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Specialty guides for patient management during the coronavirus pandemic

# Clinical guide for the management of acute burns patients during the coronavirus pandemic

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"…and there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us…"
Dr Daniele Macchine, Bergamo, Italy. 9 March 2020

As doctors we all have general responsibilities in relation to COVID-19 and for these we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential burns care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside our specific areas of training and expertise, and the General Medical Council (GMC) has already indicated its support for this in the exceptional circumstances we may face: www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

Burns may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed. However, the non-elective patients, will continue to need care. We should seek the best local solutions to continue the proper management of these burns patients while protecting resources for the response to coronavirus.

In addition, we need to consider the small possibility that surgical facility for emergency surgery may be compromised due to a combination of factors including staff sickness, supply chain and the use of theatres and anaesthetic staff to produce intensive therapy pods. This is an unlikely scenario but plans are needed.

## Categories of burns patients to consider

- **Obligatory in-patients:** Continue to require admission and surgical management, eg larger burns. We must expedite treatment to avoid pre-operation delay and expedite rehabilitation to minimise length of stay.
- **Non-operative:** Patients with injuries that can reasonably be managed non-operatively, eg smaller, more superficial socially non-complex burns. We must consider non-operative care if that avoids admission.
- **Day-cases:** Day-case surgery can be safely undertaken for a large number of conditions. Provision for day-case surgery must be made.
- **First contact and clinics:** Outpatient attendances should be kept to the safe minimum.

When planning your local response, please consider the following:

## Obligatory in-patients

- **A consultant must be designated as 'lead consultant'.** This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call' or the consultant in clinic or theatre. They must be free of clinical duties and the role involves co-ordination of the whole service from referral through to theatre scheduling and liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the clinical director to do all of the coordination!
- Use elective theatre capacity and surgeons to ensure minimum pre-operative delay.
- Use elective rehab services to minimise post-operative stay.
- Many burns admissions are the frail elderly. Work closely with geriatricians and infection control to protect these patients during their admission.
- An anaesthetic guideline for patients requiring surgery and who are coronavirus positive will be required.
- Make contingency plans for supply chain issues.

## Non-operative management

- A number of injuries can be managed either operatively or non-operatively. Clinical decisions during a serious incident must take into account the available facility for the current patient and also the impact this may have on the whole community.
- As the system comes under more pressure, there may be a shift towards non-operative care.
- Non-operative care may reduce the in-patient and operative burden on the NHS.

- It will also protect the individual from more prolonged exposure in a hospital setting.
- It will free up beds for more urgent cases

## Day-cases

- Many burns-related procedures are clinically suitable to be performed as a day-case.
- During the coronavirus crisis, an increase in day-case burns surgery will:
  - avoid unnecessary admission
  - reduce exposure of the individual to a hospital environment
  - free-up beds for more urgent cases
  - allow staff from elective theatres to continue working in a familiar environment
- During the coronavirus emergency, it is likely that the only elective day-case surgery occurring will be urgent cases. Careful prioritisation of day-case patients will be needed across both the elective and non-elective patients based on theatre/staff

## First contact burns dressing clinics

- Emergency departments (ED) are likely to come under intense and sustained pressure and plastic surgeons can make an important contribution by reducing the ED workload so that clinicians in ED can focus on medical patients.
- We should avoid unproductive attendances at hospital. Senior decision-making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow for a greater senior presence at the front door.
- Clinicians may need to work in unfamiliar environments or outside their sub-specialist areas, or in another regional service. They will need to be supported.
- Protocols to identify those injuries that require no follow up should be reviewed.
- No patient should be scheduled for surgery without discussion with a consultant.
- Ensure all referrals are electronic and with images to minimise unnecessary travel.
- CT scanning may be limited as it is the investigation of choice for coronavirus pneumonitis.