CHIEF PSYCHIATRIST
of Western Australia

23 March 2022

Chief Psychiatrist's Community of Practice
Inpatient Care in COVID-19

Welcome

This is the first session. A summary will be circulated for review by attendees, then made available on the website of the Office of the Chief Psychiatrist (OCP). Please share the summary with colleagues who are interested in this topic.

Session Facilitator | Emma Blackman, Principal Officer, Reviews, Office of the Chief Psychiatrist

Introduction to Community of Practice

Thank you to all who attended. The OCP is invested in maintaining high standards of care. The Community of Practice offers opportunities to share learning, ideas and best practice with colleagues who are facing similar challenges, using a quality improvement (QI) approach.

Dr Emma Crampin, Deputy Chief Psychiatrist

Presentation – Key Messages

- The picture changed so much during the last two years, each planned procedure that was put in place was often changed and/or updated as the situation changed. The changes caused a lot of anxiety.
- None of our facilities were built with infection control for a pandemic in mind. Preparing the facility to cope with mental health consumers who were COVID-19 positive is a challenge.
- We set up a COVID-19 Red Zone; to do this we had to think about how consumers and staff move, donning and doffing areas, relationship with the rest of the hospital, air conditioning.
- There is a lot of demand on our beds and taking beds out of the system creates pressure, so we have come under pressure to use the beds if we have no COVID-19 positive consumers, but then if someone comes in with COVID-19, we would have to move the other people to a different location.
- We had to re-think how we managed agitation because it took staff time to don Personal Protective Equipment (PPE) and so our threshold for calling a 'Code Black' has to be lower.
- It's difficult when consumers refuse to be tested. We have found it ethically challenging to decide on the best location for them- we don't want to put them in the ward with people who have COVID-19 when we don't know if they have it.
- Communication has been really important, we have morning huddles to make sure staff have current information, but it can change hourly, and we have to work around the confusion that causes.
- It's important to support staff to work differently.
- The amount that the staff went above and beyond the call of duty remains humbling.
- Consumer advisory groups have been very supportive of the processes in place.
- Consumers have been very accepting of restrictions with regards to leave

Stephen Batson, Acting Service Director, Rockingham Peel Group Mental Health

Questions

- How often do you perform Rapid Antigen Tests (RAT)? We offer them every three days.
- What happens if there are more people with COVID-19 than beds available in the "Red Zone"? We can transfer people to Fiona Stanley Hospital.

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General Discussion

Testing when people return from leave

- The System Alert and Response (SAR) currently says "*All patients who last presented, or went on leave **more than** 12 hours ago to be screened for clinical and/or epidemiological risk factors AND have a RAT. All patients who last presented, or went on **leave less** than 12 hours ago to be screened for clinical and/or epidemiological risk factors. RAT if indicated.*"
- One service said they were carrying out the test 48 hours after the person returned, others on the day
- Another service said their voluntary consumers are not taking leave from the ward; with their consent. The consumers know the boundaries and have been happy to abide by them.
- Another service is asking staff to weigh up the need for leave and maintain least restrictive practices.

What do you do if a consumer becomes positive while in hospital?

- It depends on the circumstances .
- Staff are reluctant to make consumers undergo unnecessary testing.
- However often wards have had to test all the other consumers with RATs.
- Think about how much interaction the person has had with others and what is the level of risk, for example, if they have had their own room and have stayed in their room, the risk to others is lower. It's important to involve Infection Control when assessing that risk.
- Noted that in other jurisdictions it is common to test everyone if one person tests positive.
- The experience from nursing homes is that if you test widely, you are likely to find more people who test positive, so there is a risk associated with limited testing, but each scenario is different.
- Anyone who is anxious or worried should be offered a RAT, even if not a close contact.

What do you do if a consumer does not want to wear a mask while in hospital?

- Talk to the person about what they will accept and look for the least restrictive option, for example, they may agree to undertake a daily RAT.
- Involve Infection Control to help you assess the risk.

Is ECT scheduling being affected by staffing or bed pressures?

- Currently no, though it was noted that it easily could be.
- One service reported that currently ECT is not being performed on people who are COVID-19 positive; they are being looked after until they are well enough and not an infection risk.
- ECT scheduling could be a topic for a future session.

Thank you to everyone who attended this session.

For more info about these sessions visit
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