QNFMHS Webinar: Keeping services safe during COVID19, 7 May 2020

Questions and answers

How are you planning to reintroduce Section 17 leave for patients?
This has been an ambiguous phase as there is not necessarily a right way to do it. What we have acknowledged as a service is there is a potential wrong way to do it, which is to open the doors completely in one go. We think there are different right ways to consider and it should be done in a risk-balanced approach. We will be doing this in a graded phase, we will introduce patients across wards and facilitate group leave on the site itself. Then we will introduce ward by ward into local community leave to assess the impact, that will have to be associated with tests.

How are you managing PPE and face masks who might have past trauma who find this extremely distressing?
We did not do everything overnight. We discussed with patients during forums to offer them an opportunity to discuss this with them and we talked about what we look like before the mask goes on and with the mask on, how difficult it is and why we were doing it. We clearly highlighted that this is something that we are trying to protect them, rather than necessarily protecting ourselves as service providers. There were some anxieties both from staff and patients. For anyone that has not worn these marks, they are very uncomfortable. Initially, there were more anxieties but over time there have not been as many or any significant concerns by patients or staff over this period of time. We have proactively managed it. We have had a lot of time talking to patients about it during our forums, patients are very grateful that we are taking responsibility for not bringing COVID into the unit. The patients are acutely aware of the discomfort that we experience and worry about us. The trickiest thing is trying to diffuse difficult situations using facial expressions and patients are only able to see the eyes which can be challenging.

When did staff start wearing masks and patients offered them?
Patients are not offered them currently, it is to prevent the transmission of COVID from staff to patients, not from patients to staff.

From a DBS inpatient service: how are groups managed in other areas?
We got it wrong to start with. Initially, we were trying to reduce footfall and reduce groups as such. We have not had any positive COVID signs, so we reintroduced groups with social distancing measures. We are very fortunate, especially in medium secure service which is relatively newbuild which provides a lot of space to facilitate these groups. The feedback has been very positive. Our patients have been involved in the virtual world, for example we had our first patient council across the site virtually from all the wards. This was very positive and the patients co-chairing said it was very useful. It was also the best attended patient forum.

How do your reflective meetings take place while maintaining social distancing?
On each of our wards we have a large meeting room. every room where people can congregate we have a maximum number of people we can allow in estimated from social distancing. The big meeting rooms have a maximum of 7 people, there is also Skype set up with people who join virtually. We aim to get as many people as possible in the reflective meetings. The wards and the MDT all help each other to free up as many people as possible to get to those meetings as they are a primary importance for those working on the shop floor. We recognise that not every unit is going to have that space, but it is really recognising the importance and principles of those meetings and whatever you have to do and be creative to create that space and make it happen as it is really valuable.

How have you altered how you manage seclusion reviews and are you using remote reviews?
Amending our procedures with a view to reducing cross-transmission via remote reviews. We incorporated this in principle but not had to apply it. Seclusion reviews are still being done in person as things stand. We have an amended policy that allows for remote reviews to allow this. If a shielded staff member was on call, they would have a consultant buddy. If a seclusion review was necessary that night, the buddy would be able to come onto sight if necessary. We recognise that this is a difficult situation for all of us including consultants, the buddying system is a good system for when we are on call.

How are you managing violent incidents in terms of restraint?
There has been no change of practice. All staff are wearing masks, but there are no other differences at this time.

What is it that staff are doing differently outside of the hospital environment to not have contracted the virus?
People have taken this very seriously, the team go home and don't go out, they are good at sticking to government guidelines. Staff take advantage of the special NHS time to go shopping which is not busy, the team have been very lucky considering it is a less populated area of the country. The advantage is having the space, therefore no need for public transport as most staff drive to work. Practical challenges that are applicable elsewhere in the country do not apply out here.

What are your thoughts about the particular risks to BAME staff and patients?
The Trust organised a BAME event, there is already a BAME forum and the event took place further to the government statement in regards to recognising the risks for BAME staff. Further risk assessment and screening has sent out to identify particular concerns to that staff group, identifying with managers how their risk can be reduced to them as individuals whilst being allowed to support them in working whether on site, on the shop floor or at home. Each person is being dealt with as an individual rather than as a group.