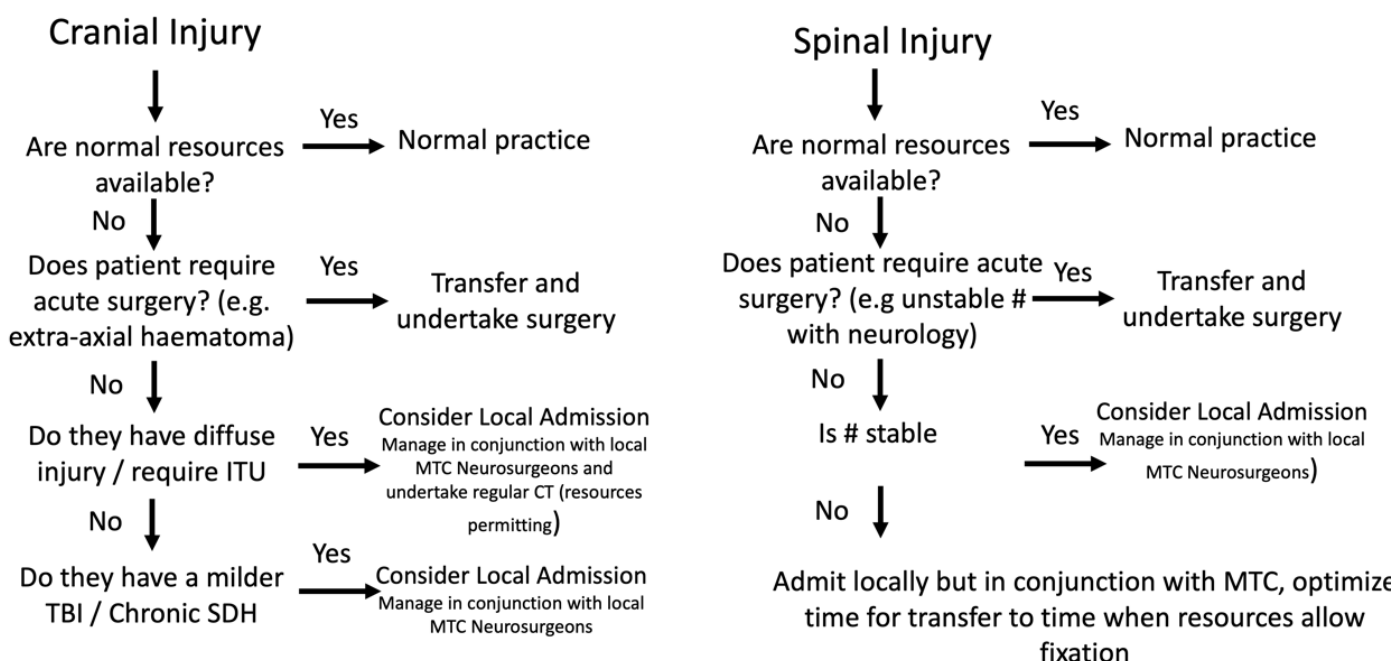


NEURO/SPINAL EMERGENCY PATHWAY FOR SUSPECTED OR CONFIRMED COVID 19 PATIENTS - SOP

REFERAL

- On call SpR receives call from BSUH or DGH A&E.
Discuss with consultant necessity for transfer and impact of infection on management pathway.
- Review HDU/ITU capacity
- Refer to Clinical guide for the management of neuro trauma patients during the coronavirus pandemic (refer to flow chart)
- Identify NCEPOD classification - Start consent form in A&E.
NCEPOD 1 or 2 – straight to theatre
NCEPOD 3 – (eg tumours/cord compression)



* Joint Management will require regular telephone / tele-video discussions

NCEPOD 4 – elective – manage as OPA until COVID 19 infection passed. – **NOT FOR ADMISSION** (unclear where the emergency theatre will be)

BEFORE THE CASE

- START OF EACH SHIFT – DISCUSS POTENTIAL PPE REQUIRED FOR THE SHIFT. – CAN USE FFP3? DOES ANYONE NEED A HOOD? Check this is available and charged. Check battery is charged.
- Register to review in A&E – complete consent form.
- Inform anaesthetist, theatre manager/shift leader and radiographer of case.
Arrange Team brief – emphasis on preparation for COVID 19 pathway. How many hoods are needed? Do you know what to do with blood gases/BM's. Ensure you are aware of all the equipment which is needed for the procedure. Shift leader pathway. Assign roles (bins, runner etc), discuss the case and decide do teams need to come in within the first 20 mins – then FULL PPE (FFP3). Please can team leader do a brief checklist?
- Sign on outer door stating COVID PATIENT

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- Transfer patient to theatre ensuring **patient** wearing normal fluid resistant surgical facemask.
Staff transferring patient to wear fluid resistant mask apron and gloves
- If patient has oxygen requirement use oxygen mask with minimum required flow (And surgical mask under oxygen mask).

ANAESTHESIA

- Bypass anaesthetic room and go straight to theatre
- Senior Anaesthetist and senior assistant to wear full PPE for AGP (FFP3).
- **NO OTHER STAFF IN THEATRE – runner wait outside. Wait to set up equipment.**
- Emergency contact person outside theatre in case of emergency.
- Video laryngoscopy RSI with COETT to minimise aeroionisation.(See COVID intubation guideline)
- Secure airway and attach to circuit and ventilator
- EXTREME CARE TO MINIMISERISK OF DISCONNECTION AT ANY PART OF CIRCUIT
- **Wait 20 mins to allow airborne particle dispersal**
- If staff need to enter prior to this then they have to wear full PPE (FFP3) – this should be discussed at the team huddle

DURING THE CASE

- Rest of theatre team can enter wearing usual theatre PPE.
- Anaesthetist and assistant can remain in full PPE (FFP3) if procedure short duration
- Surgeons and assistants to wear normal theatre PPE. **UNLESS** performing aerosol generating procedures, these are procedures via nasal cavity, pituitary cases. – **THEN FULL PPE (FFP3).**

AT THE END OF THE CASE

- All theatre team to leave except anaesthetist and assistant
- Use orange bins placed by exit to theatre and entrance to anaesthetic room.
 - Doffing prior to entering anaesthetic room. Remove gloves then gel hands. Remove gown by folding inside out and discard into orange waste bin.
 - Step into anaesthetic room Remove eye protection and put into the bin Remove mask and put in bin. Wash hands. (See doffing guidance).
- Full PPE (FFP3) for extubation – allow 20 mins before staff can enter.
- Patient **recovered in theatre** by staff wearing full PPE (FFP3).
- If patient has oxygen requirement use oxygen mask with **minimum** required flow (And surgical mask under oxygen mask)
- Transfer staff to wear surgical mask apron and glove.

- **Please complete team de-brief and look after each other.**

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