CLINICAL REFLECTION

COVID-19 triage in general adult in-patient psychiatry: perspectives from clinicians on a novel triage ward during the pandemic

Ryan Williams, Joanna Cranshaw & Mariana Pinto da Costa

SUMMARY

Intra-hospital transmission of COVID-19 is a major concern. To mitigate this risk, 'COVID-triage' psychiatric wards were implemented by some in-patient service providers in the UK. Although the effectiveness of this model has not been investigated, there are questions about the benefits and detriments of this model of care for patients and staff. This reflection draws from the experiences of clinicians who were redeployed from their planned clinical posts (and training rotations, in the case of trainees) to staff a newly established COVID-triage ward at a large urban mental healthcare provider, between August 2020 and March 2021.

KEYWORDS

COVID-19; triage; in-patient treatment; infection control; reflection.

In August 2020, there were around 1000 new cases of COVID-19 recorded in the UK per day (Public Health England 2020). Vaccines were still an uncertain prospect – the fastest any vaccine had previously been developed, from viral sampling to approval, was 4 years. Nevertheless, considerable resources had been allocated to this task, and there was a public spirit of optimism. The restrictions of the first lockdown had just been significantly relaxed.

The following months saw the arrival of the 'second wave' of infection and the second and third lockdowns, rapidly followed by the introduction of the government's 'tiered' restrictions in the wake of concerns about rapid spread of the new variant, VUI 202012/01. In January 2021, the death toll passed 100 000. One week later, Captain Sir Tom Moore, who had raised more than £32 million for the National Health Service (NHS) by walking 100 laps of his garden before his 100th birthday, died after testing positive for COVID-19.

On a more positive note – these months also saw the initial stages of one of the largest ever public health initiatives, beginning on 8 December 2020, when Ms Margaret Keenan became the first patient in the world to receive the Pfizer-BioNTech vaccination.

Against this backdrop, psychiatric services in the UK were seeking solutions to prevent the spread of COVID-19. The 'COVID-triage' wards were one such initiative, implemented at South London and Maudsley NHS Foundation Trust (SLaM) – as well as other locations in the UK and internationally (Brody 2020; Chen 2020; Knowles 2020). A more detailed account of the model of care employed by SLaM has been published elsewhere (Williams 2021). In short, in-patient services were reorganised so that all patients in the trust requiring in-patient general psychiatric treatment were admitted initially to one of two wards (for men and women respectively).

On these COVID-triage wards, patients were required either to test negative for COVID-19 or to complete a 14-day isolation period without exhibiting symptoms of COVID-19 (if they declined to be tested). Once established as 'COVID-negative' by one of these two methods, patients were transferred on to other wards for ongoing assessment and psychiatric treatment. Patients were expected to adhere to infection control measures, to prevent established COVID-negative patients from significant exposure to newly arriving patients who were not yet confirmed as COVID-negative.

Clinician experiences

Channelling all admissions from a catchment population of 1.2 million people into two wards posed significant challenges. Although triage wards are not a new concept (Inglis 2005), established examples generally receive admissions from one specific hospital or borough, rather than the nine boroughs provided for in this case.

Ryan Williams is a psychiatry specialty registrar at South London and Maudsley NHS Trust and an honorary Clinical Research Fellow in the Department of Brain Sciences, Imperial College London, UK. **Joanna Cranshaw** is a psychiatry core trainee at South London and Maudsley NHS Trust, London, UK. **Mariana Pinto da Costa** is a consultant psychiatrist at South London and Maudsley NHS Trust and a senior lecturer in the Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK. **Correspondence** Ryan Williams. Email: ryan.williams2@nhs.net

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Inevitably, patient turnover was extremely high, with 3–7 new admissions arriving per day on each ward. As the vast majority of these patients had presented acutely and were yet to receive treatment, the triage wards continually contained many of the most unwell people in the trust. Incidents involving disruptive and aggressive behaviour were frequent, and the resulting environment was often difficult for clinical staff to manage effectively.

Clinicians raised concerns about the high number of patients with significant, unpredictable needs – highlighting low staffing levels relative to the workload, and warning of potential emotional implications for patients and staff on the wards. Nursing colleagues struggled with the high turnover of seriously unwell patients, many requiring enhanced observations (1:1 or 2:1). It was not infrequent for patients admitted voluntarily to request to self-discharge shortly after arriving on the wards. Questions were raised about whether such wards presented an appropriate, safe and therapeutic environment for patients.

Although patients were transferred back to local facilities after being established COVID-negative, the initial stages of treatment began on the triage wards – resulting in the same difficulties as any out-of-area placement. Patients were distanced from their local area and support networks – including families and community services, who often struggled to provide direct input.

In addition, if in-patients on other wards were felt to have been exposed to a significant risk of contracting COVID-19 (e.g. if they had not adhered to leave arrangements and remained in the community, in contact with the public, for an extended period before returning to hospital) they were transferred back to the COVID-triage ward for re-screening before returning to their 'home' ward. In practice, this often led to disrupted admissions, with patients passing back through the triage wards several times.

For trainees on the wards, although they offered a wealth of exposure to the acute aspects of psychiatric treatment, opportunities for involvement in longer-term care were absent. Trainees who were new to psychiatry commented that they were not seeing any patients recover.

The infection control procedures on the triage wards posed additional challenges for therapeutic engagement with patients. To prevent patients from exposure to the public before their transfer onwards (which would have effectively negated the main purpose of the wards), patients were asked to stay on the ward at all times. For in-patients who were detained under the Mental Health Act, this meant that 'leave' was only granted in exceptional circumstances. Voluntary in-patients, meanwhile, clearly could not be prevented from leaving the ward if they requested this. However, they were informed that this would be documented as failure to adhere to the conditions of their voluntary admission and treated as per any other violation of ward rules.

Although this measure was unavoidable if the COVID-triage wards were to function effectively, some patients viewed this as a further restriction of their liberties. This may have contributed to increased tension and difficulties establishing therapeutic alliance with treating clinicians.

Unfortunately, despite these additional restrictions, the efficacy of the triage wards as a method of reducing intra-hospital transmission was questioned. At their inception, it was anticipated that patients would spend 48 h on the triage ward before being established as COVID-negative and transferred. However, bed pressure in the trust soon meant that patients were spending longer on the wards – up to 2 weeks, even following a negative test. During this time, patient adherence to infection control measures in place on the ward was poor (Williams 2021).

As a result, it was frequently the case that patients who were established COVID-negative were exposed to other new admissions from the community who had not yet been tested (or refused to be tested) prior to being transferred on to other wards. Therefore, it became possible that at the time of transfer onwards, a patient may have contracted COVID-19 on the triage ward (since testing negative).

Ultimately, it is not clear whether the COVID-triage wards were effective at preventing intra-hospital transmission despite this limitation. During the period covered by this reflection, there were outbreaks of COVID-19 on almost every ward throughout the trust except for the COVID-triage wards. This indicates that there may have been some benefit to the more stringent leave arrangements on the triage wards, or possibly that staff in these settings took more precautions against infection (disinfecting hands and surfaces, wearing face coverings, social distancing).

Regardless, it does not appear that any reduced risk of COVID-19 outbreak was sustained when patients were transferred to other wards, where leave arrangements were necessarily relaxed. Although possibly there might have been additional outbreaks if COVID-triage wards had not been used, whether this outweighs the drawbacks presented by these challenging environments remains open to debate. Alternative arrangements, such as requiring all wards to implement a period of isolation for any new admissions (e.g. until a negative test was obtained, or 14 days without displaying symptoms of COVID-19) may not have substantially increased

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the risk of intra-hospital transmission, while avoiding the organisational challenges posed by implementing COVID-triage wards. However, some in-patient wards lacked en-suite bathroom facilities, and these alternative arrangements were not always possible.

Conclusions

As implemented, there were significant drawbacks to the COVID-triage model – directing all new admissions in a large catchment area to a small number of wards necessitated very rapid turnover of patients, many of whom were extremely unwell. These wards were challenging to manage.

It is possible that these drawbacks outweighed the benefits of this model of care. However, should it become necessary to implement similar wards, we would suggest consideration be given to infection control procedures to minimise the risk of established COVID-negative patients being exposed to other patients and the general public. In addition, services should be aware of the considerable resources required to safely manage such high-acuity environments, in order to prioritise the safety and well-being of patients and staff.

Supplementary material

Supplementary material is available online at https://doi.org/10.1192/bja.2021.73.

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