

Receiving a suspected COVID-19 patient

Simulation as OBA (SUS)

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Background

Due to the pandemic, the CDU (clinical decisions unit) "OBA" at Stavanger University Hospital must be converted to an emergency room for receiving patients with airway symptoms. As per 12th March, all patients with coughs or similar must be treated as Covid-19 cases until a negative test case are admitted to OBA. Nurses at OBA were not familiar with the procedure for receiving patients. Need for training to receive patients was therefore necessary, as well as training on the procedure for receiving actual Covid-19 patients, or suspected ones.

Brief

We are here to learn together. This is not a test, simply a training session so that we can all take part in protecting the weakest in our society.

Learning goals

Receiving a suspected Covid-19 patient in accordance with procedure, with main emphasis on:

- Using ABCDE examination methodology
- Maintain correct protective measure in accordance with appropriate procedures

Group information and demonstration of protective equipment

HAND HYGIENE

First and foremost hand disinfection. In the case of visibly dirty hands, after using the toilet or before handling food, perform appropriate washing of the hands applies. Follow the hand disinfectant routine which is posted in your ward. Remember the tips of your fingers, thumbs and wrists. Infection prevention staff have observed a lot of poor practice here. You MUST spend 20-30 seconds working in hand disinfectant. Your hands should be dry by the time you finish.

Previous tests: Hospital staff spend on average 9 seconds working in hand disinfectant. Not good enough!

PUTTING ON PROTECTIVE EQUIPMENT

Put on a clean gown. Fasten at the back, so that the "dirty" side is in front and the "clean" side is behind. Do your best to have the front facing the patient at all times while keeping the back as clean as possible.

Gloves: Remember that gloves must be put on over the outside of the gown's sleeve (just as you put gloves over the jacket sleeves of small children).

Face mask. The darkest side out. Apply as securely as possible so as to avoid touching your face when in the vicinity of the patient.

Eye protection gear donned.

At this stage, everything is clean, so it doesn't matter which order you put the equipment on.

NB 1: If you come into contact with something unsterile in the emergency room (e.g. urine bag), remove your gloves. Carry out hand hygiene. Put on new gloves! The patient deserves to be handled with clean hands.

NB 2: Try to minimise the number of gowns by planning well before going in and out (so that you don't have to use a new gown simply for taking in a glass of water).

NB 3: Use the «assistance button». DO NOT touch the door to pass on a message!

NB 4: DO NOT touch your face, ears etc, with dirty hands!

NB 5: Hold your hands together when not in use so you don't touch surfaces you shouldn't!

REMOVING PROTECTIVE CLOTHING:

- Start by removing your gown
If single-use, pull it off, holding it away from the body, fold inwards so that the clean side faces outwards. Pull off the gown down to the gloves, removing the gloves in the same movement. Roll the gown up. Ensure that the clean side faces outwards the whole time. Dispose of in the bin.
- HAND HYGIENE
- Remove glasses (grab only behind the ear. Place in own container that can be found in each room.
- HAND HYGIENE
- Remove face mask (grab only behind the ear)
- HAND HYGIENE
- Go out of the room
- HAND HYGIENE

Infection prevention personnel evaluate from department to department and on a daily basis if gowns should be re-used or not. Primarily, gowns should be single-use only at OBA. Infection prevention can re-evaluate and updated instructions can come at short notice. Be aware that if a gown is re-used, other routines for its removal apply. (Remove gloves. Carry out hand hygiene. Remove gown. Hang on a hook with the dirty side facing outwards into the room.

ABCDE methodology

Short «just in time training» on ABCDE methodology. Systematic method for examining the patient. Check that participants are aware! Mention also the SATS (South African Triage System) form that is used in emergency reception.

Scenario

We used standardized patients. Remember: do not expose the stand-in more than necessary (ensure dignity). Do not penetrate the skin with needles. Do not perform swallowing or nasopharynx testing.

Take vital signs readings on the patient. We will adjust if necessary.

Lessons learned from previous groups: Take all tests immediately (nasopharynx, swallowing tests, blood tests and arterial blood gas(ABG)) so you don't have to go out of the room several times. Prioritise so that ABG isn't delayed and ruined. This part must be done last. Remember to have a person outside the room to receive the tests (place them in the "kidney dish" with an antibacterial serviette so that the receiver can quickly clean/wipe it with appropriate disinfectant, and deliver it)

PATIENT DESCRIPTION

45-year-old female. Been on holiday. Now at home. Breathing heavily and feverish. Called her GP. GP referred her to the hospital, based on the phone conversation. Her husband drives her in and we are to receive her.

PRIMARY INDICATORS:

- A: Free airways, conscious
- B: SpO2 93% RF 28
- C: P84 BT 106/60
- D: GCS 15; Temp 39,2
- E: No rash, petechiae, etc.

DEBRIEF/TALK:

ABCDE – discuss how this was done.

Infection prevention – was this maintained or not? Feedback and solutions to discussed.

Learning points from the simulation – take home for the next real patient!

Remember: Patients are very frightened, need information and someone who can reassure them. Explain why we're doing what we're doing, especially with regard to protective equipment. Also explain what will happen to the patient. The patient must receive EQUALLY good treatment as those who are not isolated, but unnecessary examinations need not be carried out.