

Living with Covid-19 (Long Covid) and Beyond

Community and Primary Care Nursing Resource





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Listen to and believe the person's lived experience of Covid-19, allowing time and space to process the experience.



Introduction

The Queen's Nursing Institute (QNI) was commissioned by NHSE/I to develop this Living with Covid-19 Community and Primary Care Nursing Resource, following the publication of the NHS After-care needs of inpatients recovering from Covid-19 guidance published on 5th June 2020.

It is predicted that there will be a 'new wave' of physical and emotional health problems as people, family and carers try to recover from their Covid-19 experiences, not least those who have been treated with mechanical ventilation in intensive care, and a surge in other mental health issues resulting from the social and economic impact of lockdown, such as isolation and unemployment (Royal College of General Practitioners (RCGP) 2020).

The term 'Long Covid' is a term widely used on social media but is not a well-defined term and not a diagnosis used widely by medical staff. There has also been a degree of caution around settling on a fixed definition at this early stage, attributing all the reported problems to a single diagnosis. In October 2020 NICE acknowledged the uncertainty around the long-term effects of the virus and defined Post Covid-19 Syndrome as symptoms lasting longer than twelve weeks.

It is also important to remember that a significant number of people will have profound symptoms, without hospitalisation and that support needs to go beyond the person with the symptoms as there is a ripple effect on the family and carers too. However, it has become increasingly clear that, for some people, Covid-19 infection is not a discrete episode but one that marks the start of ongoing and often debilitating symptoms.

For some this is related to the rehabilitation from a severe acute infection but others are reporting life changing

experiences that follow a mild initial infection, with symptoms becoming more severe over time. Support needs to extend beyond healthcare to include the social impact (including the impact of moral judgements/stigma of having 'Long Covid') and returning to employment. There needs to be a recognition that this support needs to be across a range of settings, including people's own homes, in care homes, prisons, places of employment and within homelessness services. Covid-19 has disproportionately affected certain groups in society and we need to understand more about the long-term impact on traditionally underserved people such as those with a learning disability, mental health problems, older and frail people and people from ethnic minorities. It is the care of these groups of people that this resource is mainly aimed at.

The aim of this document is:

- To provide information primarily to nurses working in community, care homes and primary care and also to the wider multi-disciplinary team to ensure access to the required clinical knowledge, care responses and skills when caring for people during their recovery and rehabilitation from the virus
- To help nurses assist people, families, carers and employers to work towards managing post Covid-19 symptoms realistically regaining everyday life activities and returning to independent living

This resource is to be used to support learning and NOT to mandate how learning is achieved. It is essential that all registered nurses continue to work within the scope of practice and their capabilities when developing extended skills in practice. The emphasis must always be on maintaining and providing safe, high quality and effective care.

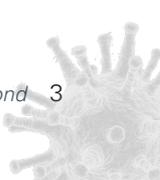


Figure 1. Living with Covid-19 (Long Covid) and Beyond Community and Primary Care Nursing Resource



Many people admitted to hospital following Covid-19 infection have done so as a result of pneumonia infection, and it is important to remember that a significant number of people will have profound symptoms, without hospitalisation.

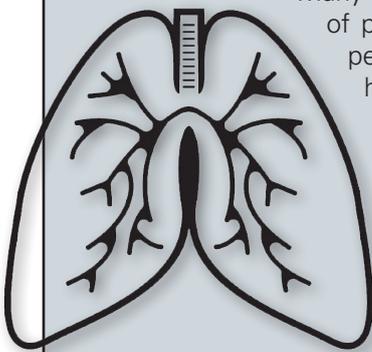


1. Physical Care

The long-term physical complaints of people recovering from the Covid-19 virus are wide ranging and varied and described as lingering, fluctuating with an element of 'remission and relapse' which can prevent a return to normal daily activities. The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body. The general symptoms can include:

- Extreme fatigue and weakness
- Shortness of breath on slight exertion
- Joint pain
- Persistent low-grade fever
- Continuing headaches
- Red eyes – conjunctivitis
- Vertigo
- Runny nose
- Sore throat, voice changes and difficulties swallowing
- Protracted loss of or change in smell and taste
- Hair Loss
- Gastrointestinal disturbances including loss of appetite, abdominal pain, bouts of diarrhoea and vomiting
- Inability to concentrate or process information (sometimes referred to as 'brain fog'), memory lapses and changes in mood
- Sleep difficulties

Respiratory



Many people admitted to hospital following Covid-19 infection have done so as a result of pneumonia infection, and it is important to remember that a significant number of people will have profound symptoms, without hospitalisation. Many of these may also have a prolonged recovery phase and may suffer complications. Recovery time from symptoms of pneumonia varies and will depend upon the severity of the illness and an individual's health status considering co-morbidities and overall frailty. The expectation is that:

- 4 weeks - muscle aches, chest pain and sputum production should have substantially reduced (significant sputum production is less common in Covid-19)
- 6 weeks - cough and breathlessness should have substantially reduced
- 3 months - most symptoms should have resolved but fatigue might still be present
- 6 months - symptoms should have fully resolved unless the patient has had a complicated ICU stay, in which case mobility and/or respiratory difficulties may be prolonged.

Possible complications may include but are not limited to:

- Chronic cough
- Hypoxia
- Pulmonary fibrosis (post-infective)
- Breathing Pattern Disorder
- Post Viral Chronic Fatigue Syndrome
- Venous Thrombotic Disease (VTE).

Contributing Factors:

- Tobacco, addiction, alcohol use and obesity, fitness and lifestyle

Referral – Pulmonary rehabilitation programme

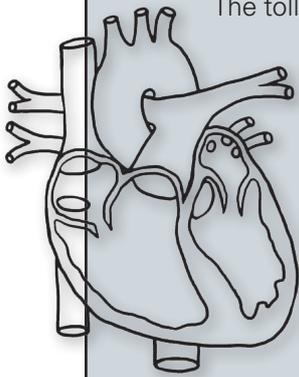




The toll that Covid-19 takes on the heart and the cardiac system is emerging with reports of new onset damage after people show signs of recovery, even if their illness was not severe enough to require hospitalization.



Cardiology

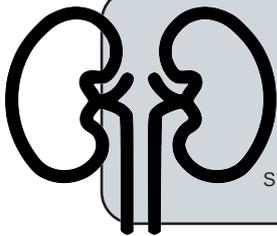


The toll that Covid-19 takes on the heart and the cardiac system is emerging with reports of new onset damage after people show signs of recovery, even if their illness was not severe enough to require hospitalization. This is compounded when the person has a pre-existing heart condition and also some of the medications used to treat the virus may contribute to cardiac toxicity. The list of cardiac related complaints is emerging and includes:

- New onset hypertension
- Palpitations
- Chest pains
- Angina
- Cardiac arrhythmias / tachycardia
- Heart attacks
- Clotting disorder including thrombosis and pulmonary embolism
- Infection induced myocarditis or other cardiac disease such as ischaemia
- Heart failure
- Cerebrovascular accidents.

Individuals may be subject to a variety of diagnostic tests to ascertain cardiac involvement ranging from arrhythmia, ventricular tachycardia and ventricular fibrillation to cardiac injury, myocarditis and heart failure. Appropriate heart failure therapy should be initiated and maintained when required, and plans put in place to optimise doses according to expert medical supervision and advice. Standard advice regarding physical activity and cardiac rehabilitation should be given where appropriate.

Urology



The virus can infect the cells of the kidney and liver leading to acute kidney injury and liver failure, potentially damaging tissues that can lead to long term moderate or severe kidney disease. Another possibility is that kidney problems in people with the coronavirus are due to abnormally low levels of oxygen in the blood, a result of the pneumonia commonly seen in severe cases of the disease.

Neuromuscular



People with pre-existing neuromuscular disorders such as myasthenia gravis (MG) tend to be more vulnerable to infections like Covid-19, and the infection often exacerbates their conditions.

In addition, immunotherapy treatments place these people at greater risk of infection. It is important to remain vigilant for neuromuscular complications that may be directly or indirectly related to coronavirus infection.





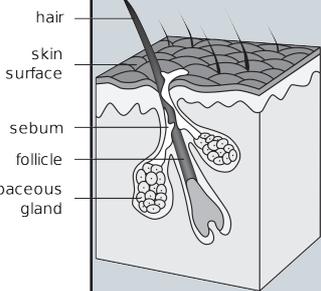
Endocrinology

There is some evidence that there is an association between serious complications from the coronavirus and type 2 diabetes where people become temporarily hyperglycaemic, especially during hospitalisation for the infection. This issue is most definitely compounded if the person has pre-existing Diabetes where there is an increased risk of severe Covid-19.

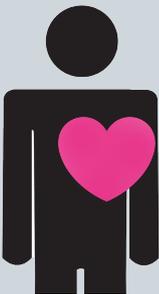
Skin

There have been some reports that people with Covid-19 can develop rashes and skin ulcers associated with the virus. The five main rash types are:

1. Covid toe - chilblain-like lesions around the hands and feet, which could be itchy or painful. Generally found in younger people and can present as a later complication and can last longer than 14 days
2. Outbreaks of small blisters, often itchy, found on the trunk and limbs and can last around 10 days
3. Pink or white raised areas of skin that look like nettle rash, and often itchy. Mostly on the body but sometimes on the palms of the hands.
4. Small, flat and raised red bumps anywhere on the body
5. General blotchy skin that can be red or blue, with a net-like pattern can present in older people that also have poor blood circulation.



Self-management



For the majority of people recovering from Covid-19 the emphasis will be relying largely on self-care, where people will take actions to recognise, treat and manage their own health and there have been initial reports that this has proved to be somewhat challenging for this group. Health and social care professionals in partnership with individuals play a significant role in facilitating self-management education, to help build knowledge and understanding and initial contact may need to be via video or telephone consultations, bearing in mind the difficulties of conveying and describing symptoms in this manner. It will also be vital to take into consideration any inequalities and accessibility barriers, and the approach taken must be personalised and based on 'what matters' to the person.

A realistic conversation around aspirations, goal setting and maintaining a routine at home includes:

Physical

- Diet
- Exercise
- Rest and Relaxation
- Sleep
- Complimentary Therapies
- Alcohol and caffeine intake

Mental wellbeing

- Use technology to maintain social connections with loved ones
- Consider a regular check-in schedule to give the person something to look forward to
- Encourage positive thoughts on the present
- Listen to music or read books
- Employ pastime or hobbies
- Consume reliable news sources that report facts and limit this exposure if anxiety provoking
- Personal beliefs systems and faith for support.

NHS Your Covid Recovery: <https://www.yourcovidrecovery.nhs.uk/>

How to manage post viral fatigue after Covid-19 – Practical advice for people who have recovered at home: <https://www.rcot.co.uk/how-manage-post-viral-fatigue-after-Covid-19-0>

The social impact of the pandemic on people, households and communities cannot be underestimated and is again wide ranging and evolving.



2. Psychological and neuro-psychological Care

The long-term psychological complaints of people recovering from acute Covid-19 are wide and varied. The initial lockdown measures and restrictions only allowed people to leave home to exercise once a day, travel to and from work when “absolutely necessary”, shop for essential items and fulfil any medical or care needs. Premises such as libraries, playgrounds and places of worship were ordered to close and people with significant health issues were asked to shield for up to three months. This triggered a dramatic change in the day to day routines and quality of life of a significant part of the UK’s population: millions of people lost their jobs or were furloughed, working from home became commonplace and people were suddenly confined to their homes often without their usual equipment such as dual screens, or an ergonomic desk/chair; their working environment was catapulted into some form of professional isolation, where colleague presence was minimal yet with all members of the household constantly present, all with the back drop of a deadly viral, airborne disease that can spread via asymptomatic patients, increasing uncertainty and anxiety. While for the greater public good, these measures created heavy psychological, emotional, and financial problems for some people.

The assessment of the psychological effects of Covid-19 remains unknown and unpredictable. Services to support mental health were already stretched with an inability to meet the demand prior to the pandemic. There are some fears that people are staying away until reaching crisis point. It is within this landscape that community and primary care nurses are adapting their services, to ensure that untreated mental illnesses are detected early and referral and monitoring for ongoing support occurs.

Post-Traumatic Stress Disorder (PTSD)

During the current lockdown, GPs are already anecdotally reporting a rise in the number of people with anxiety, depression and trauma symptoms, particularly in those who have pre-existing physical and mental health conditions. Symptoms of post-traumatic stress disorder include flashbacks, nightmares, feeling very anxious and difficulty sleeping. The main treatments for post-traumatic stress disorder are antidepressants and talking therapies.

If the person does not improve after four weeks and the feelings and memories are becoming more intrusive, PTSD should be considered and actively monitored. <https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/>

Where available, timely occupational health referrals should be commonplace for those returning to the workplace after experiencing debilitating symptoms of Covid-19. This gives the opportunity for thorough holistic assessment of coping mechanisms and continued recovery, and the need for any workplace / contractual adjustments.

3. Social Impact

The social impact of the pandemic on people, households and communities cannot be underestimated and is again wide ranging and evolving. The economic impact of lockdown has hit people causing an effect on their physical health with job losses, unemployment and fear of the ability to meet household bills and the worry of not having enough food to meet basic needs. Many people have lost their jobs or been furloughed and people have spent far more time than usual in their homes. The quality of housing and the opportunities it affords including personal and outdoor space is very variable and for many people their private space is very limited. This has highlighted the pre-existing gaps in inequalities in health and social care, which directly impacts people’s health and wellbeing.

Inequalities in health for many people from an ethnic minority community in the UK prior to the pandemic have been extensively documented with a whole variety of social, economic and biological factors. There is





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It is vital to establish that people who present with Covid-19 Symptoms to general practice or to community nursing services may or may not have been investigated for specific organ damage.



clear evidence that black and minority ethnic groups are at higher risk of dying from Covid-19 than the rest of the population, though that risk may not be the same for all ethnic groups. Further epidemiological research is needed to establish the extent and reasons why these groups are at greater risk.

Referral to social work professionals to assess and advise accordingly is paramount and takes on many different forms and helps people of all ages. It is held together by a common purpose: not just helping people with a wide range of needs, but helping people to live the best possible life.

4. Combination: physical, cognitive and psychological needs following admission to intensive care

Post Intensive Care Syndrome (PICS)

Being admitted to an intensive care unit can affect a person's body, thoughts, feelings, mind and interactions with friends or family. Post-intensive care syndrome (PICS) results from the combination of factors, such as respiratory failure, sepsis and the use of life-sustaining equipment such as endotracheal tubes and mechanical ventilators. The use of sedative, pain and other medications that have mind-altering (including delusional) effects can result in ongoing problems. The unique stressors during the Covid-19 pandemic have been compounded by the compulsory use of personal protective equipment and the inability for relatives to be with their loved ones during admission.

Effects of mechanical ventilation can include:

Brain (cognitive) symptoms: Decreased memory, thinking problems, delirium, difficulty talking, forgetfulness, poor concentration, trouble organizing and problem solving

Emotional symptoms: Nightmares, unwanted memories, anxiety, depression, decreased motivation

Physical symptoms: Muscle weakness, fatigue, decreased mobility, difficulty breathing, insomnia.

Post-intensive care syndrome (PICS) can be treated by:

- The health and social care team may use many different methods to treat, and post ICU patients may have a recovery plan or may have access to a Seacole type convalescent or rehabilitation facility
- Getting the patient moving as soon as possible after the ICU stay, physical therapists and occupational therapists can continue to reduce weakness and improve physical functioning
- Recommending pulmonary (lung) or cardiovascular (heart) rehabilitation (if appropriate) due to the high prevalence of respiratory and cardiovascular disease in patients after ICU discharge
- Treating depression, anxiety and post-traumatic stress disorder with a combination of medications, psychological and behavioural therapies
- Encouraging the person and family members to keep a post ICU diary
- Providing follow-up counselling with a psychologist or psychiatrist for people with emotional symptoms.

It is vital to establish whether people that present to general practice or community services with post Covid-19 symptoms (who may or may not have had a hospital admission or a previous positive test) have been investigated for specific organ damage. The emphasis must be on listening, history taking, investigation, assessment and referral to the newly formulated ' Long Covid -19 clinics' or 'Specialist Centres'.

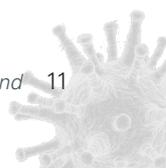


Figure 2 – Living with Covid-19 (Long Covid) Physical/ Psychological/ Social - Support



'Some have reported 'floating' symptoms whereby they suffer an illness linked to one part of the body – such as the respiratory system, the brain, cardiovascular system and heart, the kidneys, the gut, the liver or skin – which later abates only for new symptoms to arise in a different part of the body.'

Dr Elaine Maxwell

‘What is now becoming clear is that mortality is not the only adverse outcome of this infection and our surveillance systems must keep up and reflect that.’



Living with Covid-19 Stories

Living with Covid-19 in the community

‘I went out for a 20-minute slow walk yesterday evening with my little girl who was desperate to see the flowers on the way. My exercise capacity is still terrible, and I knew that by doing that I would pay the price the day after. Indeed, I woke up with the familiar chest heaviness and utter exhaustion which gets worse by sitting at my desk to work. This has been a pattern since the start of my Covid-19 symptoms in the second half of March. Of course, I was never tested because community testing stopped altogether in the UK on the 12th March so I have no proof of my infection other than the accounts of thousands of people who are describing a similar experience of prolonged, fluctuating, and debilitating symptoms lasting for months. We are the unrecorded. The pandemic has been measured in deaths and in hospital admissions. I struggle to find any precise case definition for “mild” Covid-19, which is what I supposedly had and still have not fully recovered from.

It seems common in many countries that anyone with symptoms, but not hospitalised is counted as a “mild” case, but the degree of Covid-19 severity must be defined by the duration of ill health, not just the need for hospital admission. If symptoms last for more than a month and are debilitating to usual activities, it is unreasonable to call this a “mild” case. This misconception of “mild” is not ideal for prevention efforts during the pandemic

As a public health doctor and epidemiologist, I strongly think we must now clearly define and measure “recovery” from Covid-19. This way we can quantify non-death health outcomes and monitor long-term implications of the virus. The definition needs to be more sophisticated than just hospital discharge or testing negative for the virus. It must take into account symptom duration, fluctuation, overall functionality and quality of life in comparison to before infection. If we do not have enough information to define “mild” at this stage, then let us not use the term loosely, otherwise it is detrimental to pandemic control.

What is now becoming clear is that mortality is not the only adverse outcome of this infection and our surveillance systems must keep up and reflect that. I am advocating for precise case definitions for Covid-19 morbidity that reflect the degree of severity of infection and allow us to measure moderate and long-term health and wellbeing outcomes. At this stage of the pandemic, it is vital that we accurately measure and count all degrees of infection, not only in research cohorts, but as part of population-based routine surveillance systems. This includes people like me who were not tested at the time of their initial infection. Death is not the only thing to count in this pandemic, we must count lives changed. We still know very little about Covid-19, but we do know that we cannot fight what we do not measure.’

Nisreen A Alwan is an Associate Professor in Public Health at the University of Southampton and an Honorary Consultant of Public Health at University Hospital Southampton NHS Foundation Trust. @Dr2NisreenAlwan July 2020

Care Response – General Practice Nurse (GPN)

- Clinical assessment and examination – a whole person perspective would be adopted and clinical assessment and initial management would incorporate a multi-system examination process, due to the uncertain course and pattern of the virus
- Clinical testing - whilst clinical testing is not always necessary it can assist in identifying the causes of continuing symptoms. It can also help to exclude more serious conditions related to the virus and act as a ‘safety net’ when diagnosing
- Managing co-morbidities – as many long-term conditions present and are managed in primary care the GPN has an overview of co-morbidities including hypertension, ischaemic heart disease, kidney disease and diabetes. These will need to be managed in conjunction with the Covid-19 treatment





‘Sidney presented with flu-like symptoms at home which he felt he was able to cope with, then became acutely unwell and rushed to hospital with breathing difficulties via an ambulance and ended up in ICU.’



- Self-management – will assist with setting goals and realistic targets whilst giving health and wellbeing advice to assist with general health
- Referral – make appropriate referrals to other members of the MDT.

Care Response – General Practitioner

‘GP’s will be at the forefront of helping patients cope with ‘lingering and difficult legacy’ of Covid-19’- RGCP 2020

The role of general practice in caring for people post Covid-19 will be central and essential to the recovery and rehabilitation in dealing with the physical and psychological health consequences of the virus. GP led post Covid-19 reviews and robust referral pathways for investigations and clinical interventions to manage people with delayed recovery will be vital.

Living with Covid-19 after a hospital admission

Sidney (not his real name) is a fifty-four-year-old accountant who lives in a large house in South London with his wife and two teenage daughters who have been deeply affected and worried about their dad. Since his ill health his wife has been working to help with the finances and they are struggling with school and university fees. His parents live miles away and are shielding so they cannot visit to see him, so his wife having very long difficult telephone conversations every day which is adding to her stress.

Sidney presented with flu-like symptoms at home which he felt he was able to cope with, then became acutely unwell and was rushed to hospital with breathing difficulties via an ambulance and ended up in ICU. Sidney has no past medical history or underlying health conditions and has been physically fit. After a three-week hospital stay, he was discharged with muscle wasting and difficulty mobilising having to use a Zimmer frame. He has a urinary catheter in sICU due to incontinence, a granulating tracheostomy wound and residual swallowing difficulties and a developing pressure sore on his heel. He is depressed and upset, as he is reliant on carers for all basic hygiene care.

Care Response – District Nurse

Comprehensive person-centred assessment – involving Sidney and his relatives in all decisions about his care and setting realistic goals around rehabilitation and recovery. The emphasis being on self-care and management allowing Sidney to make decisions for himself.

Physical Examination

- Clinical investigations – regular monitoring and update on all tests and hospital appointments
- Catheter – apply catheter valve to assist in retraining bladder with a view to community TWOC as soon as possible. Teaching on how to care for his catheter independently to reduce embarrassment. Monitor fluid intake to prevent complications
- Wound assessment and wound care planning of tracheotomy site and pressure sore on heel
- Mobility - pain from heel reducing ability for mobility rehab so appropriate pressure relief equipment put in place e.g. heal up boot, off-loading advice, assessment of wound and treatment accordingly, providing appropriate foot wear to allow mobility e.g. Kerrapad shoe over dressing

Referral – involve health and social care professionals and co-ordinate care delivery, including presentation at MDT meetings

- General practitioner – close liaison
- Tissue viability nurse – long arm consultation regarding wound management
- Community speech and language therapist – consultation for communication aids and loss of speech
- Community dietician - nutritional assessment – Encouraging a well-balanced high protein diet to help with healing and muscle building
- Community mental health team – if required



- Physiotherapist
- Occupational therapist
- School nurse
- Social services for welfare assessment and advice regarding finances.

Carers Support

- Building relationships with the immediate family and obtaining consent to liaise with the wider family regarding Sidney's progress and update. Encouragement of family involvement with aspects of care and facilitation of self-care wherever possible. Utilising virtual and remote communication devices as needed.

Social Support

- Explanation about self-certification for prescriptions and also referral to social services for additional advice.

Care Response – Physiotherapist

- Full holistic assessment (Via OT or PT) - goal setting
- Environmental assessment- as appropriate addressing mobility/ ADLS/ myopathy/ neuropathy/ prone lying related injuries/ core stability/ MSK issues eg joint pain/ pain
- Provision of mobility aids and adaptations as appropriate.
- Fatigue assessment and management
- Memory and concentration assessment as appropriate and referral to OT
- Assessment of pre and post exertion observations to establish cardiovascular response to exertion and postural hypotension
- Exertional oxygen assessment
- Progression of mobility towards independence and individual strengthening exercise programme
- Assess for inspiratory muscle weakness and treat with inspiratory muscle training as appropriate
- Shortness of breath management.
- Advice and education of patient and carers/ family. Signposting to appropriate support websites
- Liaison with other members of MDT team /escalation back to medical secondary care team as appropriate.

Care Response - Occupational Therapist

- Information gathering/core assessment (holistic approach)
- Physical (mobility, transfers, activities of daily living, feeding, postural/tonal management to include splinting as required, bed mobility for skin care, fatigue management)
- Environmental (communication, seating, adaptations and assistive devices)
- Cognitive (delirium prevention and non-pharmacological delirium intervention, orientation, cognitive assessment to include attention, visual progressing, information processing, memory, executive function)
- Other interventions: discharge planning, patient diary, education for patient and MDT sleep management, fatigue management
- Joint working with MDT colleagues particularly physiotherapy, SLT, nursing
- Participate in the ward MDT to establish individualised goals.

Care Response – School Nurse

- Post-traumatic stress support needed for teenagers
- Referral to young carers
- Supervision for them?
- Coping strategies and talking therapies
- School links and counsellor support including a reduced timetable if needed
- Desensitisation work regarding medical equipment in the home for them
- Relationship and counselling between father and daughters
- Access to free school meals
- Identify sources of support, family
- Immediate plan, and long-term plan – what can they control and what they cannot control

Building relationships with the immediate family and obtaining consent to liaise with the wider family regarding Sidney's progress and update.



Care Response – Occupational Health Nurse

- Once some form of adequate recovery is evident, in preparation for the consideration of Sidney returning to work, an initial biopsychosocial clinical assessment to be arranged, taking a full clinical history – past and present.
- Undertaking a full analysis of the role in which Sidney is employed is vital, as is assessing the impact his sICUation may have upon his functional ability, from both a psychical and psychological perspective – listening carefully, and understanding and respecting Sidney's experience, his thoughts, his perception and beliefs; consideration should be given to:
 - ✦ Work type, work demand and control
 - ✦ Level of responsibility and usual expectation
 - ✦ Personal desire to resume work
 - ✦ Line management and responsibility / support for others
 - ✦ Environmental factors - such as location re accessibility and access to clean and private welfare facilities, space re mobility, manoeuvrability and circulation maintenance, temperature, lighting, noise and the volume of movement (people traffic) re concentration, mood, interaction with others etc.
 - ✦ Ergonomics i.e., mobility / circulatory aids, seating, specialist equipment
 - ✦ Cognitive functioning - aids / memoirs pens / environment etc.
 - ✦ Hours and shifts – reduced hours / flexibility, start / finish times, sustenance breaks, time off for attendance at medical appointments etc.
 - ✦ Travel requirements and access – consider whether Sidney is able to “attend” the workplace, and if so, how will he travel to and from work
 - ✦ Management support – it is vital that management are understanding of any residual effects that may impact upon Sidney's ability to perform in his role. Management to be advised on reasonable adjustments that Sidney would require to assist him in undertaking his work, and where possible, they should be aware of the potential timescales that adjustments are required



Resources

- Covid Symptom Study: <https://covid.joinzoe.com/post/covid-long-term>
- National Institute for Health Research- Living with Covid-19 Themed Review <https://evidence.nihr.ac.uk/themedreview/living-with-covid19/>
- How to manage post viral fatigue after Covid-19 – Practical advice for people who have recovered at home: <https://www.rcot.co.uk/how-manage-post-viral-fatigue-after-Covid-19-0#:~:text=You%20need%20to%20rest%20both,relaxing%20music%20can%20also%20help.>
- NHS Your Covid Recovery: <https://www.yourcovidrecovery.nhs.uk/>
- Asthma UK/BLF Post Covid hub for patients: <https://www.post-covid.org.uk/get-support/>
- NHS to offer 'long Covid sufferers help at specialist centres' <https://www.england.nhs.uk/2020/10/nhs-to-offer-long-covid-help/>

Supporting organisations

- Association of Chartered Physiotherapists in Respiratory Care: <https://www.acprc.org.uk/>
- Critical Care National Network Nurse Leads: <https://www.cc3n.org.uk/>
- Faculty of Intensive Care Medicine: <https://www.ficm.ac.uk/>
- Faculty of Sports and Exercise Medicine UK: <https://www.fsem.ac.uk/>
- Intensive Care Society: <https://www.ics.ac.uk/>
- Royal College of Nursing (RCN): <https://www.rcn.org.uk/>
- Royal College of Physicians (RCP): <https://www.rcplondon.ac.uk/>

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Sue Boran and Matthew Bradby – editors

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Carol Stonham	GPN/ Respiratory Specialist	Gloucester
Dr Laura Evans	Professional Head and Principal of Occupational Therapy	Sheffield Teaching Hospitals Foundation Trust and Sheffield City Council
Rachel Smith	Professional Head of Physiotherapy	Sheffield Teaching Hospitals Integrated Pathway Manager for ARC and Active Programmes
Helen Chapman	Head of Integrated Community Care Combined Community and Acute Care Group	Sheffield Teaching Hospitals
Michelle Pullman	Complex Care and Frailty Nurse	Witley & Milford Medical Partnership
Michelle Rafferty	Advanced Nurse Practitioner Mental Health	Dorset Healthcare University NHS Foundation Trust
Sarah Winfield-Davies	Safeguarding Nurse/Team Lead, North Devon Care Homes Team	Northern Devon Healthcare NHS Trust
Tracie McKelvie	Occupational Health Nurse Specialist	Carmarthenshire, West Wales



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