Community Nursing Response to Covid 19

1.0 Introduction and Background

In response to the current Covid 19 situation and in order to ensure that essential services and core functions are delivered by Community Nursing it has been necessary to establish an outline of the key elements of care and staff groups who will provide community nursing interventions.

This paper sets out some common key principles for community nursing services that will support the allocation of resource and skills to the areas of need within our populations.
Community nursing as a whole is defined by a range of nursing job roles, skills and knowledge operating across different parts of our services. The staff that we identify as part of community nursing have an extensive and varied range of skills, however all staff share the same goal; the delivery of person centred safe and effective care to meet the health needs of their local populations and their families.

It is also the case that Community Nursing staff are being approached to work on a voluntary basis within a range of settings, some which are different from their usual place of work to support the service efforts to manage the current Covid 19 situation.

2.0 Principles

The paper sets out the range of community nursing services and interventions.

The following key principles apply across all areas of community nursing;

- Adoption of Right Person/Right Place/Right Time philosophy
- Assessment of Individual needs should clarify level of appropriate care during the current period
- Care will continue to be guided by the principles of safety, effectiveness and being person centred.
- During essential care delivery, minimising the number of people involved in home visits or home visits required
- For the safety of all concerned, all staff who are visiting people in their own homes or for people that are asked to attend a community clinic it is important to establish prior to visiting if patients or those who live with them have:

  - Been advised to self isolate or have symptoms
  - Are shielding
  - Have a fever/high temperature
  - Have a persistent cough
  - Are short of breath or have breathing difficulties

This is to ensure visits and /or clinic visits are triaged appropriately and correct level of PPE is selected by nursing staff for the episode of care or treatment intervention. (Link to HPS guidance on staffnet)

3.0 Community Nursing Services

The following role, scope and intervention guidance should support and inform the service responses in each HSCP

District Nursing

District nurses will establish ability of patients or carers in relation to the self management of simple procedures such as eye drops/simple dressings/administration of medication or consider where patient and family education could assist for such interventions as administration of insulin/clexane. If people are discharged from hospital it is expected that this will have been explored

Interventions that should NOT be referred to DN service at this time include non urgent phlebotomy/BP checks/routine wound checks, or any other intervention that could be safely carried out by family/informal carers

Daily prioritisation of District Nursing visits will be necessary to respond to a rapidly changing position, therefore it is possible that guidance regarding priority visits will change

All decisions need to be risk assessed, person centred and recorded appropriately:

Priority visits at this point should include the following.

Palliative and end of life care

- Patients in receipt of end of life care, including Verification of Expected Death/ Confirmation of Death where appropriate
- Patients in receipt of medication via T34 syringe pump
- Breakthrough medication
- Patients receiving palliative care interventions (clinical judgement)
- Essential assessment visits i.e. discharge from hospital for end of life care
- Patients with Hickman/PICC lines which require flushing to maintain patency
- Pre Chemotherapy bloods
- Patients with PICC lines: discontinuation of chemotherapy

Other priority care activity:

- Patients who require administration of insulin where there is no self management or family alternative (please ensure patients have vial/needle and syringe where this is possible and not a device)
- Patients who require administration of essential medication where there may have been a breakdown in usual care arrangements
- Complex/ exudating wounds which would strike through within 24 hours
- Wound management - wound management requiring nursing intervention needs to be based on clinical and professional judgement regarding the frequency of visit/s
- Catheter management particularly unscheduled visits including blocking/bypassing
- Patients who require administration of Enteral Feeds/Total Parenteral Nutrition, if there is no self-management or family alternative
- Administration of hormonal cancer treatments including Prostap and Zoladex

Out of Hours District Nursing services

OOH District Nursing is provided as below:
Victoria ACH: for Glasgow South and service to Eastwood locality of East Renfrewshire
Stobhill ACH: Provision of service to NE/NW Glasgow and East Dun
Mile End Centre: Renfrewshire and service to Levern Valley locality of East Ren
Vale Centre for Health and Care: West Dun including SLA to cover Helensburgh and Lochside from 2300 to 0800.
Greenock HC: Inverclyde HSCP

HSCP's have a mix of dedicated OOH staff and those who also work in day services. Most areas have a number of planned visits including Enteral Feeds, as well as increasing numbers of unscheduled visits, including in particular Palliative and End of Life care/breakthrough medication/Verification of Expected Death (and going forward Confirmation of Death) and rapidly deteriorating patients. In addition issues with catheter patency are a pressure for most teams.
In the current situation it is reported that teams are seeing increasing numbers of people referred with Covid symptoms, many of whom are experiencing distressing unmanageable symptoms such as hypoxia/excess secretions/distress. It is important to note that teams need to prioritise visits and as such there can be unavoidable delays due to the geography of some areas.
Smaller HSCP's are reporting anxiety related to maintaining these services with increased demand at this time.
In relation to the provision of the DN > GP OOH Professional to Professional Line, this service is currently still limited to Sat and Sun 10am- 4pm, extending this to evening and overnight has been raised to OOH CD as it is noted DN's are still having to navigate the entire NHS 24 system, impacting upon both a timely service to patients and effective and efficient use of DN time, particularly during these unprecedented circumstances.
In addition, regarding the implementation of Confirmation of Death there is a need to review the volume of referrals and demand in ongoing weeks and going forward.

Visits requiring discussion and clinical consideration
Interventions including Hydroxocobalamin injections should be discussed with GP and whilst there may be potential for alteration of schedule depending on medical judgement, no clinical intervention will be stopped without discussion with GP or clinical team.

It has been confirmed at the Primary Care Clinical Advisory group in relation to haematology guidelines (particularly B12) that we should be referring to GGC prescribing guidance only. Link at the end of paper, which relates to medical decision making.

Non-Medical Prescribing:
All non-medical prescribers must carry prescription pads when carrying out visits. Prescriptions should be issued to patient/family at time of visit.

General Practice Nursing

The current situation has changed the working priorities within general practice. Clearly this is a fluid situation. It is possible that GPNs may have reduced requirements to undertake normal practice activity for brief periods during the pandemic.

Some General Practice Nurses may also be able to offer additional time beyond their usual working hours. There may be new tasks the nurses undertake within practices, such as Shielding contacts or care planning.

GPNs will also already be involved with essential long-term condition management, Anticipatory Care Planning and follow up and may already be using new ways of working for these such as telephone and video consultations. However, it may be that the nurses have some short term capacity to consider work outside the practice and GPs, as the employer, may be willing to agree to this, during what would have been the practice's time. Each general practice employer can consider their response to releasing any general practice nursing resource to potentially support discrete areas of care as well as supplementing community nursing.

If there is any capacity, it may be possible to consider other essential care such as:

- Community assessment centres – where there is a specific need over and above current core staffing
- Support to community nursing resource – such as district nursing, care homes
- Testing
- Possibly home visits

The possibility that GPNs and their HCSW might be undertaking home visiting where relevant might need to be explored. There would need to be discussion and clarification around a number of areas such as indemnity, contracts, travel, PPE and lone worker protocols.

Shielded patients – Advice from the Primary Care Clinical Advisory Group on shielded patients should be adopted (Appendix 1). Shielded patients requiring routine, urgent or have potential COVID symptoms should have individual care needs directed through an integrated community nursing response."

Treatment Room Nursing

HSCPs are at different stages of developing their Community Treatment and Care services (CTAC) as part of the Primary Care Improvement Plans. Some HSCPs already had established Treatment Room services whilst other HSCPs have had to develop this as a new service and are at an early stage of delivery.

Although there are still clinic based services operating these are reduced in number.

Many patients either do not wish to come, or cannot come to treatment room services due to shielding or self isolation. Some are carrying out self care.

Some areas have already integrated Treatment Room Nursing with District Nursing to provide support and carry out treatment room interventions in a domiciliary setting. If patients are self isolating or are in the shielding category they are being triaged and assessed and suitability for home visit is being considered.

Advanced Nurse Practitioners (ANPs)

These roles have been utilised differently in different settings and HSCPs.

Glasgow City HSCP has ANP's working in the 5 Residential Care Homes focusing on assessment, anticipatory care planning and avoidance of admission to hospital. These posts are benefitting both practices and patients and are being evaluated by the Primary Care Programme Board. These staff are currently augmented by Palliative Care Facilitators and District Nurses and wider team of AHP and other community staff. These roles continue during the Covid 19 pandemic providing support and treatment to these homes.

In Renfrewshire the initial model involved HSCP employed ANP's working within GP practices which has benefited both practices and patients and is currently being evaluated for the Primary Care Programme Board.
Latterly we have employed 2 WTE ANP's for residential and local authority Care Homes, focusing on assessment, anticipatory care planning and avoidance of admission to hospital. These roles continue during the Covid 19 pandemic, albeit more remotely, utilising Near Me or similar technology where appropriate.
This team currently is augmented (in Renfrewshire) by the CHLN's/Palliative Care Nurse Specialist and a wider team of AHP staff deployed via RES and Rehab services. There are robust links with both local hospices regarding support/in reach to Care Homes

Other HSCPs have developed models similar to the two examples above with a number of ANP's who are practice based, and others focusing on services across Care Homes.

The role of the advanced nurse practitioner within a general practice setting usually focuses on triage and on the day minor illness presentations and acts to meet the needs of patients presenting to the General Practice. These ANP roles offer a wide skill set which could also potentially be utilised within the community assessment centres but would be dependant on there being spare capacity in their general practice. It might be possible for their skills to also be utilised effectively within a wider community setting to support care/residential/nursing homes, thus linking in with the wider ANP response as above.

Phlebotomy – including domiciliary visits.

When the arrangements to reduce footfall into general practice were put in place it became obvious that both treatment room services and phlebotomy would probably have to include an outreach/domiciliary service to manage demand.
A core service was retained in a smaller number of bases and staff began to work with other community nursing services such as district nursing to facilitate the most efficient use of the staffing. Phlebotomy will support district nursing to concentrate on areas such as palliative care, insulin administration etc
Phlebotomy services continue to operate on both a clinic and as required on a domiciliary basis.

In some partnerships phlebotomy operates as an integral part of treatment room and District Nursing. Glasgow HSCP have a separate phlebotomy service with its own Single

Point of Access phone number- **0141 355 1525.**

If a patient needs a domiciliary visit, the general principle of this being provided by the area in which the patient resides will be applied. Referrals from GPs for patients who fall into this category will be passed on to the appropriate area by the phlebotomy service in their area.
In other HSCP's a number of phlebotomy posts have been created as an element of the Primary Care Improvement Plans, therefore phlebotomy services continue to be provided although teams may currently be deployed across District Nursing settings.

General practices could also consider their own Practice Nursing or HCSW resource to support local domiciliary phlebotomy particularly within a shielded population who are unknown to community nursing.

4.0 Additional areas of consideration

The following areas should be used to guide services and resource/skill allocation to areas of need within community services

Confirmation of Death
In May 2017, a Directors Letter from the Chief Nursing Officer (CNO) [DL(2017)9] signalled a change in policy; so that any trained healthcare profession could verify death in all circumstances. NHS Education for Scotland (NES) have been leading on this with resources being developed over the last few months. The Confirmation of Death (CoD) policy permits any trained Registered Health Care Professional to confirm death in any circumstance. Medical Certification of Cause of Death (MCCD) remains the responsibility of medical staff. CoD trained staff will be able to assess and confirm that a person has died. They will complete a Confirmation of Death Recording Template, returning one copy of the form to the GP practice and leaving a second copy in the patient's home for the undertaker. In GG&C a SLWG chaired by Karen Jarvis (Chief Nurse Renfrewshire) has produced a range of resources for staff in addition to the national resources, to support staff to attain confidence in Confirmation of Death. It is important to note that in these unprecedented circumstances this implementation has been facilitated rapidly in order to respond to the current crisis, as opposed to a more managed and incremental approach. The initial Standard Operating Procedure has been developed for Community Nursing Staff who are already competent and confident in Verification of Expected Death, and has been written specifically to apply to the Covid 19 situation, with review thereafter. Other groups of staff exploring initial implementation are: • Hospital at Night and other Acute ANP roles • Prison healthcare It is vital to note that there are risks in relation to this implementation within Community Nursing,

particularly with regard to the potential for demand to outstrip capacity especially in the OOH period.

Recommendation
As such, it is vital to consider at pace other staff that could be trained utilising the online resources and it is suggested that this is explored from a General Practice Nurse perspective, particularly for patients in the practice population who may have died unexpectedly and have had no involvement with District Nurses.

Additionally, (DL (2017)9), states that Confirmation of Death is a role which should be explored by boards in relation to ALL registered healthcare professionals, going forward it is expected that this will be considered by AHP leads.

The entire resource is available at https://www.palliativecareggc.org.uk/cod
Please note that the communication and resources are being tabled at the HSCP Tactical Group 22/04/20 and Area Partnership Forum 23/04/20
Please also note that we have not yet had final agreement from our staff side colleagues regarding implementation, this is currently being discussed with a view to agreement by 18/05/20

5.0 Conclusion

HSCP's are currently working to minimise disruption and are supporting staff to deliver essential services to patients and families to provide the greatest impact to those who need care.
This document should clarify the principles and support decision making at local HSCP level, and has been developed by Professional Leads and Heads of Service in partnership.
Operational managers maintain responsibility for service delivery.

Links and references

B12 injections

GGC B12 COVID19 prescribing guidance

CNO guidance

https://www.gov.scot/publications/coronavirus-covid-19-nursing-and-community-health-staff-guidance/

Testing guidance

https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/covid-19-workforce-education/

Appendix 1

Shielding Patients Guidance for NHS Gre