Bradford Teaching Hospitals
NHS Foundation Trust

DATE: In the near future

PHASE ONE:

You arrive in the morning for hand over and are given your current bed status

BED STATUS CARD (Insert appropriate bed status for your trust here)

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e.g.
Beds: 13/ 16 occupied
Side rooms: 8/11 SR occupied, 3 MRSA, 1 CPE and 4 cases confirmed C-19.

How do you find out what the situation is in the rest of the hospital?

Do you have a planed SITREP? Who is responsible for keeping, updating, handing over that information? Are you planning a control hub? Who is your bronze commander? Do all your staff know who and what their role is and how to contact?

***SpR back from holiday wants to know what the current PPE SOP is?**

Where is this information found? Is it readily available?
What is your PPE plan at present?
Where is your PPE kept? Who is responsible for ensuring adequate stock? How many do you need per day per patient? Do you lend out to other areas? What patient contacts require it?
Is this information clearly available on the ward? ASAT?

Do you have a system for alerting none clinical staff about possible infection risk? e.g. Meals/cleaners/members of the public or visitors.
Do you have methods to reduce staff exposure, minimise contacts where possible?
Does each patient have their own observation equipment? How is this cleaned?
Do we have a record of everyone fit tested? What do we do if there is a breach?

Are the answers to these questions available to all staff on all shifts?

Same doctor wants to know how we are testing and how long the results take?

How confident can we be in a negative test result if the patient remains symptomatic? At what point can we exclude COVID-19 and step down the patient from isolation? How might we find out this information?

If the AMU consultant refers patient P?

Will you accept this patient? If you do accept who arranges the patient transfer? Who transfers? Are porters trained in PPE? What is different about this transfer? Who else should be informed? Is there a system of alerts when moving COVID-19 positive patients around the hospital?

What is your current isolation plan in a patient with suspected or confirmed C-19?

What is your escalation plan in terms of bed capacity?
What is your escalation plan in terms of additional staff due to sickness or increased capacity?
Is there a hierarchy of infection risk? MRSA, CPE, COVID?
Is this information available to all staff on all shifts?

PHASE TWO:

A nurse comes to inform you that, PATIENT S, has deteriorated rapidly

PATIENT S

*** It is your clinical impression this patient is going to die. The patient has a very large family and the relatives are unhappy with the decision not to escalate. They think the diagnosis is wrong, a friend has told them this could be a PE and they want to know why he hasn't had a CT scan, how are you going to manage this situation? ***

Where are you going to speak to them? Are they an infection risk? Can they see their relative on the ward? What if they are dying/you plan to withdraw care? If so are we limiting numbers? Do you provide relatives with PPE? Do you separate 'healthy' relatives? How do you discourage large groups from aggregating on the ward/in the hospital? Do you have other methods of communication installed? Nominated relatives? Password protections?

Do you CT patients with confirmed or suspected COVID-19 if there is an indication? How do you rationalise? What is the procedure with a protected/unprotected airway? How do you protect staff including radiographers? Clean resources?

If ED telephones about a new patient

PATIENT J

If you accept the for NIV what is your procedure? Is there an SOP? How many people need to set it up with respect to PPE? How do you clean the device between patients? With respect to aerosol how long do you leave a previously occupied, 'infected' room before admitting a patient with suspected, not confirmed COVID-19?

If you run out of side rooms would you consider NIV on an open ward?
Are certain treatments higher risk? Is there a benefit to Physio ? Bird? Cough assist? Is there a policy or will this be decided on a patient by patient basis?

Is this information available to all staff at all times?

PHASE THREE:

***One of the junior doctors comes to tell you he doesn't feel very well, he feels very hot and has a sore throat ***

How do you manage your junior? Do you send them to ED? Are you testing health professionals?
How do you keep in contact during their isolation? Buddy system of check up on progress/health?

How are you going to care for the psychosocial impact of this crisis on your staff?

The emergency buzzer sounds as a patient with suspected COVID-19 has become unconscious in the side room, they have had a respiratory arrest, PATIENT L. What do you do?

Do you attempt resuscitation in a patient with COVID-19 and an unprotected airway? Has this been discussed with members on the crash team? How many people would be needed for CPR on a ward, and therefore how many PPE. Discuss with other teams.

AND FINALLY….. ASAT….. All Staff All Times

Great if you know all of the answers to the above. But does every member of your team?

How good are the lines of communication? Is the required information available to **ALL STAFF AT ALL TIMES?**

Discuss ways of clarifying, educating and informing and means of improving communication between all the members of your team.

END OF EXERCISE

PATIENT CARDS

PATIENT P

69 F Severe respiratory distress, febrile, bilateral inspiratory crackles.
BGN: IDDM, COPD (1 exacerbation requiring NIV in last year).

PATIENT S

74 M Confirmed COVID-19.
BGN: Prostate Ca. CKD Stage 4.
Severe respiratory distress. DNACPR in situ.

PATIENT J

68 M 3/7 dry cough, now febrile.
BGN: IDDM, cachectic, COPD (several exacerbations requiring hospital admissions with NIV).
Has expressed clear instructions that he does not want to be in-tubated.

PATIENT L

60 F Respiratory Distress, Confirmed COVID-19
BGN: IDDM, Smoker
On NIV

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