardiac arrest): cooling and sedation for 48 hours from admission.
- **Sedation hold**s – The need for a sedation hold should be reviewed daily to assess their appropriateness upon waking. If sedation is held and the patient is not awake for days, plan for an EEG.
- **Blood Pressure** – Any vasopressor support? MAP? Trends? Fluids?

- **Ventilation management**: Intubated and sedated > ETT/trachy on bilevel > ETT/trachy on spontaneous >Trachy on TC100 (2 hrs to 4 hrs to 6 hrs until 24 hours)>Trachy mask (2 hrs to 48 hrs or more) > take out trachy.
- **Oxygenation plan** – Consider how much Oxygen is being delivered, in what way, and what the targets are. Normally PaO2 >8kPa is the target. Assess PaO2 on the patient's most recent ABG and compare this to the percentage of inspired Oxygen it is normally roughly 10 less than the percentage of inspired Oxygen e.g a person with an Fi02 of 0.4 will have an inspired oxygen percentage of 40% an PaO2 of around 30.
- If you are struggling to come out with a management plan, always think from A to E.

- Most patients are sedated. Thus, daily sedation holds need to be done to assess their appropriateness upon awakening. If they are not appropriate, they will be sedated again. If sedation is held and patient is not awake for days, plan for an EEG. -Ventilation step down: Intubated and sedated > ETT/trachy on bilevel > ETT/trachy on spontaneous >Trachy on TC100 (2 hrs to 4 hrs to 6 hrs until 24 hours)>Trachy mask (2 hrs to 48 hrs or more) > take out trachy - keep MAP>65, PaO2>8kPa -If you are struggling to come out with a management plan, always think from A to E. eg: airway: to be extubated or not Breathing: what is the next step to patient's ventilation Circulation: to reduce the vasopressor or inotrope support, fluids etc.

You will be expected to present the patient you have seen to the rest of the ward round. This can be stressful, but it gets better with time. **If you are unsure about an aspect of patient care, don't hesitate to ask, even if it's mid-presentation.** This is also a great opportunity to sign off SLEs.

For the ward round (usually happens at 12 pm or later), make sure to take the red, hardcover, doctors' jobs book. Note down the jobs required for each patient and the times they were seen (the ward clerk may ask you for this). **Any urgent jobs will need to be done right after the ward round**, with the rest okay to be completed after lunch. **The rest of your day will involve the completion of the jobs**; however, the jobs are split between all the doctors (bar the consultants) so it's quite efficient and you should be done far before your shift ends.

If the ward is quiet, ask any of the senior doctors (even the consultants) if they'd be willing to give you some teaching. Otherwise, go on the computers and get some work done. Just let the registrar or CTs know where you'll be.

Make sure to update the handover sheet frequently.

Most of the jobs are regarding ventilation, sedation or family discussion – these are done by the nurses and the seniors as we are not experienced in those areas yet. It is good to observe breaking bad news done by consultants to patients' families as they are amazing at it.

Long days:

Long days are spent on ICU, either completely or with a morning start in theatres before coming onto ICU. The workload varies as the first placement found it to be light but the second placement felt the winter pressure. If there are not much going on, make use of it to get some work done or ask for teaching. The registrars shift over at 8:30pm and will usually let you head home too if it's quiet. As for staffing wise, there can be only 2 consultants, 1 registrar (who holds the bleep and has to attend to the emergency) and 1 junior doctor. On those days, you might need to increase the number of patients to review.

<u>IT Access</u>

In ICU, the Handover and Discharge paperwork is only accessible via the 'ICURegistrars' login as this has the Handover sheet and the SBAR discharge paperwork, Personal PC logins will not have this paperwork. **The login password for this is printed on the daily handover sheet** and is located on the ward printer as well as in the top left corner of every handover sheet.

Discharging Patients form ICU

Discharging patients from ICU is slightly different as we discharge the patient to the ward and not to their home. **The discharge folder can be found on the 'ICURegistrars' desktop**, under the file name "Discharge and Transfer Paperwork". Use the template to create new discharge sheets – they are in an SBAR format. It can be quite taxing as you will have to sift through the whole patient's folder to determine everything that happened during their stay in ICU. The SBAR form is a way for your colleagues to know the severity of patient's stay in ICU and is needed for every discharge.

It is important to handover the patient before the patient is sent out to the ward to the doctor in charge of the ward that the patient is going to be discharged to – remember to note down their name at the end of the SBAR form.

The discharge paperwork pack consists of the SBAR sheet (as stated above), a ward drug chart (transcribe relevant medication from the green ICU drug chart to a (white) ward drug chart, remember to also transcribe other charts like anticoagulant and PCA charts) and the co-morbidity sheet (green sheet in the nurse's paperwork pack).

Try and get a head start on discharges when you have the time as they take a while to do (especially with long-stay patients) and they need to be ready relatively quickly if a ward bed is found for a dischargeable patient a good way of predicting is looking for the Level 1 or 2 patients, these will usually be going to the ward soon.

The overall process is something like this:

1. Review the patient during the ward round – **document the decision to discharge.**
2. Complete the SBAR discharge paperwork form (and other documents) using the "ICURegistrars" Login.
3. Name the document with patient initials and date of discharge e.g John Doe being discharged on 2/2/23 would look like "JD 2.2.23"
4. Check with the nurse in charge on ICU if the patient has a confirmed bed and ward.
5. Once confirmed call the ward and ask for handover to a doctor on the ward. Nurses will handover to their counterparts also. Remember to ask for the name of the doctor you're speaking to and the Consultant on the ward as you'll need them to complete the form.
6. **Print 2 copies of the SBAR form.** One copy goes with the patient to the ward and the other stays with the ICU ward clerk.

Skills to get signed off during this rotation

- ABG, CXR, ECG interpretation
- Arterial Line insertion
- CBDs on critically ill patients
- Case presentation
- Treatment and recognition of clinical emergencies e.g Cardiac arrest, AF, Seizures.

Theatres

Where to go?

Report to the operating theatres for your shift from 8:00am till 4:00pm.

Walk in through the main hospital entrance, take the first left, go to the end of the hall, and turn right. Proceed until you see the operating theatres on your right-hand side. You'll have to ring the bell for access on the first day and until your access card is updated. Report to the reception desk right through the operating theatre entrance. They will be able to show you the changing rooms and the coffee room. The theatres go around, in a loop, numerically, with the coffee room in the middle (a few meters down from the reception desk).

What should you bring?

A pen and a piece of paper (if you take notes).

A stethoscope is not needed.

Red surgical scrubs can be found in the changing rooms. They are usually very well stocked with multiple sizes. Ask the reception girls if you could get some theatre shoes and they will direct you to the stock. That way you'll get your own new pair and won't have to wear differently-sized crocs meant for visitors. You may also wear blue scrubs if you prefer.

Daily Schedule

You are expected to arrive for a start time of 8:00am (this is when the handover starts so arrive a bit earlier). Get changed into red, surgical scrubs and head towards the reception. On the way to the reception desk, you'll pass by the recovery rooms on your left. On your right, you'll see the consultants' room and a computer room. In between these, on the hallway wall, will be the theatre lists. Check the list (separate lists of morning and afternoon) that you are allocated to. Check the location of the patients and report to that location to find the anaesthetic doctor doing pre-assessments. Most are located at SAL (surgical admissions lounge) but paediatric patients can be found at Rainforest or Safari unit. Report to the patient's location for ALL theatre lists, EXCEPT 1 and 2, and find the anaesthetics consultant that you are allocated to for that list.

Theatre 1 is the Emergency Cepod list. This gets decided on the day and your best bet is to report to theatre 1 instead of finding the patient's location. The staff in the room should be able to direct you to the anaesthetic consultant.

Theatre 2 is the Trauma and Orthopaedics list. There is a trauma **meeting at Shuttleworth ward at 8:00am.** Report to the trauma meeting and introduce yourself to the anaesthetic consultant present. You will be shadowing them in Theatre 2.

Once the pre-op assessments are done, the theatre list is ready to go. Head back to your allocated theatre and enter the anaesthetic room. Here you can help to prepare the anaesthetic agents that the patient will require (under the supervision of your consultant or core trainee). Once the patient is brought in, you will have the chance to cannulate them. The anaesthetic room is small so be prepared so awkwardly manoeuvre yourself around everyone and the equipment. As the patient is induced, you can help to oxygenate them via bag-mask ventilation and insert an appropriate airway under supervision. Once the patient is anaesthetised, there's not much to do in between. You can fill out the anaesthetic charts for the patient by reading the figures off the ventilator machines. The anaesthetic charts are in

yellow; the front page consists of the pre-op assessment, the middle consist of the graph of the vital sign, and the last page is the 'other'.

During the procedure, ask the consultant/CT if they can give you teaching otherwise it can get tedious.

Once the procedure is over, the patient will slowly wake up. Be patient – some patients can take quite a while whilst others wake up very quickly. Once the patient is successfully breathing on their own, they will be wheeled to the recovery room (paediatric patients have a separate recovery room).

The only note for theatres is to not wear any necklaces/chains and ensure you're always wearing a surgical cap inside (otherwise you will be kindly told off).

<u>Skills to get signed off in theatre</u>

Dr Potter provided us with a skills sheet for the Anaesthetics rotation. It is as follows:

- Bag mask ventilation
- Basic airway skills and use of adjuncts
- I-Gel insertion
- Laryngoscopy and intubation
- Pre-operative assessments
- Post-op prescribing of analgesia
- Drawing up and administration of IV medication

Top tips for the rotation:

- **This rotation is very self-directed.** You can either get a lot out of it or get through the whole rotation without doing much – it all depends on how much you are willing to put into it. You have 4 days of SDTs but you have to apply yourself by contacting Aimee Curtis.
- Common jobs for FY1s – Requesting investigations and referrals, chasing bloods, investigations and referrals, discharge paperwork writing drug charts, cannula insertion, NGT insertion/adjustment.
- **There are also opportunities to learn ICU-specific skills** like Arterial Line insertion, Central Line insertion, intubation and extubation as well as transfers.
- **Be proactive -** There will be many days where you have nothing to do on the ward, use this time to complete your Horus, brush up on medical knowledge, ask the registrars/consultants for teaching.
- **Departmental teaching –** Happens rarely (roughly once every 1.5 months), it will be shown on the weekly schedule if there's any.

Teaching:

Teaching depends on the workload and the patients' condition. It's given by an anaesthetic trainee or can even be conducted by you. They're informal and a great way to learn about ICU/anaesthetic related topics. It's not scheduled so ask Heather (the ACP) if, and when, the next session will happen. Some consultants prefer to do teaching during ward rounds. So they can ask any questions regarding the patient's condition. There's a monthly teaching session involving all the anaesthetic trainees. It is optional for us and can be found on the rota. The first placement junior doctors weren't informed

about it till their last week. As for the second placement junior doctors, it was scheduled in our weekly rota that is posted by rota coordinator.
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