Tips and learning from the Marathon ESICM Sessions

Intensivists connecting and sharing- 28.03.2020

ORGANISATIONAL LEVEL POINTS

- What about other non COVID 19 patients and their ongoing care and management – they may have better survival chances – ensure this is given sufficient planning and consideration.
- Patient selection for non invasive ventilation requires and experienced ICU team- if there is a staff attrition then this may no longer be available as in Italy currently. **NB staff care and safety**
- There is a balance to be struck between no of ICU patients and the quality of care delivered – expect and plan for complications in this regard- ie decubitus ulcers/ IV site problems - accept this and prepare staff for same
- Human resources are the most precious resources particularly ICU nurses – there is an attrition rate. How do we plan to staff the field hospitals? IN Spain – using junior staff- acting as senior staff – with Senior leadership – without ICU skills but senior leadership. Eg Consultants. ***Solution is not in the hospital but in the governance***
- What about staff exhaustion -?? How do we guard against it?? Increased risk of burnout of ICU staff as not working in their usual teams
- NB Prevent Moral Distress
- Consider the effects of staff exhaustion and sickness/ death on teams and system into the future
- Contingency planning for resource depletion – eg reprocessing single use items- reuse of equipment- Downgrading of policies are affecting staff in other countries- consider the effect of this on staff psychologically and staff safety
- **Provide Telephone support:** For ***staff self isolating who are well*** and wish to support they can provide phone support for collegues/teams to do check in for ICU staff
- In Spain patients over 70 years are not being admitted to ICU due to increased mortality and reducing resources – Intubation rate 1 patient per hour. Norway does not have an age cut off but have a frailty consideration for ICU admission.
- As no rapid test unable to diagnose infected/non infected cases - causes challenges in treating the non covid cases
- If staff knew they had antibodies they would be able to work more safely and securely.

Questions to ask ourselves :

- What interventions are most useful in the community to prevent worsening of pneumonia and progression?
- Philedelphia leveraged telemedicine in a very useful way – if they had time back again he (Lewis Kaplan) would have created a national dashboard for oversight of resources
- ECMO – judicious use …? Very resource heavy -? Saving 1 to lose 2???

1. **Anticipate exhaustion from the beginning – Policy guidance at the outset is useful**

2. **Accept different standards – we have different ways of working in different conditions - these are akin to wartime conditions**

Staff Recruitment:

Consider using ***staff experiences*** where they best fit – eg consider Geriatrician/ Oncology/Cardiology teams to manage family issues

Challenges:

We start with well formed structured ICUs but COVID 19 debilitating factors are:

- Pandemic
- Drop out and loss of staff nursing and others
- Testing time
- Compatibility of Hardware
- Need for disposables
- Lack of training for staff

Longstanding Global Pandemic so the effect is ***unprecedented shortages*** of:

- Tests
- PPE
- Equipment for ICU
- Drugs for ICU – Muscle relaxants

Insufficiency creates Urgency