SUSPECTED OR CONFIRMED COVID-19

SOP for Prone Team Structure and Operations

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Version: 1.1 **Issue Date: 10/04/2020** **Review Date: March 2021**

Introduction:

The aim of this document is to provide a guideline for the prone team. It will identify the structure of the team, the team members and their daily responsibilities. The document will also explain how more than one prone team will work collaboratively across different areas of critical care and the hospital, as our Covid positive patient numbers increase.

Overview:

The prone team project has been a huge undertaking to ensure the provision of life-saving therapy. The aim is for around 100 staff members to be specifically trained to ensure up to 4 operational prone teams during the daytime and 1 team at night. All teams will work 12 hour shifts, with each team assigned to a 'zone' of critical care patients e.g. prone team 1 will provide proning cover on critical care (A3 North & south and B3 North & South); prone team 2 will provide proning cover for CCU, C3 and CITU. The number of required teams will evolve as the situation develops and more 'zones' of critical care patients are created.

Team Structure / Roles:

Prone Team Lead

Who:

- Regular member of critical care staff training in the proning process

Role:

- Co-ordinate proning team and complete team briefings at start and end of shift
- Advise bedside staff of order of proning and approximate timings to allow beside staff to prepare the patient in advance of team arrival
- Obtain relevant equipment required in advance including single patient use proning sheets and multi-patient use proning straps. Must also ensure reusable (orange plastic) proning straps are cleaned with acticlor between each patient
- Ensure proning spreadsheet updated regularly (NB this is the central record of all patients proned in the last 48 hours)

- Ensure the procedure checklist for proning and supination is completed for each patient turn as this the procedure record
- To carry the 'prone emergency bleep' when not in hot zone

<u>Airway:</u>

Who:

- Ideally ST5 or above anaesthetics or ICM – NB if the airway lead is less experienced that this there **must be** a clinician of ST5 + grade in Anaesthetics or Intensive Care Medicine available to provide assistance in case of accidental extubation. This support clinician must be aware of the support role they are providing.

Role:

- Ensure ETT is not displaced while turning the patient
- Emergency airway management if required
- Advise RE: use of emergency drugs if required and to ensure that emergency drugs for CVS instability and reintubation are immediately available and accessible should the need arise
- To risk assess patients based on previous grade of intubation and personal experience of providing emergency airway management (including re-intubation if required)

<u>Core Team:</u>

Who:

- 5 individuals form variety of backgrounds who are specifically trained in the 'Cardiff Proning Method' (NB must also have undergone 'mask-fit testing' and training in the donning and doffing of PPE)

Role:

- The team of 'turners' to move patients between supine and prone position, under the supervision of the prone team lead
- No involvement in any other aspect of patient care will be expected, but can be considered for certain staff groups (e.g. medical students) providing proning workload allows

<u>Proposed Timetable:</u>

The following timetable is suggested for each prone team:

<u>Day Team:</u>

- 0800:
    - All team members to meet at identified 'cold zone' meeting point e.g. prone team 1 meet outside B3 Sisters' office (night prone team lead to attend)
    - Team lead and team members to introduce themselves
    - Team to discuss patients for turning using the proning database (see S:drive; Critical Care; Covid documents; Proning database)

  - Team leader to ensure the co-ordination is all completed in the cold zone to minimise the time spent in PPE especially given the physical activity being undertaken
  - Team leader to ensure all staff adequately hydrated as per PPE SOP
- Post Briefing – 12.00:
  - Optimal time for turning patients from prone position to supine
- 12.00 – 16.00:
  - Update proning database
  - Re-hydrate and eat lunch
  - Ensure sufficient procedure checklist paperwork available (electronic copies to be located in file with proning database)
  - Liaise with clinical team in zone regarding patients requiring proning during the afternoon session (NB: clinical team should ensure patients name is entered on the proning database once the decision has been made – it is excepted that this may not always be possible depending on clinical workload)
  - During this period staff may be educated and invited to participate in other aspects of patient care, according to their background and skills mix. This involvement is not an expectation for any staff. All staff from the proning team should remain within their allocated zone to ensure they are available for emergency turns during this window
- 16:00 – 20:00
  - Optimal time for turning patients to prone position (including any new patients inputted by clinical team)
  - Update prone database with time of turn and details of next action required (e.g. head/ arm move to be completed AT LEAST every 6-hours; or time to return to supine)
  - Debrief team as required
- 20:00 – 20:15
  - Team leader to handover to night prone team (meeting point outside Sisters' office on B3 corridor) and handover prone emergency bleep
  - Discuss any patients unstable or likely to require return to supine position overnight (i.e. if oxygenation worsens after 4-hours then advice would be to return this patient to supine position to avoid risk of prone-related complications, including pressure area formation)

<u>Night Team:</u>

- 20:00 – 20:15
  - Team introductions and briefing as per day team
  - Receive handover and emergency prone bleep from day prone team (meeting point outside Sisters' office on B3 corridor) – this bleep must be carried by the prone team lead when not in the "hot zone", and left with a responsible member of staff in the "cold zone" if the team are required to don for a turn. The bleep holder must take a message and relay this to the proning team at the earliest opportunity.
  - Obtain list of patients currently in prone position and discuss any unstable patients

- Team leader to ensure team members have eaten and hydrated before entering the "hot zone"

- 20:15 onwards:
    - Overnight, full turning from prone to supine should only be performed as an 'emergency procedure' where: oxygenation has worsened after 4 hours in prone position; concerns around airway displacement (on advice of senior anaesthetist/ intensivist); at the request of an Intensive Care Consultant
    - Unplanned/ unpredicted turns from supine to prone may be required for patients with worsening hypoxaemic respiratory failure who meet the proning criteria (see prone ventilation SOP)
    - For circumstances of emergency prone turns overnight the team should be readily accessible, and should make every effort to respond as quickly and as safely as possible, taking care to meticulously don own PPE
    - Where workload allows, overnight prone team should assist with head & arm repositioning for patients in prone position – the recommendation is for position to be changed at least every 6-hours to prevent prone position associated complications, including potentially life-changing facial pressure areas
    - The night prone team must be available via bleep when ever not in the hot zone – when entering hot zone the bleep must be left with someone able to respond if bleeped and communicate with the prone team within the hot zone. All bleeps must be responded to as soon as practically possible allowing time to don required PPE

- 07:00 – 08:00
    - Update proning database including any additional patients that required proning overnight
    - Team debrief