Bradford Teaching Hospitals
NHS Foundation Trust

DATE: In the near future

PHASE ONE:

You arrive for work and are informed your current bed status is as follows

CARD ED BED STATUS (Insert realistic cases here with respect to your trust)

Majors:
84 F Fractured NOF
19 M Deliberate self harm
24 F Abdominal pain ? appendicitis
86 F Nursing home resident reduced responsiveness

Resus:
46 F Acute respiratory deterioration, Suspect C-19
34 F Asthma , acute exacerbation

You want to check they have isolated the patient appropriately in resus. Is there an SOP?

What is the SOP for isolation of a patient requiring in resus? What is your escalation plan if the number of suspect cases goes above your current capacity for isolation?

What is your current plan for patient isolation in ED majors? What is your escalation plan when the number of suspect C-19 patients goes above your current isolation capacity?

Will these plans be possible at 4 am?
Is this information clear and available to all staff at all times? What about new recruits or staff pulled from elsewhere to cover?

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

Who is your bronze commander? Do all your staff know and know how to contact? Do you have a planned daily SITREP? How does that work? Who is responsible for keeping, updating, handing over that information? Do you plan to have a control centre or hub? Who is responsible for setting this up and ensuring appropriate space/communication equipment?

A new SHO has started and wants to know what the current PPE SOP is?

What PPE are you using for your suspected COVID-19 patients? Where is it stored? Who is responsible for ensuring adequate stock on a daily basis? Have you made estimations of number needed per patient? Have you a system to monitor this as the situation progresses. Will you lend out to other areas? Who needs to wear it? Is this information clearly available on the ward?

*** What other systems are in place to reduce spread? Contamination?**

Do you have a system for alerting none clinical staff e.g. cleaners/members of the public/visitors to the possible infection risk? Are areas adequately labelled as 'NO GO'.
Do you have methods to reduce staff exposure, minimise contacts where possible? Are you fit testing? Do you have a record of everyone fit tested? What do you do if there is a breach?

How are areas and equipment cleaned between patients? How are you protecting your cleaning staff? Do they need additional training? Who would take responsibility for this? How long after a suspected case of COVID-19 in a bay/room before a new patient can be cared for their? What about the risk of aerosol duration?

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

Nurse interrupts handover to say the patient in resus is deteriorating rapidly and needs a clinical review

PATIENT A (details on card)

You contact ICU for assistance

***Where do you manage the airway of this patient?* Joint discussion with ICU**

How have you protected other patients? What is your minimal number of staff to reduce risk and required PPE removal/application/numbers? Staff in resus prior to and during intubation? Do you have an SOP for intubation in ED of a COVID-19 patient?

What happens to the airway equipment following intubation? Single use? Disposable? How is it cleaned? Who is responsible for cleaning it? Do you have adequate supplies if items have to go away for more thorough cleaning? Who is responsible for this?
How is the area cleaned?

*** How is the patient going to be transported to ICU?***

Who collects and transports patient? Are porters trained in PPE? Do we clear corridors? What about ventilators, do you disconnect and reconnect in ICU or keep on same ventilator and trade? Is this possible with the ventilators you have? Is there a designated route that is less risk to the public than others?

What do we do with equipment from ED when the patient has been deposited on ICU? Who is responsible for cleaning trollies, pumps , etc. Is this information available to all staff at all points?

PHASE TWO:

The ambulance alert you they are bringing in an acute exacerbation of COPD, possible C-19, where would you like them to come, the patient is unstable?

What is your procedure for ambulance delivery of C-19 patients? How can you minimise exposure to members of the public? Staff?

Patient arrives and is to a resus area

PATIENT J

Clinically you agree this could be COVID-19 on COPD, how do you manage?

(if wish to refer to critical care do so)

If critical care deem it is inappropriate/against patient wishes……

You feel the patients only possibility for survival would be NIV, how are you going to facilitate this?

Do you feel it is safe/appropriate to commence NIV in the ED? What if it was the only possible means of potentially saving the patient? What are the additional risks to NIV and how can we mitigate these? Is there a policy about use of NIV in ED for possible COVID? Is this information available to all staff at all times?

How many staff are needed to apply? How do you clean NIV devices between COVID patients? If you do use NIV do you have enough devices if they are removed from the unit for more aggressive decontamination or if they continue with the patient to their onward destination?

You consider appropriate imaging in this patient

How can you protect radiographers? Do you rationalise imaging in patients with suspected COVID-19?

What if the patient had needed a CT scan? How do you rationalise this? Is it on a case by case basis or do you have a guideline? Is this different for a protected/unprotected airway?

How do you clean imaging equipment? Who is leading this?

***If critical care decline patient, refer on as appropriate ***

Is the referral process the same during out of hours/at the weekend? If you have minimal respiratory beds remaining do you need explicit respiratory consultant acceptance for every bed?

Discuss practicalities of transport with accepting team. This patient has an unprotected airway, how do you protect staff and public? Does the patient wear a mask? Do you clear corridors? Is there a more direct public free route to these areas?

The large family of PATIENT A has arrived in the department. They are very upset. They want to talk to you and are demanding to see her . She has already been transferred to ICU. Where are you going to speak to them?

Are they an infection risk? Can they see their relative in the ED? Wards? ICU? What if they are dying/you plan to withdraw care? If so are you limiting numbers of visitors? How do you separate 'healthy' relatives to 'potentially exposed' relatives. How do you discourage large groups aggregating or do you forbid it and limit group size on site? How are you going to manage upset/distress? Do you have sufficient security on site?

PHASE THREE:

***One of the junior doctors comes to find you as he has just examined an 86 year old nursing home resident in the main area and he is concerned ***

PATIENT Q

How do you manage this patient? Do you now isolate? Are there strict testing/isolation criteria or is it decided on a case by case basis?

How do we test for COVID-19 safely, is there an SOP?
How long before the test result is known? How sensitive is a single test? At what point can we step patients down isolation? How would we find out this information?

If this patient was highly suspicious of COVID-19 with severe co-morbidities and from a nursing home how would you manage? Is the hospital responsible for accepting effectively palliative patients due to lack of PPE/isolation provision in nursing homes? Will clinicians need support with these increasingly difficult questions?

Where are you going to refer patient Q?

Refer as appropriate

What information do you give the care worker who has been sat with the patient all morning? Whose responsibility is it to report a case of COVID-19? Is this different if it's 'suspected' rather than 'confirmed'?

***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 check them in to ED in order to test? Are you testing health professionals in the hospital or must he registrar as a patient? 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 buzzer goes in resus and PATIENT J has arrested, he has not yet been made DNACPR

Will the nurses commence CPR as they pull the crash buzzer? What is your management of an arrest in a COVID-19 patient in the emergency department or on transfer to a ward? Do you undertake CPR? Does it make a difference if they are already intubated? Do you intubate during an arrest? Is there an SOP? Is this information available for all staff at all times?

How many people/sets of PPE would be needed for CPR? Are these immediately available? Discuss with other teams.

If the ambulance brought in a patient, dead on arrival, cause of death unknown does the possibility of C-19 in the community change our management in the ED? Mortuary?

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 in your department? 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.

PATIENT CARDS

PATIENT A

46 F Respiratory distress
BGN: Smoker, Care worker
Febrile, P 138, RR 40, bilateral inspiratory crackles. On high flow oxygen and tiring.
Clinically needs intubation.

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 COVID-19.

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