Healthcare Resource Management and Pandemic Preparedness for COVID-19: A Single Centre Experience From Jodhpur, India

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The institute formed a COVID-19 pandemic preparedness core-committee comprising of representatives from all departments and the administration to plan and execute activities of patient-care, infection-prevention, pharmacy, laboratory, security, engineering, maintenance, waste-management. A nodal officer was nominated to liaise with government administrative authorities.

The hospital was divided into 5 zones: COVID-19 Screening desk (Triage zone), Wards for COVID-19 suspected patients, Wards for COVID-19 stable patients, COVID-19 Critical care units (CCCU) and Emergency services for non-COVID-19 patients (Figure 1). All COVID-19 designated areas had specific rooms for donning and doffing of personal protective equipment (PPE). We suspended elective surgeries and routine outpatient services. Beds allocated for COVID-19 were 410 including 100 critical care beds.

Workflows were managed by a single-point hospital entry. A triple check system with: flu-help desk, COVID-19 screening desk followed by emergency physician evaluation was arranged. Patients were given surgical masks and educated about preventive measures. Separate areas for COVID-19 suspected patients requiring surgical or obstetrics care were designated. Pathways from screening desk to COVID-19 zones were marked with yellow lines and a separate lift was assigned for transportation of patients. A hospital attendant with designated trolley in PPE transferred patients (Figure 2).

Deployment of residents and nursing personnel was planned in groups according to core speciality and capability at various working zones. We describe the plans for resident doctor deployment. Similar plans were made for other HCWs. Each day was divided in three shifts of 8 hours. Those working in COVID-19 zones are provided with separate facilities for stay and food at hospital campus during duty days to avoid mingling with other HCWs.

We constituted teams comprising of junior residents (postgraduate trainees) and senior residents (Post M.D.) according to working zones (Table). For example, residents from clinical departments with critical-care experience are posted in CCCU while non-clinical residents are posted at screening desk and stable COVID-19 zones (Table). A 9 days duty-cycle was assigned to residents in CCCU and 15 days
duty cycle in other COVID-19 wards followed by 14 days quarantine. Surge plans were prepared for activating multiple wards/teams simultaneously in case of exponential patient admission. These plans were communicated in advance to the duty residents and their departments to allow flexibility (Figure 2). Teams were serially activated as and when patients were admitted to the COVID-19 wards.

All HCWs were trained in 3 modules - standard operating procedures with transfer protocols, infection control measures including PPE donning-doffing and endotracheal intubation/mechanical ventilator management. In these sessions, patient communication was also emphasized. A module for psychosocial wellbeing of HCWs was arranged.

Infection control measures included greeting with folded hands rather than handshakes, termed as “NAMASTE” campaign and social distancing. Donning/Doffing areas and patient movement paths were marked within COVID-19 zones. Negative pressure for COVID-19 wards was created on temporary basis. Teleconferencing facilities were installed for communication with stable patients to reduce HCW exposure time. Reusable PPEs designed in collaboration with Indian Institute of Technology, Jodhpur, ensured sufficient availability.

As on June 7, 2020, we have managed 856 COVID-19 suspect, 280 COVID-19 positive patients with two deaths. All HCWs including 452 resident-doctors, 176 faculties and 900 nursing and allied staff have successfully completed the training. As on date, we have only three cases of infection in HCWs who were isolated early, preventing further spread. All contacts of these HCW were line-listed and tested, none of
whom came positive implying that strict infection control and training measures are useful.

Strengths of our plan include the early actions we have initiated compared to national pandemic response as illustrated in Figure 2. However, still in the early days of pandemic, our experience so far suggests that careful planning maybe the key to weather the crisis.

Acknowledgements
We thank Dr. Shashikant Saini, intern, Department of Internal Medicine for his help with the figure illustrations.

Ethical issues
Not applicable.

Competing interests
Authors declare that they have no competing interests.

Authors’ contributions
SK, NM, DK, GKB wrote the first draft of the manuscript. MG, BK, and VS were involved in editing and revision of the draft. GKB and DK are in-charge of screening desk and triage. DK, SH, and MG are involved actively in providing clinical care to COVID-19 patients. MKG has provided overall guidance for clinical care as well as pandemic preparedness.

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