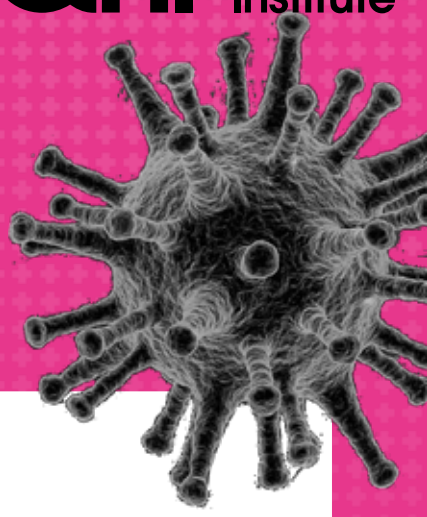
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

North Manchester Acute Home Visiting Support Service



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Personal details

Name: Madeleine Bevan
Job title: Community Nurse - Active Case Managers
Employer: Manchester Foundation Trust (MLCO)

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Please describe your practice innovation.

The North Manchester Acute Home Visiting Support Service (NMAHVSS) was established as a result of the COVID-19 pandemic to support primary care networks (PCNs) and North Manchester GPs to manage adults over 18 who are confirmed COVID-19 positive, suspected, are in a household with COVID-19 or who are on a shielding list and for whom surgery visits are not appropriate.

The NMAHVSS offers a one off urgent home visit to support GP management of patients with an acute clinical need. The service is available to all practises that have activated the EMIS data sharing agreement with community services. The service supports GPs to manage the care of patients by offering a home visit, including observations of respiratory rate, heart rate, 02 saturations, BP, temperature, blood sugars, chest examination, consciousness and capacity, undertaking of bloods, swabs and assessment of wellbeing.

The service provides a face to face assessment within two hours of the referral, completion and recording of observations within EMIS, telephone and/or video consultation on scene for the GP to make the onward management plan and referrals to community pathways if required.

The NMAHVSS is delivered and managed by the Active Case Management (ACM) service. The ACM service is already an established team of highly skilled community nurses situated in four integrated neighbourhoods across North Manchester. This innovative way of working has enabled patients to access healthcare services and community services, thereby reducing Crisis intervention and hospital admission.

3/

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

The NMAHVSS has allowed COVID-19 positive, suspected or shielding patients access to healthcare and for appropriate treatment to be delivered. As above, the NMAHVSS provides a face to face consultation within two hours of the referral being made. This has reduced Crisis situations and inappropriate hospital admissions, reducing further exposure or introduction of COVID-19 into hospital settings, and reduced further risk to patients.

The ACM service has already well established links and care pathways in the community and this has allowed access to wider services when required. The ACM service manages patients with long term health conditions. Throughout this pandemic, the ACM service has continued to support and manage these patients and also accept new referrals to the service. This has ensured continuation of care delivery, access to appropriate treatment and reduction of Crisis intervention and hospital admission.

4/

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

The ACM service is already an established team within community services. The NMAHVSS has allowed ACMs to work more closely with GP practices as part of the primary care networks (PCNs). This has enabled ACMs to widen their already established care pathways and link services, collaborating for patient care.

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

The ACM service envisions the NMAHVSS as a permanent/evolving change because the service has demonstrated in practice how this innovative way of working provides timely intervention, appropriate treatment delivery, prevents crisis and reduces hospital admission, is cost effective and allows patients better access to community services.

6/

Please describe any particular challenges you had to overcome.

Managing risk is a continuing challenge. In order to manage risk, a standard operating procedure was implemented and risk assessments where completed for all staff. Managing staff anxiety is also an ongoing challenge and in order to minimise this, staff are placed on a rota system and weekly debriefing meetings are held to review any concerns. Risk to patients is managed by following guidance from NHS England and Trust policy to ensure appropriate PPE is worn and procedures followed.

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Please describe any continuing challenges you would like to address.

Risk management continues and changes weekly with the service evolving. This requires the service to remain flexible and adaptable to change. Ongoing challenges will be to ensure practice remains consistent, policies are updated, staff continue to be adaptable to change, develop new ways of working and reflective in practise. This will be discussed weekly in debriefing meetings.

8/

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

Emis, Emis mobile, Accurx.

9/

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

The service has an allocated desk, computer and phone, monitored in working hours by an admin worker and an Active Case Manager (ACM), completing triage in one of the neighbourhood settings. The ACM completing the home visit already has stethoscope, sphygmomanometer, temperature probe, saturation monitor, pulse oximeter, Kardia monitor, equipment for obtaining blood samples, urine specimen bottles, appropriate PPE, parking permit, BM machine, ketone strips, urinalysis strips, an iPad and phone.

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Please give any individual examples, quotes or other information.

'The service appears to be a success, please pass on my neighbourhood's gratitude for the great work'.

'Really positive feedback from the CDs on the home visiting service.'

> 'The service appears to be a success, please pass on my neighbourhood's gratitude for the great work.
> Patient feedback