HONG-KONG ICU PREPARATIONS

12/3/20 DR LOWELL LING

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SUMMARY BY:
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STAFF TRAINING - PPE, INTUBATION DRILLS, ASSESS WORKFLOW AND PRACTICE

CHANGES TO THE ICU - CLEAR, CONCISE POSTERS. HOMOGENISATION OF AREAS. COMMUNICATION IMPROVEMENTS

MANAGEMENT - NOT EVIDENCE-BASED, BUT PRACTISED IN HONG-KONG ICU

HOSPITAL LOGISTICS - FOCUS ON COMMUNICATION WITH ALL STAFF

- PPE NOTICES ARE IN ALL RELEVANT CLINICAL AREAS.
- PPE-INSPECTOR NURSE EACH SHIFT HAS A ROLE TO LOOK AT INFECTION CONTROL ISSUES, IDENTIFY ERRORS AND IMPROVE TECHNIQUE.
- VIDEO LARYNGOSCOPY IS FIRST LINE IN HONG-KONG - ALLOWS INTUBATOR TO STAND FURTHER AWAY
- DOUBLE-HANDED BAG VALVE MASK TECHNIQUE TO MINIMISE LEAK (NEED ASSISTANT).
- VISUAL AIDS TO INTUBATION ARE AROUND THE AREA - THESE ARE CLEAR AND CONCISE.
- NEGATIVE PRESSURE ROOMS - OUTSIDE = MIRROR, PPE EQUIPMENT OUTSIDE, WARNING SIGNS, ALCOHOL RUB AND PRESSURE INDICATOR.
- DROPLET, AIRBOURNE OR STANDARD PRECAUTIONS ARE MARKED AT EACH AREA.
- 'EXCHANGE CHAIR' - DIFFICULTY IN HANDLING SPECIMENS LED TO A CHAIR OR TABLE BEING ALLOCATED TO ALLOW PASSING OF SAMPLES, MATERIALS ETC IN AND OUT OF THE AREA. THERE WERE CLEAR INSTRUCTIONS ON THE WALL BESIDE THE 'CHAIR'. SEE VIDEO FOR DETAILS.
- DOFFING AREA IS NEAR A SINK. CONCISE AND CLEAR INSTRUCTIONS AT THIS AREA LEAD TO REDUCTION IN PANIC.
- IN EVERY AREA/ROOM THERE WAS A STANDARDISED LEVEL OF EQUIPMENT. MINIMISING THE TRANSFER/BRINGING OF EQUIPMENT TO THE AREA.
- TELECOM SPEAKER DEVICES FACILITATED BETTER FLOW OF INFORMATION IN AND OUT OF THE ROOM.
- PLASTIC BARRIERS WERE UTILISED IN THE TEA ROOM

HONG-KONG PRINCE OF WALES HOSPITAL RECOMMENDATIONS

Specific Recommendations	Reason
early intubation (~6L O_2)	-more "controlled" intubation -less need for bag valve mask ventilation during induction -avoid use of NIV/potential infection risk -avoid crash intubation/CPR
cautious extubation	-avoid reintubation risks -avoid use of NIV/potential infection risk
minimize interventions/investigations	-reduce nursing workload -reduce exposure time
screen for nosocomial sepsis	-usually come to ICU after period of hospital stay
expect a period of organ support	-time to extubation/weaning of vasopressor was about 9 days

Specific Recommendations	Reason
screen all cases that need NIV/high flow	-local transmission/asymptomatic patients -infectious risk to other patients and staff -virus results in 3-6 hours
CPR use mechanical device	-reduce minute ventilation of healthcare worker -reduce dislodging of facemask
CPR use ventilator rather than bag valve mask to ventilate	-reduce circuit disconnection -reduce need for extra staff at head end -set to volume control, high pressure alarms, negative pressure triggers

Specific Recommendations	Reason
communication between A&E, ward & ICU	-workout logistic issues -triage/consultation thresholds
updates on number of COVID-19 patients on ward (especially ones on O_2)	-facilitate planning of ICU capacity -inform elective lists cancellation -workforce deployment
low threshold to consult/admit to ICU	-avoid NIV/high flow O2 -avoid intubation on ward -less chaotic transport
cancellation of elective lists	-high use of PPE for elective lists -reduce patient load on wards -allow staff redeployment
update family over phone/video conferencing	-hospital wide policy not to allow visitors -to reduce infection risk

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