How has the COVID-19 pandemic enhanced my clinical and non-clinical skills

The COVID-19 pandemic given me a different perspective of critical care (ICU); it has changed my outlook and the expectations that I have of both myself and my multi-disciplinary colleagues.

Clinical skills

During the pandemic, I anaesthetised intubated COVID-19 patients within theatre for the insertion of tracheostomies by the surgeons.

I vividly remember the morning huddle of my first COVID-19 tracheostomy, during which the surgeon was confident this could be done percutaneously within five minutes, and the anaesthetic core trainee had reviewed the patient. Unfortunately, the operating theatre had been set up to the convenience of the surgeon.

As was often the case with COVID-19 patients, nothing went to plan. The patient arrived in theatres with a very high vasopressor requirement, was facing away from the anaesthetic machine with no spare intravenous access.

Numerous lessons were learnt from this episode including:

1. Always ensure a senior review of the patient.
2. Several details are very important: body habitus, neck size, any desaturation on being rolled, number of infusions, spare intravenous access, and legible wrist bands. How does the patient react when they have a sedation hold?
3. During the WHO huddle, ensuring the patient will be facing the anaesthetic machine.
4. If I consider the shape of the neck to be unsuitable, to highlight a surgical approach maybe better.
5. If the percutaneous approach is taking too long, then I ask them to convert to a surgical approach. Task fixation happens to all of us.
6. To always have the video glideslope by my side, even if I use the bronchoscope to retract the tube, I will leave the glideslope in the mouth for visual confirmation.
7. To leave the suction in the mouth during the procedure, as these patients have lots of secretions.
8. The cardiac arrest trolley to remain in theatres, with pads on their chest, whilst many may think this is being over cautious, these patients are fragile, they're not ordinary tracheostomy patients.
9. I have taken a new appreciation of WHO sign out and the team's reflection on how things could be improved.

My involvement in intubating, transferring and proning COVID-19 patients has made me use checklists religiously[1–3] and voice my concerns of what could go wrong for that individual patient with my entire team, and explain how to manage these problems if they were to occur.

Our hospital had an intubating team; however, the difficulty was assessing the difference between whether the patient could manage on non-invasive ventilation (NIV) or whether we proceeded to intubate. I learnt the fine line between following safe protocols and being flexible at times of adversity.

During transfers I carefully reviewed the charges of all my monitors and infusion pumps before transferring the patient to the oxylog ventilators. Before proning, I made sure I knew vaguely how each ventilator works, as we had many different types of ventilators during the peak that many staff were unfamiliar with and have at hand, the Mapleson C circuit ready.

Non-clinical skills

The most important non-clinical skill during the pandemic is and was communication. My verbal communication became more succinct, easy to understand and loud, as my JSP PPE mask[4] often muffled my voice. My written communication was direct and unambiguous. Speaking to families gave a human perspective to these patients, but at first it was difficult not to become too emotionally involved, such that I would stay awake thinking of these patients leading to sleep deprivation and insomnia. Throughout the peaks, I have learnt to balance the need for emotional engagement with the patient's family, maintaining professional boundaries and looking after my own wellbeing.

We had a fully integrated electronic patient record system, an unsung hero of the pandemic that enabled decision makers to have an overview of all the COVID patients, whilst reducing the variability of message transmission through different handwriting and lost pages from otherwise very large paper-notes for those long stay patients. The most important aspect of COVID-19 ICU was providing continuity of high level individualised care for each patient despite a high staff turnover. I started to appreciate the importance of clinician engagement with electronic record systems, such that by the end, I participated in super user meetings, began to understand how data was being collected, and how it is intimately linked to data input by front line staff.

My situational awareness changed throughout my time with the pandemic, the ICU nurses were not always ICU nurses, they did not all automatically wean ventilation or know how the pumps worked. I am used to having ICU nurses tell me what they think is appropriate and make a balanced decision, this changed to becoming more assertive with new clinical staff members that were unfamiliar within the ICU environment but still maintaining my normal friendly cordial manner. I became more aware of the stress levels and well-being of our nursing colleagues.

Well-being service

For me there are three things that have the greatest impact on staff wellbeing:

1. The intensity of the rota and its consistency, so that it is fair and equitably between different teams providing ICU service, the rate of variability between day and night shift and how rota gaps are managed.

2. Being paid correctly. One of the most stressful aspects of COVID-19 is trying to find the day time hours to contact human resources (HR) that are offsite and often difficult to contact, about incorrect pay.
3. Sleep, even a twenty minute uninterrupted power nap[5] during a night shift can do wonders, and for that we need a place to rest.

The prize money should be invested in a start-up, 'well-being service' to help all hospitals acquire foldable sleeping chairs, ensure adequate rest facilities exist for all staff. This 'well-being service' should be accessible for all NHS hospitals, and have enough bargaining power to procure equipment at a reduced rate. Part of this service includes the breach of the difficult topic with Health Education England (HEE) and hospitals on how HR will be held accountable and ensure correct timely payment of trainees.

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