

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for anaesthesia service reorganisation during the coronavirus pandemic

17 March 2020 Version 1

Summary

- 1. Creation of an expanded and trained critical care workforce:** Ensure all medical, nursing and allied health professionals have sufficient time for training in how to manage coronavirus patients, including cross-skilling non-critical care staff from theatres/ anaesthesia into critical care roles.
- 2. Provision of safe, efficient care for continuing essential non-coronavirus clinical activity, reducing burden on hospital beds:** Ensure that services supported by anaesthetists that cannot decrease clinical activity (eg emergency surgery, obstetrics) are safely staffed.
- 3. Providing clinical leadership and co-ordination of inpatient emergency work.** Clinical management oversight of all surgical, obstetric and other work involving anaesthetic and critical care doctors.
- 4. Work collegiately with surgical and medical colleagues.** Ensure as much interventional work as possible is undertaken as day case.
- 5. Collaborative working to maintain safety and efficiency:** Anaesthesia and critical care must work together to support best care for the critically ill. This includes facilitating safe efficient intubation, transfers, support with procedures (eg line insertion) and providing additional critical care services.
- 6. Reduce outpatient attendance:** Use video or teleconferencing if possible
- 7. Look after your personal safety and wellbeing** and that of your colleagues

1. Training and development

Workforce:

- Reduce elective work to facilitate training of the expanded workforce

Training:

- Train staff how to manage coronavirus patients, including cross-skilling non-critical care staff from theatres/anaesthesia into critical care roles.

Assurance:

- Create local systems (eg rotas and registers) to ensure all staff have completed relevant training.

Resources:

- Check [Intensive Care Society](#) and [joint anaesthesia/ICM coronavirus website](#).

In order of priority, time should be made to ensure staff **can complete and are able to maintain competence** in the following areas:

Priority 1: Personal and patient safety for all staff members

- **Anaesthetists; doctors/HCP with airway skills; anaesthetic nurses, operating department practitioners, recovery ward staff**
 - personal and patient safety, particularly personal protective equipment (PPE) [donning/doffing](#), [airway management](#) and [CPR for coronavirus patients](#)

Priority 2: Clinical Training: check <https://icmanaesthesiacoronavirus.org> for materials

- **All anaesthetists, nurses, operating department practitioners, recovery ward & theatre staff:**
 - simulation training for [prone positioning](#)
- **Anaesthetists:**
 - [refresher training](#) for principles of critical care for coronavirus patients
- **Anaesthetic nurses, operating department practitioners, recovery ward staff:**
 - principles of critical care nursing for coronavirus patients:
 - tracheal tube / tracheostomy care; suctioning/mouth care
 - titration of sedation, vasopressors and inotropes.

Priority 3

- **Expanded medical and nursing workforce:** put a call to arms out locally: e.g. research staff, clinic staff, clinical academics, recently retired, surgeons/physicians with some experience of critical care: will require training in PPE [donning/doffing](#) and [airway management](#) as appropriate

- **Theatre nurses:**

- principles of critical care nursing for coronavirus patients: (see above)

Note that this additional workforce is likely to be the highest risk for accidental exposure and human factors-related issues – so consider allocating them to lower risk work (eg maternity)

All priority 1 training needs to be complete within one week of issue of this guidance and all priority 2 training within two weeks. **Cancel non-time-critical activities to facilitate this.**

Recruit priority 3 workforce within two weeks and enable training within a week after that

Have a strategy for being able to call staff in should there be a rise in clinical caseload

2. Provision of safe, efficient care for continuing essential non-coronavirus clinical activity, reducing burden on hospital beds

- **The goal is to reduce hospital length of stay for all patients.** This will be enabled through quick, efficient processes both before and after interventions.
- Uplift workforce for maternity units and emergency surgery
- Maintain standards for emergency surgery, particularly high-risk such as emergency laparotomy (EL) and hip fracture: consultant care delivered within 24 hours of admission to hospital in all cases, sooner depending on clinical urgency for EL.
- Do as much as possible on a day-case basis to avoid hospital stay altogether

3. Co-ordination and clinical leadership and of emergency work

Coordinating cover: consider

- at least one co-ordinating consultant anaesthetist free of clinical duties for theatres
- at least one co-ordinating consultant intensivist free of clinical duties for critical care
- in larger departments, enable one consultant to attend the Trust command meeting etc. Leadership is stressful during a crisis. The clinical director cannot do it all. Please support them and spread the load!

The roles of co-ordinating clinicians will be to:

- provide an overview of the state of the hospital with regard to critically ill, potentially critically ill, and other workload anaesthesia/critical care relevant workload
- work with managers to maintain a handle on bed numbers and staffing capacity.

Consider allocating one consultant and one trainee for each of critical care and anaesthesia to manage 'administrative duties' (e.g. rota management, disseminating guidelines, governance issues, etc. This could be rotated to enable some 'downtime' from clinical duties.

Clinical cover: aim for

- at least one consultant (critical care or anaesthetist) for the 'unit' (more if larger unit)
- at least one consultant (critical care or anaesthetist) for outreach and liaising with the emergency department (ED)
- at least one consultant (critical care or anaesthetist) for patients on supplementary 'units' of coronavirus patients (depending on caseload).

5. Collegiate working between anaesthesia and critical care to maintain safety and efficiency of the care of the critically ill

Consider the following service needs in addition to your usual staffing for critical care, outreach and all anaesthetic work areas, depending on the scale of the total workload:

- an intubation team (two to three people including a consultant & skilled assistant)
- a transport team (anaesthetist, ODP, porter): for radiology / other essential transfers
- a proning and procedures team (e.g. for line insertion, bronchoscopy)

6. Reduce face-to-face outpatient attendance

- Use video / teleconferencing or online preoperative self-assessment tools

7. Look after personal wellbeing and that of your colleagues

- rewrite consultant and middle-grade rotas to avoid prolonged periods of continuous work/on call eg plan at least two days off after a run of more than three shifts
- regular multidisciplinary team (MDT) debriefs and after-action reviews: encourage open dialogue focusing on pragmatic problem-solving
- support physical and mental wellbeing: emotional support, nutrition, hydration and sleep
- direct staff to occupational health protocols; support staff in higher risk groups, eg immune suppressed, co-morbidities, older
- reduce risk of infection and exhaustion by avoiding staff being at work if no stated role.
- [guidance](#) available from the Intensive Care Society.