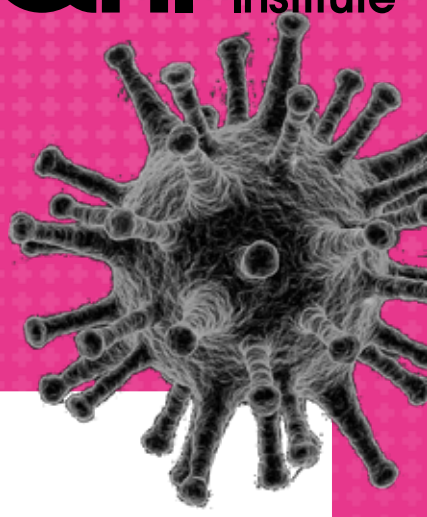
# Community Nursing Covid-19 Innovation/Best Practice

# CASE STUDY



## 1/

**Personal details**

Name: Anna Darwick
Job title: Lead Nurse Homeless Pathway Team Hull
Employer: Bevan CIC

## 2/

**Please describe your practice innovation.**

The Pathways Team in the hospital has supported our Local Authority Housing Options Team and our Rough Sleepers Outreach Team (Emmaus Hull) in a fantastic MDT approach to placing our clients - who face multiple exclusion homelessness - into 'Covid Protect' Accommodation across the city.

The relationships between services have strengthened and we have been able to wrap around our clients to assess holistically their complex situation, addressing rooflessness, poor physical and mental health, vulnerability and addictions.

Covid has enabled to us to act to create very quickly a pathway for clients that is person centred, that extends from the hospital into the community and is inclusive of all relevant services: a real joint working success that puts the patient first.

## 3/

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

Our clients have complex health needs and often interact with several agencies, including Addictions services, mental health, criminal justice and housing. In Hull, we have a Pathways Team which started in Oct 2019, working in hospitals to support safe discharge of patients facing homelessness and also to maximise the opportunities to address health and social care issues that an admission to hospital can create.

We work closely with Emmaus, who do street outreach and we have been able to support clients into hospital and into 'Covid Protect' spaces and off the streets. The relationships built between services have enabled this to happen, with joint working at all times of the day to get the best outcome for our clients. The team have done outreach into the Covid Protect placements to address ongoing health needs, by linking up primary care and secondary care services where needed, involving addictions services and mental health.

## 4/

**Patient Example – client consented to this being shared.**

Client had been sofa surfing for four years. During Lockdown, she developed a skin infection. She has a history of IVDU, was anaemic with uncontrolled asthma and was very weak, had collapsed and was brought into hospital. The team saw her and identified she was roofless and unable to return to where she had been sofa surfing after her hospital admission. The place she had been staying was being used by many different people and safeguarding concerns were identified. The client was therefore identified as needing a Covid Protect placement.

A 'Duty to Refer' was done and we discussed her case with the local authority as a priority, due to her health issues and she was offered a ground floor place in a hostel. We identified that she had not been accessing her GP, as she had been unable to get to the surgery and did not have a phone. As part of Covid provision, the team have been given mobile phones to issue to clients, to enable them to be in touch with services, so we gave the patient her own phone with £10 credit on it. The client wanted to move to a GP surgery nearer her new address, so this was facilitated by our team.

**Patient Example – continued.**
We arranged for District Nurses to go into the Hostel so she could continue to have the wound care she needed. A discussion was held with the dietician as the client was assessed as needing extra calories through Skandishakes, but the hostel did not have a fridge. An alternative product was arranged that was more practical for our client in her current living conditions.

Our client was not on any drug treatment, so we discussed the case with Renew, our Addictions Service, and she was started on opiate substitute prescribing within 24 hours of referral.

Our client had no possessions with her, her very few things having been stolen at her previous address. The team provided her with a bag of clothes and toiletries. The client is now in a place of safety and has been able to shield as needed during the pandemic and is being supported to continue moving in a more positive direction.

## 5/

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

We recognised early on that joint working was essential to get the outcomes needed for our clients and to enable the identification of risks and needs. A sharing agreement was in place already but was adapted for the pandemic to allow a truly holistic, multiagency approach to providing care and support for our clients. We now hold a weekly MDT which is very well attended by housing, Renew, Mental Health, health and others. We have utilised the VARM (vulnerable adults risk management) approach to many of our cases to ensure a robust safeguarding approach when needed.

## 6/

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

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## 7/

**Please describe any particular challenges you had to overcome.**

There was a lot of work to get the Covid Protect spaces identified in the first place with health, housing coming together and securing the best we could within Hull.

## 8/

**Please describe any continuing challenges you would like to address.**

The biggest thing for us to do is 'prove our worth' so we can secure further funding to keep this amazing project moving forward. The skills and passion of the teams involved deserve to be nurtured so we can continue to make a real difference to the health and well-being of our clients with multiple exclusion homelessness. For the Pathway Team, the focus will continue to be around educating the acute trust about the needs of our clients and how they can support us to get the best outcomes for our clients, and avoid discharge to the streets at all costs.

## 9/

**Please list any websites, online platforms or apps that have helped you.**

Faculty of Homeless and Inclusion Health, Pathways, Shelter, Crisis, Emmaus App

## 10/

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

We have used our phones and laptops to facilitate the majority of our work

## 11/

**Please give any individual examples, quotes or other information.**

Client with 'severe and enduring mental health issues and street homeless was supported extensively by our team, initially with engagement and building trust over several attendances at A&E, when he left before his assessment was completed.

Each time he left we spoke to the Outreach team with his consent and they then did welfare checks and followed him up. The team liaised with Housing and completed the 'Duty to Refer', raising his case and challenging some of the reasons that had been given from being excluded from being placed in hostels (issues around his behaviour). The team worked closely with MEAM (Making Every Adult Matter Team) and through the MDT approach was able to place the client in a Covid Protect B&B.

Once he had an address, Intensive Mental Health Support could be provided. His placement was straight forward and all teams remained involved. He had to be supported into an alternative placement after a breakdown in his mental health. Addictions services and Mental Health along with ourselves have worked closely with this client who is now so much better, off the streets, eating, taking his medication and engaging with all support on offer. Seeing him makes us all smile and we know we have made a difference that wouldn't have been possible without us all doing our little bits and focusing on what our client wanted and needed.

> 'The skills and passion of the teams involved deserve to be nurtured so we can continue to make a real difference to the health and well-being of our clients with multiple exclusion homelessness.
>
> Anna Darwick