

# Tips and learning from the Marathon ESICM Sessions

Intensivists connecting and sharing- 28.03.2020

**Prepare for a marathon - this is not a sprint**

## 3 Rules for organisations

- Move Fast
- Accept Unknowns- everything is unclear
- Accept Mistakes- we are making 100% of our decisions with 50% of the information so work on the best available evidence

Good contingency planning is required : **PREPARE , PREPARE , PREPARE**

- **Expect frequent changes to plans**
- **Caring for staff will translate into caring for patients**
- **Focus on preparation while and if you can. There are limits to resources – staff/ventilators – contingency planning is vital. Plan for high sickness/ self isolation and the impact of these across all staffing levels**
- Avoid High Numbers of additional staff in the ICU early on.
- **State the expectations from the outset - care will be delivered differently**
- Current ICU staff will be required to look after a number of patients -become a supervisor of aspects of care rather than delivering episodes of care. Acknowledge that there is increased pressure teaching and training in the pre-surge.

**Increasing Nursing Capacity is supported through provision of:**

- Simulation training
- Orientation to ICU
- Video snapshots of key aspects
- Additional educational resources such as guidelines & educational packages should be readily accessible across the hospital for nurses and MDT working in unfamiliar areas

## Remember:

- **We are not trying to create ICU nurses-** We are up-skilling staff to support care in ICU and enable them to manage aspects of care.
- **People are working in different roles : communicate, communicate, communicate.**
- **Use stickers/write on PPE gowns** with Name and role on shirts/scrub tops/aprons/gowns as it is difficult to recognise team members with PPE equipment in use
- **Be patient -communication is a challenge with masks & face shields** -speak slowly and as clearly as you can– where possible communicate in advance and say what will happen next- have a buddy to communicate with when you are in full PPE gear or to observe you when in a room area in case anything is needed.
- **Delivering care in PPE-** there is a physiological slow down which increases workload
- **Staff will tire more easily-** factor in for more breaks for food and hydration
- **Breaks from PPE-** as part of the key focus of organising the shifts
- **Altered priorities-** staff parallel to the patients
- **Establish process for calling for help –** especially in side rooms – ?Walkie talkies – avoid phones!

## Anticipate:

- New working conditions – New teams
- Be Flexible
- Different backgrounds will evolve a different way of working but brings combined experiences
- Unusual unfamiliar tasks – but only for a while – they will become familiar
- Be willing to do uncommon tasks
- Feelings of deficiency
- Feelings of uncertainty
- Increased Anxiety levels
- Morally distressing situations in relation to EOL

**EVERYONE is feeling these**

**Task based Nursing:** Consider making task directed teams – eg turning/proning /intubation etc. Outline the tasks for supervising staff and supporting staff so roles are clear. Clarify if someone is a runner/ care delivery support/specific task eg– managing reducing risks IV sites/lines , eye & oral care etc More simple but important elements of care.

**Manage Expectations:** Increased numbers in ICU and increasing demands will be balanced by a possible reduced standard in care - some decubitus ulcers/ iv access site issues etc resulting in ICU patients in other countries managing the COVID surge in ICU. Accepting we are not the best we can be but we are good enough in each moment.

**Minimise risk and complications** – agree a strategy to manage this in each unit

**Set clear goals /parameters at ward round-** share and review

**Escalation points – what are they? How do we escalate ? And to who ?**

**Adhere to ‘key principles’ of documentation:** **Consider ‘Lean Charting’** – documentation for key elements only. Agree the ‘Key Principles’ of documentation and charting in patients receiving critical care in your ICU– it may not be possible to maintain all current practices. Ensure anyone can safely take over care without a detailed handover. Concentrate on Key Concerns and a patient care plan – consistency across all patients and a clear plan present-evident to all.

**Resilience:** Have no Assumptions of how staff will cope with increasing mortality rates - Resilience is not innate!! We all play a part in each others resilience especially leaders and managers. Consider increased risk of burnout of core ICU staff as not working in their usual teams.

Resilience is **Everybody’s** business. Reinforce the sentiment that: **IT IS OK NOT TO BE OK**

**Social Media:** Consider reducing or limiting Social media to **reduce Overload-** advise staff re same

**Tips to prevent/detect burnout in ICU**

- Promote: Early psychological support and ensure some strategies are put in place
- **Checking in and checking out** at start and end of shift.
- Buddy system
- Setting a foundation of looking after each other so you can look after patients

**Telephone support:** Suggest that **staff who are self isolating who are well** –and wish to support - they can provide phone support for colleagues/teams **to do check in**

\*\*\*\*\*Using **high flow nasal cannula** staff need FFP3 when close to patient as there is a high risk of a **turbulent gas cloud** dispersal if the patient sneezes or coughs \*\*\*\*\*

**Ensure all staff have a communication strategy agreed to contact families** – at a time that suits the care activities and this prevents staff getting calls and having to doff **PPE** unnecessarily

**End of Life :**

- divert as senior a nurse as possible to manage this and meet family
- Support those less familiar with EOL
- Intrusion of PPE
- Prepare for new team to debrief

There will be occasions when staff have to inform family of a death by phone – consider how best to do this - have a guide for this to assist staff at those times.

\*Stimulate family visits (with limits, effective PPE)

\*Standardized written information for the relatives

\*Set up routine telephone calls with the relatives

\*Solicit family members creativity (use video / the virtual ICU visit / diaries / text messages / media groups)

\*Start up a different model close to the end of life

**\*The 5-S Strategy**