Bradford Teaching Hospitals
NHS Foundation Trust

DATE: In the near future

PHASE ONE:

You are having your ICU morning handover and are given your bed status

BED STATUS CARD (Insert critical bed occupancy for your trust here)

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e.g.

ICU 15 patients (12 tubed)
Three patients with C-19, tubed in rooms 0, 16 and 1.

How do you find out what the situation is in the rest of the hospital?

SITREP plan? How does that work? Who is responsible for keeping, updating, handing over that information? Hub? Who is your bronze commander? How do you contact them? Control room?

Night SpR reports on a patient just reviewed overnight on AMU with suspected COVID-19

PATIENT P

You trust his clinical review, decide an escalation plan and action.
? For NIV ? Respiratory ? Who co-ordinates?

SpR back from holiday wants to know what the current PPE SOP is?

Where is it kept? Who is responsible for ensuring adequate stock? Do you lend out? What patient contacts do you wear it for? Is there a limit on numbers of staff in room? Are you doing fit testing? Do you have a record of everyone fit tested? What do you do if there is a breach?

ED phones, acute respiratory deterioration, suspect COVID-19, request emergency assistance

PATIENT A

***Where do you manage the airway of this patient?* Joint discussion with ED**

Where is the patient going to go? Who collects and transports patient? Is there any additional equipment you need to take to ED for this patient? What do you do with their belongings from ED? What about the airway equipment used? What about the ventilator, do you use two per patient and have disconnections or transfer a ventilator with the patient and keep the patient on it. Is this compatible?

Who is responsible for trolley cleaning SOP? Pump cleaning , etc.

What is the SOP for intubation in a room on ICU?

How many staff are necessary? What happens to airway equipment? Single use? Disposable? How is it cleaned? Who is responsible for cleaning it? Do you have adequate supplies if items have to go away for more thorough cleaning? Is there an SOP for intubating in ED/on a ward/during CPR?

Patient needs lines, how do we minimise exposure to ourselves, radiographers?

Who is responsible for reporting COVID-19? Is this different if they are suspect or confirmed?

PHASE TWO:

PATIENT A has a very big family and they want to see their relative on the unit. They have a lot of questions for you including whether he is going to have a CT scan? How do you manage?

Where/how are you going to speak to them? Are they an infection risk? Can they see their relative on the unit? What if they are dying/you plan to withdraw care? If so do you limit numbers? How do you separate groups of relatives/discourage large groups aggregating? What additional methods of communication are being made available?

*__AMU phones to request critical care review of patient, suspect COVID-19__ *

PATIENT B

What is your process for opening a second unit?

How are you going to co-ordinate moving patients from one unit to another?

How are you going to staff it today? Who has organised additional staff rotas? Where are you going to get additional staff from?

What do you expect of the theatre staff? What training do you think is essential? Has a formal programme of training been planned/carried out? Who is taking the lead on this? Who would be best suited/has the capacity to give this training? Who is responsible for the care of the theatre recruits?

PHASE THREE:

Trauma anaesthetist calls after he has been to review an 84 year old lady booked for a fractured neck of femur

PATIENT C

Wants to know where to get PPE/how to arrange a test? She is well enough for theatre but where do they perform it? What is the SOP for theatre list plan/PPE and personnel requirements/who supplies the PPE to the ward/transfer team? What is the SOP for theatre decontamination? Where will she be recovered and by whom?

Where are they running acutes?

***A nurse has informed you that he feels unwell with a sore throat, muscle aches and fever. How do you manage? ***

How do you manage his care? Do you send him to ED? Are you testing health professionals? How do you keep in contact during their isolation? Buddy system of check up on progress/health?
How are you going to care for the psychosocial impact of this crisis on your staff?

Consultant anaesthetist on delivery suite contacts you, they have two patients with symptoms, one post delivery, PATIENT D, one in labour, PATIENT E. They would like your advice

PATIENT CARDS D and E

What is your plan for patient D?

Who do you inform? What about the other patients? What about the baby?

Patient E is having her third FBS and looks like she might need a C-Section, discuss her management

Where is she now? What PPE does her midwife have? Who is responsible for ensuring adequate staff protection? Where does she go for her section? How do you prepare theatre staff? Theatre? What about electives C-Sections? What about post delivery care?

An intubated patient on ICU needs proning how are you going to plan it?

How many staff are required? Can we minimise, optimise and standardise this? And therefore how many PPE? What happens with a disconnection? Have we educated existing staff on disconnection management? Are the theatre staff happy with proning? Do they need additional training?

Twenty minutes later the same patient arrests, they are for full escalation

How many staff are necessary for CPR? Can we optimise and minimise this on the unit? Is there a CPR SOP for Suspected COVID patients, is this different in other areas of the hospital? Transfer? Respiratory Ward?

AND FINALLY…… ASAT…… All Staff All Times

Great if you know all of the answers to the above. But does every member of your team?

How good are the lines of communication? Is the required information available to
ALL STAFF AT ALL TIMES?

Discuss ways of clarifying, educating and informing and means of improving communication between all the members of your team.

PATIENT CARDS

PATIENT A
46 F Respiratory distress
BGN: Smoker, Care worker
Febrile, P 138, RR 40, bilateral inspiratory crackles. On high flow oxygen and tiring.
Clinically needs intubation.

PATIENT B
62 M Admitted overnight in respiratory distress query pneumonia, query COVID-19.
BGN: HTN and Raised cholesterol
Respiratory condition deteriorating, PR 138 despite multiple fluid bolus. Likely to need critical care within hours.
69 F

PATIENT C
84 F Fracture NOF.
Admitted last night via A+E, starved.
BGN: Nursing home resident, moderate dementia, mobilises independently.
Febrile and coughing.

PATIENT P
69 F Severe respiratory distress, febrile, bilateral infiltrates.
IDDM, COPD with 1 exacerbation requiring hospital admission and NIV in the last year.

PATIENT J
68 M 3/7 dry cough, now febrile.
BGN: IDDM, cachectic, COPD (several exacerbations requiring hospital admissions with NIV).

Has expressed clear instructions that he does not want to be intubated.

PATIENT D
32 F Day 1 post delivery by forceps, baby well
BGN: Smoker
Febrile and sore throat with dry cough.
On open post delivery ward

PATIENT E
38 F Primip, in active labour.
BGN: Asthmatic
Partner in room

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