F: Ok, so the first thing is we just want to know if you can explain to me your position and responsibilities at the hospital.

**R: So, I am a nurse. Uhh, so we usually help patients with different problems, yeah, including the COVID-19 patients, are the ones we are helping.**

F: Ok, alright thanks for that, so that was just enabling me to know what you do on your daily day work. So will now go into details of our discussion, so uhh, I will now would like now to know the clinical management of COVID-19 cases, so if you can explain to me the planned pathway at Queen Elizabeth Central Hospital for the management of suspected cases or confirmed cases of COVID-19 from the time they will arrive at the hospital uhh to the time they get discharged. So what is the pathway or the planned clinical pathway?

**R: So, uhh from my experience patients were, when someone is a suspect or has come to hospital and we are thinking is a suspect, he or she is a suspect, so they were being kept at tent where they were taken sample and while waiting for results they were isolated there. After the results when positive they were brought to the ward, when negative they were brought to ATC where they were allocated to the right ward depending on the condition, uhh in some cases if we have received patients maybe they were missed and they go into the ward and they are found they are positive they are brought to the ward. So there are different pathways. Some, I remember we received a patient who tested positive, was sent from Mwaiwathu being suspect and was brought at ATC, I mean tent where she was tested positive and brought to the ward so.**

F: Ok, so I think two interesting things there, you just quickly mentioned about uhh suspects being kept at the tent,

**R: Yeah.**

F: for how many days or for how long?

**R: It was as long as the sample comes, the results comes.**

F: Ok.

**R: So the only thing we are trying to reduce the contacts until we know the results whether positive or negative, so we decide what next step to take.**

F: Ok, and you also mentioned about Mwaiwathu.

**R: Yeah, so we had this one patient who was brought, who was being treated and Mwaiwathu and now the people looking at manifestation thought this could be COVID and was sent here where was tested and came positive and was being treated in the ward.**

F: Ok, so this was, was from Mwaiwathu to Queens?

**R: Yeah.**

F: And then after being diagnosed of COVID-19 the patient was kept at Queens?

**R: Yeah.**

F: Ok. Alright thanks for that, and in terms of the recommended management and treatment protocols required at each stage of the pathway. Do you know what used to happen at each and every stage?

**R: Yeah, so the patients we were having were the ones with COVID or critically ill. So the ones depending, needing oxygen, needing close monitoring; so we were having those patients so one of the things we were doing to them, we were giving them high floor oxygen, where the patients were given fifteen litres of oxygen, piped one.**

F: Ok.

**R: And another thing was we were giving them dexamethasone then we were giving them herbalin.**

F: Ok. Alright, so throughout all these stages or throughout the pathways that the patient were going through which stage do you think works or works better, or which will work better at the moment and why do you think that stage works better that other?

**R: Uhh, so from my experience early diagnosis, of course it was dependent on commodities like some having hypertension, having asthma were very critically affected by COVID-19, so one thing is we need to sort what are commodities, once we sort those things, we are able to stage them, so people with asthma and especially asthma and co-pulmonary disease, so we are supposed to, oxygenation was important. When we give them oxygen early and some management like giving them some dexamethasone and heparin, we were helping them a lot.**

F: Ok, so because you mentioned about patient coming at the gate and then they are suspected or confirmed case go to the tent and then if it’s confirmed they go to the ward for management and then when they improve they get discharged. So all these stages which one do you think uhh works better? So from the time the patient enters the hospital to the time the patient is discharged, so at which stage, do you think things were working ok?

**R: Uhh, I think in patient one the things were working ok, from experience I think the entry part the outpatient department of COVID-19 like the tent we weren’t much effective because 1; we could delay the patient when they are, I don’t know maybe the problem was because we never been there maybe the problem was the samples were not handled immediately like maybe it took time to have the results concluded but I think patients were delayed, some patients might have been delayed there.**

F: Ok.

**R: Yeah.**

F: So, do you think there is any stage in the pathway that needs improvement?

**R: Yeah, yeah, one of them should be the entry,**

F: Ok.

**R: the entry, the timing and uhh I think they should be, of course I don’t know how we can manage to do that but we should be, when the patients come I think we should find a unit inside the hospital; being a tent I think care that side is not that standardised like in the ward. I think it should be something like the ward where the suspects could be lodged while waiting for results.**

F: Ok.

**R: Yeah.**

F: Do you have any protocols for the management of COVID-19 patients?

**R: Of course, we do like I said the high floor oxygen**

F: Yeah.

**R: and of course like in our unit we don’t have thermo-lighting but in discussion and trainings, this is what we supposed to be doing,**

F: How were they developed?

**R: I think it was from learning from other countries, adopting what people are doing outside and looking at the conditions we have and,**

F: And it’s interesting you mentioned that most of those protocols are developed from other countries,

**R: Yeah.**

F: do you think those that you are using at the moment or those that you are used at the moment at Queens suit our settings or our context? Do you think they work in our context or?

**R: They, I can say fifty percent of them work, like from experience we had a patient with asthma, all we were doing with the patient was sticking to the guideline of how were are managing COVID patients,**

F: Yeah, yeah.

**R: while we were like not looking at the main conditions. I believe COVID was the main cause but now there are other problems that were precipitated, which we were to look into them. So I feel fifty percent of the guideline was helping but now when we don’t look at the commodities, we are like missing the whole thing.**

F: Ok, so how about access of these guidelines and protocols to the health care workers at Queens, is it accessible to everyone do you think people have access to this information to these policies, or protocols?

**R: I can say they are not available like we can find them these are the protocols, but it takes interest to get them; like now if I want like I will talk to a consultant who will help me like uhh ok this is how we do it, from my experience I can tell you the time I have been helping the COVID patients, I didn’t see this is a guideline and in this case that’s why we give dexamethasone and this no.**

F: So you say its like learning from what others are doing and what others are saying.

**R: Yeah.**

F: Alright, thank you so much for that, so the second section we will discuss about the preparedness or the preparedness and response strategies at the hospital. So if you can explain to me, how prepared you are as an individual uhh, and the hospital in at large to respond to a high number of COVID cases assuming we have higher numbers of COVID-19 cases, how prepared are you as an individual and how prepared is the hospital?

**R: So, uhh one of the initiative the now hospital is doing is having refresher courses, which I went through so which means the COVID data the management is changing now and again because more studies are being done,**

F: Yeah.

**R: and meaning more things are coming into the management of COVID, so having refresher puts us at a good point of helping them better. Another thing is the tent despite reduction of the numbers,**

F: Yeah.

**R: but the tent is still working the same, everybody with signs is being taken sample.**

F: And, do you think everyone is doing what they are supposed to do? So I’m talking about you have the management team they have their own responsibilities then you have the health care workers as you are you have your own responsibilities. Do you think everyone is working atleast towards improving the preparation?

**R: Of course, I’m seeing people are getting relaxed, looking at the reduction of numbers people are getting relaxed which means it’s putting us at like the increasing number can surprise us because people now are like COVID maybe is going, so if there’s an increase in number many people can be surprised so in other words I’m saying people are not working effectively on their roles.**

F: Ok.

**R: Right now people are like I think the illness is now going away, so.**

F: So, now if you try to compare the time we did not have cases of COVID and this time where we had few cases, do you think people’s preparedness or people’s mind set is still the same, something has changed?

**R: Uhh, I think we had fear for the illness, people were fearing COVID looking at how deadly it was in other countries,**

F: Yeah.

**R: people attached so much fear to the illness so now looking at how it hit us people are saying it didn’t hit us hard, so people are like now having confidence that is putting us that we are not following the measures as we need to, and another thing is the hospital is not testing anyone is just testing only the person having the signs. Meaning if someone is having COVID but now not having the signs he or she is at risk of spreading which is putting us at risk.**

F: Ok, so I think one of the most important thing in COVID-19, as I understand, is about the infection control measures.

**R: Yeah, yeah.**

F: So how readily available are the personal protective equipment to the staff when they are needed. So, I mean today if care workers or any support staff when they need it, do you think these are readily available?

**R: Yeah, there is provision of, there is continuous provision of reusable gowns by MLW and the masks are readily available in the matrons units which means whenever we want to get them, we can go get them. I think many of the materials we need are available.**

F: Ok, and how about in terms of ability of staff to follow the recommended infection uhh prevention and control procedures in the hospital. So, in terms of regular hand washing, or use of the PPEs or proper disposal of the equipment?

**R: So, like from my units,**

F: Umhuu.

**R: where we have patients we don’t know whether, who have not tested for COVID, in those ones we make sure we are wearing N95 gowns so we protect ourselves and another thing is we always ask the study that is testing the patients with patients with signs of COVID, so ask them normally because our unit is respiratory meaning everyone coming to our unit can be suspect for it.**

F: Yeah, yeah.

**R: So we usually keep in touch with them so they do help us test those people. So, I can say we are4 doing better in our unit.**

F: In terms of supportive, how supportive is the infrastructure set-up, so I mean in terms of you have had cases and let’s say from the time that we did not have cases in the country up to this time that we had few cases. How supportive is the infrastructure set-up, so in terms of do you have the dedicated isolation rooms, spacing in rooms or in wards?

**R: Uhh, I think in our unit we don’t have specific isolation rooms.**

F: Umhuu, but as a hospital do you think you have special room or how is it the spacing of the beds in the wards?

**R: Of course, our beds are I think it’s around 1.5 or 2 metres apart.**

F: Umhuu.

**R: But you meant having a COVID patient or?**

F: No, so like this is preparation for.

**R: Ok.**

F: COVID cases. As one way of, I mean one strategy is to have, for example to reduce bed capacity in the wards.

**R: Yeah, yeah.**

F: Don’t you think all those are practiced or do you think the hospital has a specific isolation unit or isolation rooms for COVID-19 cases or such (??) apart from the tents.

**R: Our unit has just recently stopped admitting cases because of reduction but our unit was one of them.**

F: Ok.

**R: But now there is isolation room now 3A, room 3A is now a unit specifically for COVID patients,**

F: Oh, ok.

**R: so that means if somebody is positive and maybe in admission, they are being kept there.**

F: Ok, so how about in terms of the capacity looking I’m looking or we are looking at the number of health care workers to care for COVID-19 cases, in case we have increased numbers do you think we have the enough capacity to?

**R: Yeah, I would say the capacity, yeah there is a capacity from health workers because now there is a lot of, I mean there is compensation like remuneration; special allowances that is making health workers to be excited to work in the unit.**

F: Ok.

**R: That means there is always people that are available to work in the unit.**

F: Ok, and has that increased the number of staff working in those units or maybe generally there is already an increased health care workers at Queens who can work for COVID?

**R: People volunteered but in our unit, I think we didn’t need some people to, of course we had some shortages which were covered by outside people,**

F: Yeah.

**R: but most of the shifts were covered by ourselves.**

F: Ok.

**R: We had a need for others but now we managed to cover the all the shifts by ourselves. Despite some just needing several people to help.**

F: Ok, so how about the availability of medication and other resources for the management of patients. Do you feel confident that you had enough the recommended (??) management of patients?

**R: The pharmacy fortunately was supplying us with all the drugs we needed, most of the drugs we needed were readily available from the pharmacy and getting them wasn’t much a problem.**

F: Ok, so and what do you see as key barrier or key facilitator currently affecting COVID-19 as far as strategies or anything that will affect, what do you see as a barrier that will affect management of COVID-19, if there is any?

**R: The barrier I think, it should be public understanding of the illness. If they don’t understand it they will attach a lot but if you don’t know something, I think you are not at a better place to either prevent it or see it coming. So the barrier can be the public if you don’t, like from experience with people, ok the patients we had when we admitted COVID patients, I remember if you are to take a role where to keep the guardians informed always, in the scenario where everybody was anxious like stressed now like all they could think like our relative is going to die, we are just waiting for he or she to die.**

F: Ok, but in terms of the hospital itself, in terms of how prepared the hospital is, do you think there is any barrier to the response management of COVID-19?

**R: Maybe in terms of materials can be a barrier, resources. I don’t know what they have put into the system to keep the resources available.**

F: Ok, alright, now let’s talk about the perspective of health care workers in rationing care, so rationing care is making sure that other services don’t suffer because of COVID-19. So in the event of an epidemic measures such as reverse triage; triage that you know is people come and then you make sure that those who are seriously ill are prioritised. So the reverse triage is the same process but when you are discharging them home, so measures such as the reverse triage maybe required within the health care system. So, we would like to explore your perception around the potential need to ration care assuming the demand for care exceeds it’s supply, so if for example I mentioned about if we happen to have many cases that what we can manage. I want to hear your thoughts on that one, around the potential for rationing the care. So what do you perceive will happen in reality if we have more cases than what we can manage?

**R: Alright, so I will give it from experience, so after ENT was opened to be admitting the COVID cases looking at demand they thought it wise to open STRU as one of the units for COVID-19. So when we started admitting for COVID-19, we had capacity for six patients, we opened six beds for patients, our unit is eight bed unit, but now we agreed to only be admitting eight patients, I mean six patients,**

F: Six patients.

**R: so six patients we find some people were waiting like we could discharge a patient, maybe a patient is stable for home or maybe has died. So, just the moment you are done with the patient, has gone home or is being taken to**

F: Mortuary.

**R: mortuary, you find there is a demand. The other patient is just on waiting list,**

F: Ok.

**R:** **so they opened the 3A unit as rehabilitation ward where the patient is stable now we can just take him out to the main ward where he will just receive supportive care while being stabilised, now stabilised but just waiting for patient maybe to be ok to go home, so in rationing we are doing that. I believe if cases increases maybe they would think of opening our unit ENT, which will be like an acute unit then when stable they will be brought to 3A for retention.**

F: Ok, but generally looking at the situation if you look at the management of COVID-19 patient and management of other patients in the hospital do you think COVID-19 has affected the care of the general care of other patients in the hospital?

**R: Uhh, of course it has partially affected, but not that much. One of the problems was people took much interest in COVID-19 like in the scenario I was giving that someone is having another problem, so we could not focus entirely on that problem but now we will be focusing on the COVID-19 which is like now leaving other things unattended to.**

F: Ok, so how about the VIPs, so these are people with higher social status in our country how are they treated or how would they be treated if they have COVID-19?

**R: We had several of them, but from my experience we didn’t have anything different like everybody,**

F: So everybody was treated the same

R:  **was treated the same. I don’t know about ENT because I heard ENT had some VIPs but the VIPs that we treated we didn’t have anything different we just treated them as, so.**

F: Ok, alright, uhh, fine I think now let’s talk about the attitudes towards COCID-19 and the perception on risk, so considering the level of preparedness for you as an individual and the hospital as an institution can you explain to me your attitude and the perceived risks of COVID-19 infection. So what did you think as the most risky thing or what are risky perception on COVID-19?

**R: Looking at how contagious it was,**

F: Umhuu.

**R: everybody was worrying about getting it and transmitting it to the households and the other problem was, for mine there were no measures for like quarantine the workers after you work so they would be quarantined, it was nothing like that meaning all we were doing was just work and go home which were putting if you are like are staying with your relatives at home, parents and so forth we were like putting them at risk. That’s only one of the things we were worrying about that there were no procedures put in place like quarantine, uhh, yeah.**

F: And how has your work changed due to COVID-19, so in terms of, you are free to describe any changes that you perceive as important for patients as well as yourself or your team and the institution, so how has your work changed due to COVID-19?

**R: Emphasis on infection prevention, this was the key thing like personally I deemed important in the management of COVID-19 patients, because like infection prevention you can wear the personal protective equipment but now when you are maybe doffing it, maybe you can do all the things but now when you are doffing that can be the time you can get the infection.**

F: Yeah, yeah.

**R: So like now the emphasis we put much was to make sure we are wearing well and doffing well.**

F: So when you try to compare with the time when we did not have COVID and now when COVID came do you think something has changed in terms of using PPE?

**R: Yes, a lot has changed.**

F: Ok.

**R: There were many trainings on how to put PPE which has given us a lot of knowledge on how we should put on the PPE. And now by virtue of we are treating COVID-19 which was another thing a motivating thing to make sure we are wearing PPE rightly and doffing rightly.**

F: Ok and how do you feel that health works or you do feel you are sufficiently protected from infection, when you are working in the hospital?

**R: So you are trying to get what tries to make us feel.**

F: No, no, do you feel like you are protected from COVID-19 or being infected with COVID-19 while working in the hospital?

**R: Uhh, so, from my experience, like personally how i was feeling when treating patients.**

F: Umhuu.

**R:** I was feeling my PPE as insufficient. So every time I am treating the COVID-19 patients, I could still say maybe I’m still putting myself at risk of getting infection.

F: Why? Did you think the PPE’s were not working or?

**R: Of course, I didn’t believe much in the PPE.**

F: Ok.

**R: Yeah.**

F: Alright, and how about other health care workers? If you know how they felt about their risk of COVID-19.

**R: Of course, my fellows.**

F: Could it be the same?

**R: Most of them had doubt on it. So other thing was looking at health workers from other countries who were being affected with COVID, so we could look at them they were wearing even better PPEs than ours.**

F: Umm..

**R: And in the end of the day getting infected, so we could still say this might not be enough to protect me from COVID-19.**

F: Ok, s if you had any concerns about your risk of getting infected with COVID-19, uhh do you feel that your concerns about the response of COVID-19 were properly addressed by the management or any responsible teams?

**R: Yeah, so they weren’t taken into consideration, so one thing they could say this is the best thing we can give you.**

F: Ok.

**R: To the management we believed, the PPE was enough, so since the management said so we couldn’t do otherwise to make sure what we are doing we are doing it right.**

F: Ok, so from your experience now, because you’ve had cases of COVID-19, so in cases of risks for infection what are the ways of trying to avoid or trying to mitigate these risks? How can you reduce the risk of COVID-19?

**R: One of the ways is reducing exposure tongue. So these what you mean what you need to do is block your air, that’s if I’m going inside I need to say I’m going to spend inside ten minutes, so I’m gonna do this, I’m gonna do this, I’m gonna do this . When I’m done with that I’m gonna make sure that I’m going out of the ward.**

F: Umhuu.

**R: Instead of like going two hours into the ward, now the exposure time is increased and puts someone at risk.**

F: Now let’s try to look at the relationship between the risk reduction and the financial incentives because you mentioned that people are now given allowances when they work for. Do you think the perception of risk is the same? When you try to put in the issue of financial incentives, do you think you will feel the same risk when you are getting some incentives?

**R: I think receiving uhh,**

F: Risk allowance.

**R: allowances doesn’t remove the risk but just gives you reason to appreciate being there. (laughs)**

F: (laughs) Alright, so what is the one thing that could be done to support you more at this time of the outbreak?

**R: Support like hospital or health workers?**

F: From your own perspective as a health care worker.

**R: Let me understand the question.**

F: What is the one thing that could be done to support you, so if the management was to do one thing or if any organisation or institution was to do one thing in the hospital, what do think that thing could be to support you more at this time of the outbreak?

**R: Ok, so uhh, I take much interest in the health workers, so I will give you from my experience,**

F: Yeah.

**R: like we are treating COVID-19 patients, after we stopped treating COVID-19 patients there was nobody who asked us to get us tested.**

F: Umhuu.

**R: So nobody was tested, maybe in interest maybe after two weeks into the management or they could test us to see how we are, so nobody took interest that means the welfare of one’s treating COVID-19 weren’t taken care of.**

F: Ok.

**R: Meaning the next thing I would ask if we are treating COVID, like if COVID cases increases take an initiative to know the status of the workers.**

F: Ok.

**R: Because if health workers now are not tested meaning if I get Covid-19, and I’m asymptomatic then everybody will consider me not positive which means when I am with my friends in the offices, nursing stations, not even a mask, meaning I’m putting my friends at risk,**

F: At risk of infection.

**R: So that’s one of the things that was missed.**

F: and what are the uncertainties or any areas you feel like you are unsure of the relation to COVID-19 management and preparedness, any uncertainties or anything you are not sure of, or everything is fine?

**R: I think I don’t have any.**

F: Ok, so let’s just a little bit talk about the testing procedures. I don’t know if you have gone through the testing for COVID-19 but what has been your experience so far with the nasal prongs or the throat swabs?

**R: Uhh my experience is that those things are irritating, and,**

F: And what do others say patients of other health workers what do they say about that procedure?

**R: Most say it’s irritating, of course much he comment I get is that it is irritating,**

F: Ok.

**R: that others reach a point of slapping them.**

F: Alright, there are some suggestions to start about using saliva in testing COVID-19. What can you say about this, do you think it’s a better way than the nasal prongs or?

**R: I would still go for nasal prongs sample, because nasal prongs sample can be the Best sample, saliva can be better but cannot surpass the nasal (??) one.**

F: Yeah ok, so just to conclude what are priority recommendations in improving the level of preparedness and the strategies for responding to COVID-19, in case we have an increased number of cases? So what are your priority recommendations?

**R: Yeah, one of them is continuous trainings for health workers, training every health worker on management of COVID, because maybe we can exclude the surgical wards but in the end of the day someone can have a leg problem or a bone problem.**

F: Umhuu.

**R: But in the end of the day having COVID, so everybody has to be trained every health worker and provision of enough PPEs to every ward.**

F: Ok, is there anything you would like to add on everything we talked about?

**R: I think I have talked much. (Laughs)**

F: (Laughs), But if you have anything you can talk about it, but otherwise I would say thank you for your time and for all the responses you have given, all the information is necessary and important for us to look at so that things improve in the hospital. Yeah, so I would stop recording if you don’t have anything to.

**R: Yeah fine.**

F: Alright.