Bradford Teaching Hospitals
NHS Foundation Trust

Date: In the near future

PHASE ONE:

You arrive on the ward and are given an updated bed status

AMU BED STATUS CARD *(complete with your own hospital status)*

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e.g.
WARD 1
Beds: 10/14 occupied
Side rooms: 7/7 SR occupied including 3 MRSA + 1 CPE + and 3 suspected C-19, one has just been reviewed by critical care the second is pending critical care review.

WARD 4
Beds: 14/21 occupied
Side rooms: 3/3 Occupied

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

Who is your bronze commander? Do you have a planned SITREP? How does that work? Who is responsible for keeping, updating, handing over that information? Do you have a hub or control centre area? Do all your staff know this information and how to access it?

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?

Do you have a system for alerting none clinical staff about possible infection risk? What happens at meal times? Are there clear signs to protect 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? ASAT?

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 C-19 and step down the patient from isolation? How might we find out this information?

***What is your current isolation policy for patients with suspected or confirmed COVID-19?**

What is your escalation plan if you run out of side rooms? Who is responsible for this?
Is there a hierarchy of infection risk? MRSA, CPE, COVID? ASAT?

The Critical Care registrar is just leaving the ward and has gone to discuss PATIENT P with his consultant, but he doesn't think they will take the patient.

If critical care do not accept the patient consider other referral possibilities.

Refer as appropriate

Discuss the practicalities of transporting the patient with the accepting team. This patient has an unprotected airway, how do we protect staff and public? Do we clear corridors? Is there a more direct public free route to these areas? What is different about the transfer of this patient? Who else should be informed? Is there a system of alerts when moving COVID-19 positive patients around the hospital?

PHASE TWO:

The nurses alert the consultant that one of the patients is deteriorating and request a doctor review. They are isolated pending a COVID-19 test result. What is your management?

PATIENT B

Who is best placed to review to minimise contacts? Referral capacity?

What is your next step? Refer as appropriate

If critical care accept this patient who is responsible for transferring them? Have porters been trained in PPE? What mechanisms are in place to protect members of the public and staff on patient transfer?

PATIENT P has a very large family and they are extremely upset about the plan not to take their mum to ICU. They have a lot of questions including why she hasn't had CT scan yet. Where are you going to speak to them?

Are they an infection risk to members of the public/staff? Can they see their relative on the ward? What if they are dying/we plan to withdraw care? If so are we limiting numbers? How do we separate relatives/discourage large groups aggregating?

Do we CT patients with confirmed or suspected C-19 if there is an indication? How do we rationalise? What is the procedure for this? Is it different with a protected/unprotected airway? Protect staff including radiographers? Clean resources?

PHASE THREE:

One of the healthcares alerts you that PATIENT CJ has spiked a temperature, and their breathing now seems more laboured, she has been on the open ward since admission 6 hours ago. What do you do now?

If you were suspicious of a previously undetected C-19 how would you manage? Will we restrict visitors to other patients when a case of C-19 is on the ward? Is there a policy or is this reviewed on a case by case basis?

Do we have established testing/isolation criteria? Are these available and clear to all members of staff? Is there a referral system to escalate potential breaches in isolation? Failures of the system?

***Prior to her transfer to the respiratory unit Patient P arrests, she has not yet been made Not for resuscitation. Will your nursing staff start resuscitation? ***

Do you attempt resuscitation in a patient with C-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. Is there a hospital policy with respect to CPR in suspect/confirmed COVID-19?

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

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?

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 B

62 M Admitted overnight in respiratory distress query pneumonia, query COVID-19.
BGN: HTN and Raised cholesterol
Respiratory condition deteriorating, PR 138 despite multiple fluid bolus. Likely to need critical care within hours.

PATIENT P

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

PATIENT CJ

48 F Nursing home resident post traumatic brain injury 4 years ago, mobilises with zimmer, PEG fed as unsafe swallow. Admitted as less responsive, mild WCC, positive urine dip. Now febrile, PR 120, RR 30, quiet chest. Admission CXR poor quality film, nil obvious.

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 intubated.

PATIENT Q

86 F Nursing home resident with dementia (poor historian). Has care worker with her. Been off colour for a few days and is withdrawn. Afebrile but breathing laboured and bilateral crackles on examination. One of her relatives who visited last week has now self-isolated for suspected C-19.

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