

When a sprint becomes a marathon

Dr Sally Archer and Claire Twinn on the race to build and sustain the COVID-19 response at Guy's and St Thomas' NHS Foundation Trust

ILLUSTRATIONS BY Louise French

It seems like a lifetime ago that our trust put out a statement on its social media platforms that it was treating its first patient with coronavirus. It reassured the public that all of our services remained open as usual. That was on

6 February, and, since then, the hospital and our ways of working have changed almost beyond recognition.

We work at Guy's and St Thomas' NHS Foundation Trust in central London; at the time of writing (early April), London reportedly has almost double the number of cases of COVID-19 than any other part of the UK, and our local boroughs of Lambeth and Southwark have been hit hard (www.gov.uk). Having been an early high consequence infectious disease centre (HCID) with a large critical care department, it is unsurprising that the number of patients with the virus at our trust has increased rapidly.

Now, at the end of a week in which we have reached a milestone at St Thomas', where all of our adult inpatient referrals to SLT were COVID-19-positive or suspected of being so, we have taken stock of how far we have come and what it has taken to get here.

Moving mountains

The trust has moved mountains to increase capacity and meet the challenge presented by coronavirus; the speech and language therapy department has been working flat out on this cause, too. Our outpatient services, as well as voice, cancer and general, have completely transformed—an enormous piece of work involving careful clinical triaging and the development of robust systems and risk assessments to ensure that all patients are accounted for and managed safely.

All outpatient appointments in the voice service, and the majority of our cancer and general outpatient services, have been converted to either telephone

or virtual appointments using specific online software. This is a completely new way of working and not without its challenges, both technical and clinical; it has taken a huge amount of work to implement this change so quickly and efficiently. Partnerships between clinical and administrative staff have been key, with the admin team being integral to ensure the correct coding of appointments, as well as dealing with huge volumes of telephone queries from patients.

Our inpatient service has been subject to significant change on a daily, if not hourly, basis. Not only have we seen many new wards opening, we have also seen a dramatic increase in the number of critical care beds, with plans for more discussed daily. Patients with COVID-19 or suspected COVID-19 are being cohorted within dedicated wards and we have had to flex our usual speech and language therapy ward allocation accordingly. This means a





“PPE takes its toll. Wearing it is exhausting...”

significant change for all therapists, with many working in unfamiliar areas as a result.

Our trust has been very efficient and thorough in issuing guidance on personal protective equipment (PPE) and has produced action cards and online training videos to support staff. The infection control team, which has been working flat out, has still made time to respond to our many queries. This has been hugely helpful but still challenges have been encountered, eg when there was a mismatch between

advice provided by the RCSLT and our trust guidance on what constituted an aerosol generating procedure (AGP). SLTs would arrive on a ward to conduct a clinical swallowing assessment and request respirator masks to protect us from AGP, to the confusion of our multidisciplinary team (MDT) colleagues who are working long shifts, including feeding patients who were coughing, while wearing surgical masks. Collaboration with our infection control team has removed this mismatch leading to an update in trust

guidelines in line with RCSLT advice (see: bit.ly/RCSLTCovidGuidance), but building close working relationships with ward staff has still been central to avoid resistance in response to our requests.

Keeping on top of the changes in guidelines and the availability of types of PPE has been a daily task and a source of anxiety in the team. Having weekly huddles to openly discuss our worries, review the guidelines and videos, and practise ‘donning and doffing’ has helped. Having a named infection control SLT who is a local point of contact, providing expertise and a link between us and the infection control team, has also been invaluable.

An emerging challenge with PPE is the effects of wearing it for several hours in a row as patients with COVID-19 are cohorted; masks, visors and ‘base layer’ PPE do not necessarily need to be changed between patients.

PPE takes its toll. Wearing it is exhausting—you overheat and your face →

“Conducting assessments behind a mask, when the only facial expression is what you can convey with your eyes, is a challenge”



gets damp (at best) and at worst, very sore. We have been thinking about how to introduce more breaks and fresh air into our working pattern as a result, and accept that it may be difficult to see the numbers of patients in a session we normally would.

All hands on deck

None of the adult acute speech and language therapy team has been redeployed due to the ongoing demands on our service from the COVID-19 response. However, our adult service has been a hive of activity as teams prepare to deliver training that enables staff to transition into different clinical areas as and when the need arises (we are training our colleagues in the voice, cleft, and paediatric acute teams to enable them to join us in the adult acute team, as needed). We are excited about the cross-pollination of expertise that will no doubt arise from this and have also trained up a large proportion of acute SLTs to join our well-established critical care team to meet the increased need there. Staff who were seconded to research fellowships have rejoined the clinical fold, so it is all hands on deck.

For the first time in our trust's history we are offering a seven-day and bank holiday service. This has been set up within a fortnight's notice and is from our existing resource on an overtime model. The success of this is based on the dedication and team spirit of the therapists themselves, and its announcement was met with a round of applause from the wider critical care MDT.

The way we receive referrals has had to change. We normally receive them centrally when the MDT make a request through our electronic patient record system. However, the profile of staff covering all of the new wards has changed dramatically, with new 'surge' team members supporting existing staff, and MDT colleagues are so busy that

it is unrealistic to expect this to continue without referrals being missed. We have therefore increased our presence at board rounds and hand-over meetings, while linking in more closely with AHP colleagues to ensure we find out about patients in a timely fashion so that we can assist with safe and effective patient management and flow.

Learning and adapting

In terms of how we actually manage our inpatients, we are learning and adapting here too. Conducting assessments behind a mask, when the only facial expression is what you can convey with your eyes, is a challenge. We are noticing increased delirium, which could be for a number of reasons and needs careful management, not helped by a lack of loved ones visiting and patients being greeted by a sea of unrecognisable 'bots' in PPE.

Videofluoroscopy and fiberoptic endoscopic evaluation of swallowing (FEES) are normally integral to our routine management of dysphagia, with FEES playing a particularly crucial role in critical care. However, with the increased risks associated with the procedures, they are not currently in our toolkit, so we've had to be even more focused in our clinical assessments. We are also seeing patients in critical care who have had multiple intubations, with the likely associated damage this causes, and are working hard to create a risk assessment and protocol to enable us to safely restart our FEES service when appropriate. The next stage in the management of this virus will be the huge rehabilitation needs these patients will have—it feels like we're seeing the tsunami on the horizon, and the speech and language therapy team will need to be ready and adequately resourced to meet this demand.

A final but vital observation has been the importance of needing to look after ourselves through these strange and unprecedented

times. As a team, we have identified that the current lockdown and the relentless focus on coronavirus across the media and social media—as well as our own immersion in it at work—makes it very difficult to give ourselves headspace. We see patients with the virus with whom we resonate, and the relentless flow of cases takes its toll. There is a quote by the author Dr Rachel Remen that sums this up: “The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.”

We are very lucky in our trust as there are many systems of support available, including new wellbeing zones and access to psychological support. In the immediate team, we have agreed to have a set 'wellbeing hour' each week in which we can do whatever we need to refresh mentally (without alcohol, obviously!). We have frequent check-ins with each other, as well as team huddles. We take regular breaks too and focus on 'parking' the day before going home via an end-of-day debrief with a buddy, and going through a 'going home checklist'.

At a time when our social lives are restricted by coronavirus, our work family has become an even more important source of support. These strategies are essential as we need to focus on our own mental and physical health in order for us to last the distance of COVID-19. There is no doubt that our response to this virus is going to be a marathon, not a sprint, but it has required a sprint start to get us on track. ■

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