Southern District Health Board
Piki Te Ora

**MV Mattina Debrief** **Date:** 29 September 2021

**Attendees:** Hywel Lloyd, Lynette Finnie, [redacted], Jo McLeod, Linda Robertson, Sam Mangai, Aaron Whipp, Adam McLeay, Michael Butchard, Pete Whalley, Chelsea Wallace, Jo Stodart, Mandy Murphy, Simone Jeffrey, Brendan Arnold, Hannah Hart, Michelle Downie, Susan Jack, [redacted], Clarissa Comerford, Sam Clark, Susan Moore, Laura Bruce, Lou Oldham, Michael Wong, Rachel Pannett, Cherie Meulenbroek, Jack Dummer, Kate Margetts

**Apologies:** Sue Dillon, Wendy Findlay

| Topic: | Discussion: |
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| **Context** | • Lynette circulated a timeline of events that occurred from 18 July when the Mattina docked in bluff to 18 August when pratique was granted and the ship was released.<br>• These were the first delta cases that occurred in NZ and there were no secondary infections which was a successful outcome.<br>• This involved Public Health work supporting cases and contacts, dealing with the vessel being in quarantine under customs, needing to learn a new IT system for contact tracing and case management (there had been a recent upgrade in NCTS), alongside managing border breaches in Queenstown.<br>• Two contacts were admitted into Hospital, there was transportation up to MIQ in Christchurch, and transport to supported isolation in Southland. |
| **Management of the emerging situation** | • Information about the ship was received via the on-call Health Protection Officer The captain had declared that two crew had mild respiratory symptoms and a decision was made to not grant pratique and the ship was under quarantine. This meant that no one could go on or off the ship.<br>• We linked with WellSouth and Wendy assisted with arranging swabbing. Results were fast tracked for the symptomatic crew on gene expert and swabs for other crew members were sent to Dunedin.<br>• The two sick crew were identified as positive cases on 19 July, followed by seven more cases later in the day.<br>• Learning: there was good communication between PH, WellSouth and the lab. Noted that the port and shipping agent were really helpful. |
| **Management of cases on the ship** | • The MoH were advised and started usual processes where the Communicable Disease nurses did a scoping call. There were no language barriers, but interpreters were available if needed. |

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| | • Noted there was anxiety among the crew members about what would happened – a plan would have assisted with this.<br>• Daily check-ins went well.<br>• MoH decided any positive cases in NZ would go to MIQ. When numbers of cases increased, we worked with the shipping agent and captain and were advised there needed to be 14 crew onboard to run the ship. Seven out of 21 crew were cases and it was suspected there would be more. Discussions continued about whether to take the cases off or not. It wasn't possible to take all crew to MIQ. Guidance from the MoH was requested.<br>• This was a customs-led event which was different to what we have previously experienced. It was a maritime decision about how many crew stayed on board, rather than a health decision.<br>• We had to provide cell phones – there was difficulty getting hold of people as phones didn't work very well in some parts of the ship (sleeping quarters). We asked crew to come further up into the ship which worked. We were using one of the crew (not medically trained) to assist with contacting patients and using the pulse oximeter (there was only one of these).<br>• Realised we needed primary care support and asked WellSouth who tried to find GPs (no one was available to assist). Southland ED agreed to provide primary and secondary care. The communicable disease nurses did the monitoring calls and any issues were escalated to ED. There was a low threshold for accessing care.<br>• Two crew were assessed in ambulance then went back on board. Then we put telehealth in place.<br>• When unable to find primary care (for clinical assessment) this was raised with MoH IMT – they advised they were a Public Health IMT not an all of health IMT and it was Southern's responsibility to source this. There was difficulty because the crew weren't enrolled in a practice. WellSouth are working on a system for responding to patients who aren't enrolled.<br>• Virtual ward rounds were held daily. [redacted] and [redacted] were involved in these. Noted this was discussion for decision making not clinical assessment - rather than a ward round. ED were happy to provide backup but it was difficult given their normal workload, and this work was outside normal roles. This work significantly impacted the running of ED but there wasn't an alternative option at the time. Noted great communication with Lou and Mandy. There was also on call work for other staff involved (not just clinicians) so this was very resource intensive.<br>• Learning: Anthony providing continuity was really valuable, but this isn't sustainable – a 24-hour service is needed.<br>• Noted that when borders open this will be 'normal' BAU so planning is required for a system to manage this (resurgence planning). |
| **Transport for admission to Hospital** | • There was no system for transport - St Johns was willing to do this, but it took an entire crew out for approx. 4 hours (so compromised the community). Work is needed on IPC and processes with St Johns. |

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| | • Had to rent a van for transport which wasn't ideal. Processes need to be tightened. Sue Dillon had to clean the van every time it was used.<br>• Learnings: we need to work with St Johns and transport providers so issues are addressed in advance. We need transport solutions throughout the DHB. |
| **Patient admission in ED** | • St Johns took crew around to another entrance, in a lift and into a medical ward. This was very time consuming – this involved all security in the hospital to block other entrances and hallways.<br>• Cleaning of the lift took up to 1 hour which took out one lift. It impacted a handover, so staff had to use another entrance. It also impacted getting meals to wards.<br>• This work took a lot of different personnel from the hospital and impacted business as usual.<br>• Learning: There aren't defined red and green streams in Invercargill hospital.<br>• Security support was also required for crew accommodated in Invercargill hospital cottages. Need to consider inhouse security.<br>• There are significant environmental constraints in Invercargill Hospital re air flow/ventilation for IPC.<br>• Auckland uses 60 minutes after exposure in an enclosed environment.<br>• Staff were doing literatures searches about Delta as there weren't clear national guidelines available at the time.<br>• Susan J thanked Southland Hospital for all their work. |
| **Patients on Ward** | • There was a lot of anxiety about the physical environment from staff e.g. were the negative pressure and ante-rooms sufficient?<br>• Accessing PPE was fine and fit testing was organised.<br>• Staff exposure was limited as much as possible – staff were tested before, during and after exposure to patients.<br>• There was some unpleasantness from some staff/patients towards staff caring for crew.<br>• Vaccination of staff and their families was organised. Acknowledged the vaccination team who stood up hospital clinics for staff.<br>• Nursing staff were fantastic – there were dedicated teams looking after the crew.<br>• Learning: need to work with staff to increase confidence with physical environments.<br>• Pilipino workforce provided the crew with excellent support.<br>• Issues with discharge of ARC patients – in-patients were vaccinated before they went back to ARC facilities.<br>• Staff surveillance testing went well once the process was in place but it required a lot of resource. This needs to be included in resurgence plans.<br>• Learning: need to be able to test staff inhouse with quick turnarounds for results as delays in getting results affected staff availability for rosters. Lack of inhouse diagnostic testing is an issue which has been raised for some time. |

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| | • James: Saliva testing was set up at short notice and worked well – need to investigate if this can be done independently of Occ Health e.g. using an app.<br>• Tried to have daily meetings with the people involved which worked well as a form of communication, even if there was nothing to discuss. This was very time consuming.<br>• Communication between IMT and staff on the ground: It worked well but it was difficult to attend meetings and have time to do the work required. A DHB EOC would have worked more efficiently (and needed on the Southland site).<br>• Learning: when we have cases, we need a DHB EOC for a health system response. |
| **Discharge process** | • Crew were moved to the cottages after leaving the hospital. This was done slowly and in a planned way. This transfer took a lot of work, particularly with IPC.<br>• Decisions about discharge were made at virtual ward rounds. It was decided not to discharge over the weekend due to logistics, but it wasn't easy for the medical ward. This could have been resolved with primary care for one of the crew members.<br>• Acknowledged the hard work of Pete Whalley and Owen Black for organising accommodation.<br>• There was an impact on finding accommodation for locums who would have normally used the Southland hospital accommodation.<br>• The hospital residence was used as it was difficult to get crew moved to MIQ - eventually some of the crew were moved to MIQ. The captain stayed locally which was difficult to arrange (24/7 security was needed). Now the MoH is planning for areas without an MIQ and there is acceptance that cases may be cared for in the community, but we don't yet know what that means for security and other systems as yet. |
| **Transfer to MIQ** | • Serology was done on negative cases – three had evidence of past infection but one crew member was required to stay on the ship.<br>• There were many complex decisions that needed to be made. A DHB EOC set up at an early stage would have been able to assist with a lot of logistics work.<br>• Without a MIQ in the district we aren't connected to the RIQs that run them. |
| **Monitoring of crew on the ship** | • Once patients recovered, Mandy and Lou did daily phone calls – with ED on standby. |
| **Welfare** | • Southland hospital provided meals as this wasn't organised by customs. The marae took over this and were able to be more flexibility in meeting their requirements and could provide hot meals.<br>• There were low demands, but welfare requirements took a lot of time (e.g. picking up prescriptions).<br>• Learning: We could deal with welfare requests for a small-scale event only. |

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| | • A security firm pulled out at 6am one day, but we now have a backup.<br>• If an emergency isn't declared the Council CDEMS don't operate. |
| **Other** | • Overall it was a positive experience to be part of and there were a lot of new relationships established which will stand us in good stead for the future.<br>• Received feedback from Maritime that SDHB were very good to deal with.<br>• The captain and crew very much appreciated the care that they received. |