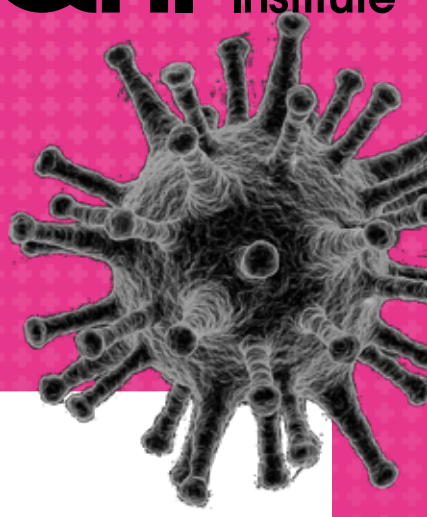
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

A Multidisciplinary Working Group to Support the Transition of Patients to the Community



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Personal details
Name: Abigail Brooks
Job title: Lead Nurse Richmond Response and Rehabilitation Team
Employer: Hounslow and Richmond Community NHS Trust

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Please describe your practice innovation.

My normal role is as a Lead Nurse in a Rapid Response, Prevention of Admission and Rehabilitation team. In response to the COVID 19 pandemic, we felt a collaborative approach to patient management was required and we have established a Multi-Disciplinary Working Group to support the transition of patients into the community following a lengthy hospital admission.

As NHS England has highlighted, those recovering from COVID-19 can suffer significant on-going health problems, including breathing difficulties, enduring tiredness, reduced muscle function, impaired ability to perform vital everyday tasks and mental health problems such as PTSD, anxiety and depression. The patients concerned have normally been on ITU/HDU, been intubated, had tracheostomies inserted or needed BIPAP (Bilevel Positive Airway Pressure). They have all had a long hospital stay with resultant complex physiological and psychological impacts. The core MDT therefore consists of clinicians from Respiratory Care, Response and Rehabilitation, Psychological wellbeing and Neurological rehab to cover the key issues. We also have access to specialists in Diabetes, Heart Failure and MSK as well as a dietician, Speech and Language therapist, Community nurses, various voluntary partners, Social Services and a GP as required. We become involved directly on discharge home, to support their onward recovery. We receive referrals from hospitals, GPs, and other community teams. Each patient has an allocated case coordinator who acts as their key contact. The case coordinator is allocated dependent on the patient's main needs. We meet weekly via video call, to discuss the patients on the caseload and collaboratively discuss what could be of benefit for that person.

3/

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

We have found that this holistic, collaborative approach has led to patients and their families feeling supported following their often traumatic hospital admission and period of ill health. By having ready access to a range of specialists with a shared vision, we have been able to offer the patient and their family timely support for a range of issues, both physical and psychological, that have arisen from having Covid-19. Often there is residual anxiety regarding health and wellbeing – patients have been closely monitored in hospital with regular blood tests etc. and are concerned on return home that they are 'not being monitored enough'. With support from the MDT, this transition back home has potentially eased some of this anxiety.

By having access to a named key worker, they can contact them with concerns that can then be addressed by the appropriate clinician. We have been able to tailor the approach to each individual, asking 'what is important to you', and where appropriate have been able to include their families in the process, addressing their psychological and social needs as well. We have also found that working together and sharing key information has resulted in the patient having to repeat their story less, reducing the potential frustration, confusion and fatigue that this can cause with complex patients- making every contact count. By being able to offer supportive rehabilitation in patients own homes, we have found that they are able to benefit from the support of their friends and family in a familiar environment.

4/

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

This has greatly increased awareness of the different services available within the trust, and given clinicians involved more insight into the service provision and how to access it – this has then been shared with the wider teams. It has improved relations between the different services and increased a shared knowledge base, really tapping into the spirit of collaborative patient centred working. Communication has been clear and extremely valuable. It has promoted the need for continuous professional development, on both a personal and organisational level. There are hopes that some valuable experiential data can be gathered from this project to support the further development of services to support our patients following this pandemic.

5/

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

Due to the potential length of recovery foreseen for the majority of the patients severely affected by Covid 19, some iteration of this working group will likely be required for the foreseeable future. It may evolve however, dependant on the number of referrals received, and the amount of involvement required with each individual. We are working with our two main hospitals to establish a clear pathway from ITU through the hospital and into the community to ensure that we are offering the service to all who need it. If this becomes larger, additional resources will be required to ensure that we can deliver the most effective and appropriate service. It may be that we adapt this service for all people who have been in ITU with or without Covid-19.

6/

Please describe any particular challenges you had to overcome.

The variety and complexity of new co-morbidities that the clients involved, as well as our rapidly developing knowledge of COVID-19 and its after effects has necessitated some very quick learning and a lot of collaborative problem solving. The age of the patients involved is considerably younger than those usually seen by our team on average, and as a result we have to consider additional factors such as employment, benefits and loss of role.

Given the multitude of differing issues that these patients are affected by, we have found it difficult to settle on a validated outcome measure to use to monitor progress. We are currently working on what this will look like, but will hopefully incorporate both quality of life as well as physical endurance. It may be more valuable to have a more qualitative approach to progress focusing on patients perceived achievements rather than their physical progress, due to the different abilities of the patient's involved, and the differences in what each patient finds important.

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Please describe any continuing challenges you would like to address.

We are fortunate that we have good access to psychological services for our patients and their families; however we are finding that these services are often underused. It has become very clear through this pandemic how closely linked mental and physical health are, so it is imperative that we continue to raise the profile of these services, improving access for those who need it and encouraging all clinicians to signpost patients and their families to use them.

Due to the unknown trajectory of the recovery from COVID-19 we cannot predict what the future holds for these patients. By continuing to work closely with them and collaboratively with colleagues, for as long as it takes, we will hopefully support these patients to transition successfully back to their 'new normal'. We are currently trying to raise the profile of the working group to ensure that we are reaching all those who require support, a time will come when we need to evaluate the resources required to support this project for the longer term.

8/

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

https://www.nice.org.uk/covid-19,
https://www.england.nhs.uk/coronavirus/publication/after-care-needs-of-inpatients-recovering-from-covid-19/,
https://www.csp.org.uk/
https://www.csp.org.uk/public-patient/covid-19-road-recovery
We also have access to ARMED (Advanced Risk Modelling for Early Detection) technology - this involves wearable patient monitors and medication devices as well as sensors if required. As we move forward with community rehabilitation we are hoping to incorporate this monitoring system into our approach to promote activity and anticipate deterioration.

9/

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

Laptop, work iphone. When using ARMED we require patient wearable, digital scales, grip strength monitor, mobile phone +/- sensors

10/

Please give any individual examples, quotes or other information.

Case study:

Background: 56 year old man, previously fit and well, Postman. PMH: Hypertension.
Admission: 6 week admission with COVID-19, Type 1 respiratory failure requiring ITU admission and BIPAP. During his admission he had multiple health issues including Hypokalemia, bilateral PEs, AKI, Heart Failure, AF and was diagnosed with type 2 diabetes.
Issues: He has residual anxiety and low mood, as well as decreased exercise tolerance, fatigue, desaturation. He has significant psychological burden not only due to his admission but also due to now needing to manage his new multi-morbidities effectively.
Support: Case coordinated by response and rehab nurse – holistic assessment completed and main issues identified.

- Referrals made to Diabetes and Heart Failure teams.
- Involvement of the Psychological Wellbeing team via phone/ video call.
- Psychological support also offered to patient's partner.
- Respiratory physio and Support worker involved for monitoring and pulmonary rehab.
- Occupational therapist involved for provision of equipment for maximising independence at home.
- Regular liaison with client's GP to support multiple health needs.

Anecdotally this patient and his partner report that they have felt well supported since returning home. Despite progress being made since return home, there is still a long road of recovery for this man that the MDT will continue to support.

> "We have found that this holistic, collaborative approach has led to patients and their families feeling supported following their often traumatic hospital admission and period of ill health. Abigail Brooks