Last updated: 29/ 08 /2021 by Dr Bertha Wu
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ROVER (Rolling handOVER)

UNIT, POSITION AND LOCATION

UNIT STAFF MEMBERS – KEY CONTACTS
Director – Gopal Taori (Gopal.taori@monashhealth.org)
Supervisor of Training – Sanjiv Vij (Sanjiv.Vij@monashhealth.org)

USEFUL CONTACTS
Haran Sathianathan **– Rostering** (Kushaharan.Sathianathan@monashhealth.org)
Sophia Traboulsi – ICU Admin, responsible for the ANZICS forms (Sophia.Traboulsi@monashhealthorg)
Wednesday teaching – Michael Toolis (Michael.Toolis@monashhealth.org; Michaeltoolis@gmail.com)

WHERE TO GO ON THE FIRST DAY
Drop off your belongings in the Registrar room – turn left on the first corridor on your left as you enter ICU – the first room on your left is the reg room
Teams usually meet at "Flight Deck" before handover – ie the main middle pod of ICU in front of the big screen

WHERE TO COLLECT PAGER (If applicable)
The team from the previous shift will usually handover the pagers to you directly at handover
There are 2 MET call or CODE BLUE pagers; usually 2x HDU Registrar holds this, but if is there is only 1 HDU registrar that day, one of the Internal Registrars will carry one of them

HANDOVER
Please fill in the following table and make a note of any specific preparation which might be required

	Who?	**Where?**	**When?**
Day to Evening	**Flight deck**	Team may decide to walk around vs paper round at the flight deck	**8am**
Evening to Night	**Same as above**		**8pm**
Night to Day	**Same as above**		**8am**

ROLES / RESPONSIBILITIES & TIPS
Day to day
- 2x CWR – AM and PM
- AM CWR happens after AM handover
- Different consultants have different styles of WR – some will be present during the whole WR, some are very particular about what they want, some will let you do your own registrar WR first before thy come along and either discuss the plan or walk around to discuss the pts quickly after you have formulated your own plan
- ICU team has max 10 pts – these are generally the sicker pts eg intubated, being dialysed
- HDU team has max 4 pts – these pts are generally less unwell or awaiting ward bed; HDU team is also responsible for referrals, MET calls/CODE BLUEs, and also the TPN Round
- AM CWR are usually long – can finish from 10am to 2pm!
- PM CWT usually happens at 4pm; these are usually brief – walk around to make sure pts are sorted for the day and there is plan for the night team
- Do jobs and action plans from AM CWR in between WRs

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- Apart from new admissions from ED that rolelin throughout the day, there are also planned admissions – typically post-op pts – laparotomies, ENT/Plastics horrendoplasties, Vascular limb surgeries needing requent neuro obs
- TPN rounds happen on Mon/Wed/Fri at 2pm – the Dietician will send you the link for the meeting (during COVID at least) – you will need to review the plan for TPN for all the ward pts on TPN, chart the TPN for the next few days, and review bloods esp electrolytes/LFTs, and make recommendations – generally the Dietician makes a very good plan and document already so they will guide you through this
- Night Registrar WR happens after night handover – Consultant usually not there for this
- Make sure handover clear plans from consultant for the night
- During the night RWR, I usually make sure plans from the AM and PM CWR have been/are being actioned, nothing has been missed, check pathology and micro, check drug chart and that all the essential meds are charted
- A good way to organize your issues/plans for your WR is this:
  - A: airway – ETT depth and size, trache size, condition of trache ?much sunctioning needed
  - B: breathing – ventilator settings, resp exam, CXR of the day
  - C: circulation – any vasopressors/inotropes and how much
  - D: disability – amount of sedation, GCS, neuro exam, any neuroimaging; if pt will have a chance of being extubated in the morning, consider weaning sedation overnight and turning sedation off at 6am
  - E: electrolytes – aim in ICU is 4.0 for K, 1.0 for Mg and Phos
  - F: fluid – check fluid balance chart ?+ve vs -ve for the day, and what is the aim? Does the pt look clinically overloaded vs dry – frusemide vs filling needed? If on HDx – how much fluid is being taken off; how much urine the pt is making
  - G: Gut – abdo exam, are LFTs OK , BSLs – need dextrose drip vs insulin, feeds – what is the current rate and target rate for NG feeds? Is the pt needing any TPN?
  - H: haem – check FBE Plt INR OK – need any blood product?
  - I: infection – last fever, WCC/CRP, micro, what ABX is pt on – is this the right one?
  - J: joints and soft tissue– VTE prophylaxis, make sure pt has no pressure sores, hidden wounds/infection
  - K: kin – has the family been contacted? Do we need a family meetinh? GOC
  - L: lines – check the date lines were inserted, do the insertion sites look clean, do lines need to be re-sited
  - M: Med Chart – make sure no errors or omissions, delete unnecessary meds

Cover shifts/After hours work
- You have no cover shifts or afterhours work

Discharge Summaries
- Generally the residents are pretty good at this; however registrars should help when they can
- Include issues in ICU, Ix, Mx and progress, teams involved, plan, things for ward to chase up post-ICU discharge
- Important to include GOC discussions

ANZICS Forms
- Forms to fill in for each pt being admitted to ICU; have to fill in some pt parameters eg reason for adm, pt comorbidities, main diagnosis etc
- data collected for research purposes for ?CICM vs health department

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- Sophia will teach you how to fill in these forms – they are on EMR under Ad Hoc, and is very easy to fill in once you've learnt how
- Best to fill them in when you have just admitted someone as it only takes 5min and the pt's details are fresh in your mind still – better than someone having to do it from scratch in a few weeks' time

UNIT MEETINGS / INTERN TEACHING / SCHEDULE

Meeting	Day	Time	Meeting Location	Specific preparation required
TPN Rounds	**Mon Wed Friday**	**2pm**	**Reg room or conference room**	**No prep required**
ICU Teaching	**Tues**	**11am-2pm**	**Zoom meeting**	**Teaching roster allocated at beginning of term – case presentation, core topic or journal article**

WORKPLACE GEOGRAPHY
Unit specific information

Location of doctors' room	
Printer location and number	
Fax number	
Consultants' Offices	
Main meeting room	
Radiology meeting room	
Outpatient clinics	
Theatre passwords/codes	
Other important locations	

RURAL ROTATION SPECIFIC
Accommodation – location, what to expect
Other important information – local restaurants etc.

COMMON CONDITIONS MANAGED BY UNIT/KNOW THE BASICS OF…
Ventilator modes and settings, NIV- Highly recommend for you to do the ICU BASIC Course before you start
Vasopressors/inotropes
Dialysis
ARDS
Shock - esp septic and cardiogenic shock
Heart failure
Renal failure
Review ALS protocol

COMMON MEDICATIONS USED SPECIFICALLY BY UNIT
Sedation: propofol, fentanyl, dexmedetomidine
Pressors/inotropes: noradrenaline, vasopressin, adrenaline, dobutamine
You can order these infusions on EMR quite easily ϑ

PROCEDURES

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Arterial line
CVC
Vas Cath
PICC line
ICU now has an accreditation process – you have to do a 1-day course + 5x supervised central lines to be accredited. Some of your prior learning can be recognized – check with Michael who is in charge of this

ANYTHING EXTRA THAT MAY BE NECCESSARY TO KNOW

USEFUL RESOURCES
LITFL
Deranged Physiology – good resource for ICU Core Topics
The Bottom Line – has pretty much all the important ICU studies there