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| **Hwamei Hospital, Ningbo, China – frontline advice/experience**  **108 severe cases – no doctors infected** |
| Mistakes learnt:  Preparedness did not register |
| Staff preparedness   1. Risk assessment before frontline work (related to morbidity) 2. Rigorous PPE training and competence assessment before frontline work 3. Roving monitors - continual review and audit of adherence with PPE |
| PPE – 3 categories employed   1. Cap, face shield, goggles, FFP3 or N95 mask, gloves, shoe covers and waterproof gowns (e.g. manning fever clinics) 2. As for Cat. 1 but switch to full body gowns (e.g. if caring for covid patients) 3. As for Cat. 2 but switch to extraction hood/tornado powered respirator (e.g. if bronching) |
| Infection control   1. screen all inpatients and visitors (limit visitors) 2. screen all outpatients (Ab test and RT PCR) 3. Face mask for all staff (high risk of asymptomatic spread) – deescalate 28d post last zero case |
| Staff working   1. 4-6h shifts ideally in isolation areas 2. Separate accommodation for doctors (secondary isolation) 3. Mandatory 7-14day isolation after working with covid cases 4. Covid testing (RT PCR +/- CT and AB testing) prior to return to routine ward work |
| Anti-infectives/anti-inflammatory Tx (for all, including mild cases)   1. Hydroxychloroquine 2. Umifenovir 3. Moxifloxacin (bacterial superinfection) 4. Kaletra – not well tolerated |
| Respiratory care   1. Hydrogen + oxygen (↓ pulmonary resistance) 2. NAC for BAL (excessive MP) 3. Early NIV intervention better |
| Prognostic markers   1. Neutrophil count 2. Viral load 3. CRP 4. CT |