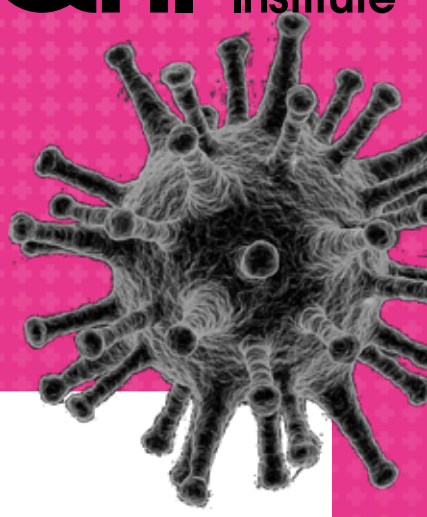
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

A Nurse/GP Dual Speciality Home Visiting Team in Surrey



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Personal details

Name: Michelle Pulman
Job title: Complex Care & Frailty Nurse
Employer: Witley & Milford Medical Partnership

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Please describe your practice innovation.

To mitigate the COVID-19 pandemic impact on vulnerable and housebound patients, the surgery has formed a dual-speciality visiting team to case manage this cohort.

The team consists of a complex care specialty nurse and a GP with interest in frailty and palliative care. Using risk stratification tools to pick out the cohort, the team uses online/phone messaging and home visiting services to proactively care for this group; this has significantly reduced out of hours and emergency services use and reduced length of stay for hospital admissions.

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How has this enabled you to treat/support patients /residents/families/carers more effectively and safely?

With intimate knowledge of the patient group and longitudinal MDT care generated from within the surgery, patients and carers have a single point of contact (with capability for review at home with the team) that can manage both medical, social, nursing and psychiatric morbidity. Access through novel routes, e.g. the surgery's online system, 'askmyGP', means there is no barrier to contact for patients and carers and the team can be fully involved with care at all stages.

4/

How has this enabled you to work more effectively with colleagues/partner organisations?

Our community colleagues and mirrored services, such as the Integrated Discharge Team at the local District General Hospital, have a set of people they know can be contacted within moments, have full knowledge and working relationships across the system and a shared commitment to holistic patient care.

Particularly during COVID, in-reach into residential homes from primary care has suffered; to have a solid and dependable link team within primary care has provided them with the safety net that they so needed.

5/

Do you see this new way of working as a temporary adaptation to current conditions, or a permanent/evolving change?

The scheme will be expanded into partner GP/nurse working in the long term; from the end of June, a complex care clinic in the surgery will be a permanent feature (paired with the home visiting team).

6/

Please describe any particular challenges you had to overcome.

A significant proportion of the interactions within this clinical setting rely on good interpersonal skills and relationships with patients. Part of the mechanism of overcoming barriers to this was using novel methods of communication. While the home visiting service was the key component of the structure, being able to communicate both his relatives and patients by SMS and messaging, along with phone and video consultations enabled accurate, timely interventions, which encouraged and fostered good working relationships between the clinical team and the patient and their family.

During the global pandemic, the issue of personal protective equipment (PPE) has also been a significant challenge to overcome, both in terms of supply and formulating safe working practices to enable visits to carry on unimpeded. By procuring industrial standard PPE, teams were able to visit patient safely at home and maintain the critical face-to-face component of the service.

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Please describe any continuing challenges you would like to address.

Due to the nature of the interactions, there are many cross-organisational challenges in terms of both record sharing and care working.

At the present time, although primary care has an excellent IT structure, interactions with other organisations and particularly record sharing could be improved. This could reduce reworking of problems, improve patient care and reduce unnecessary and inconvenient interactions for patients.

Making each contact count and be worthwhile for the patient is the priority.

8/

What are the main pieces of IT or other equipment you need (e.g. digital camera, phone, laptop, iPad).

Digital stethoscope, laptop with EMIS Web and WiFi router, respirator/PPE, portable CRP monitor.

9/

Please give any individual examples, quotes or other information.

Patient one
'These visits have given me confidence that I am supported with all the care and health needs I have, despite the challenges to the NHS of the pandemic. I think without the service there many occasions when I would have been taken into hospital unnecessarily and this has allowed me to stay at home where I want to be and helped me to live a life that I think it is worthwhile, despite my ill health.'

Patient two
'I am used to repeating my story to many different people. Having a single care team who looked after me throughout the pandemic and liaised with all the people that need to help me has been invaluable. They know me well, I trust them and I hope that all patient care could be like this.'

An excellent example of the importance of this modality of working was the team picking up a discharge from hospital on a minor issue, recognising through both frailty markers and targeted patient record searches for comorbidities, there was in fact a long-standing health and social disparity that needed addressing.

After a visit to the home, both a new formulating health condition and social deprivation were identified, with appropriate services put in place. Liaising with both social care and the patient's family, outpatient community services (heart failure specialist nurses) were able to visit the patient with the clinical nurse specialist. A targeted intervention was made possible with a team who knew the patient well and were able to provide ongoing support.

'I am used to repeating my story to many different people. Having a single care team who looked after me throughout the pandemic and liaised with all the people that need to help me has been invaluable. They know me well, I trust them and I hope that all patient care could be like this. Patient Feedback