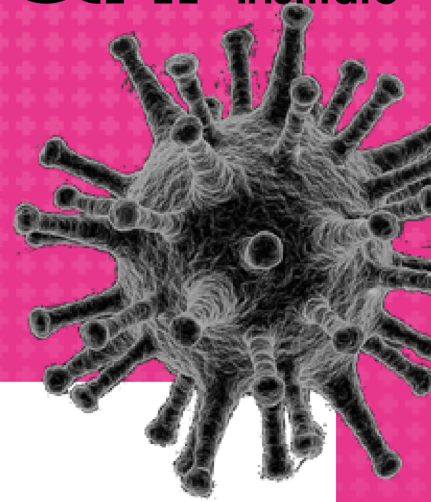
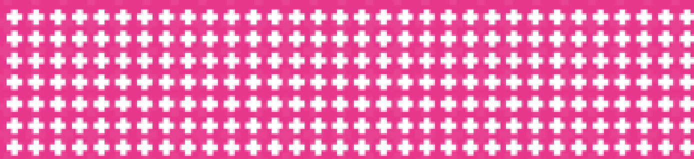
The Queen's Nursing Institute

Community Nursing Covid-19 Innovation/Best Practice

CASE STUDY

The MDT Hospital Discharge Service in Bradford





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Personal details

Name: Rachel Woodington
Job title: Community Matron/ANP
Employer: Bradford District Care Trust

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Please describe your practice innovation.

In March 2020, a document was published by the Government in response to the Covid-19 pandemic. This document 'The Covid-19 Hospital Discharge Service' was to change the way community services supported 95% of patients being discharged from hospital. Community services were to lead the way, to ensure that patients had a seamless service post-discharge, whilst keeping them safe within their own homes with prompt access to both health and social care provisions, working 'hand in glove' with social care. 45% of patients post-discharge would be able to recover in their own home, but only with support from health and social care. Alongside this it was imperative to include therapy services and a large element of case management.

Bradford District Care Foundation Trust (BDCFT) set up an Out of Hospital MDT (OOH MDT) team, which I am proud to say I was a co-ordinator for. The team included Advanced Nurse Practitioners, Case managers, Social workers, Physio and Occupational therapists and a team of Continuing Healthcare Nurses. The target was a 2-hour turnaround from identifying that a patient can be sent home with support, to them arriving at home. In addition support was given to care homes, with their ever-growing needs due to the Covid-19 pandemic.

The team looked at multiple issues that may arise for the patient once discharged, alongside the needs that were identified by the hospital trust or care home facility. These included signposting and advocacy, equipment, medication reviews, palliative care management, on-going health, social care packages and needs, reablement, PPE, and Covid-19 testing for patients being discharged to community beds/nursing homes.

The service ran from 8am to 8pm 7 days a week, with a lead accountable for each patient and the seamless co-ordination of care. Huddles were twice daily and all professionals from each discipline were present at the call. A structured handover was undertaken for each patient, identifying reason for referral, needs to be met and by whom. These needs were often met on the same day as referral, by all clinical services. This meant that the patient would not have to wait for a long period for care services, therapy, or a clinical review, when often pre-Covid there were delays accessing these services due to high demand. We aimed to reduce the number of readmissions to a hospital setting, taking the pressure off care homes during the pandemic, and providing true holistic care to all patients post-discharge.

As a team, we were very privileged to have a number of other services running alongside us that we were able to sign post to, if we felt that patient had an escalation of care needs that was outside our scope. This was called the 'Super Rota' and was run by a Doctor and a team of nurse consultants. Again, this allowed us to ensure that patients were receiving the best standard of care, whilst remaining within their own home and shielding from Covid-19.

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

A patient rarely has just health needs that need to be addressed; social care needs are in an ever growing demand, due to aging population and an increase in multiple co-morbidities. Without taking a co-ordinated approach to a patient needs through a multi-disciplinary viewpoint, care during the pandemic would have been difficult to co-ordinate and manage safely.

By using the approach by the OOH MDT we were able to ensure that ALL needs that were identified were met in a timely, safe manner, ensuring that the patient was in the correct environment, at the right time with the right person(s) providing and supporting the care needed. This helped to reduce admissions and trauma for the patient, thereby improving health inequalities and reducing the impact on families helping provide the care alongside professionals. Alongside patients in their own homes, it also provided support for staffing issues within care homes that had high covid-19 outbreaks, for example support with PPE concerns, helping provide equipment for patients who were deteriorating or who required EOL care, and providing support for staff who were struggling. This was a seamless service that provided the high-quality care through an efficient and effective MDT approach for true holistic care.

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

The OOH MDT has enabled us to work more closely with our social care providers than I have ever known in my career. It has highlighted many exceptional services and individuals that are available for patients that we often known little about, and the same can be said that our social care providers felt the same with the community services. It has offered links to therapy and mental health services that will long continue post-pandemic. By using video links, it has put names to faces and become more of a working community, a team rather than individuals and services. When working as a team the outcome will always be greater than working alone and trying to cover multiple areas of care, which is only going to benefit the patients. It has allowed us to understand roles, commissioning, referrals to services, gaps in services and highlighted effective ways of working, moving forward during this difficult time.

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

It is certainly an evolving change that needs to be met. As previously mentioned, we are aware that there is an ever-growing population, with multiple complex needs that need to be addressed in a holistic manner. However, with these needs also comes need for change, to work more closely with other providers to ensure that we can address these changing needs. This can only be done through a multi-professional approach.

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Please describe any particular challenges you had to overcome.

As with any new team, we are all eager for our voices to be heard, for our services to be understood and to find common ground. This is especially hard when the only form of communication is via a video link and not face to face. Face to face it is easier to communicate, form relationships/bonds and become a team without other distractions, poor internet connections or apps that some days will not work. Technology has certainly been my biggest challenge in my ways of working within the MDT, however with support from other team members who are 'techno wizzes' the team was able to adapt and I was able to move forward more quickly.

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Please describe any continuing challenges you would like to address.

Post Covid-19, some of the challenges for health and social care will remain prevalent due to funding and staffing shortages and increasing demand on services. It can only be hoped that some of the links made during the pandemic will have highlighted the need for more integrated care, for more proactive care for all patients and to work more closely together without corporate red tape.

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

Microsoft Teams, Zoom, Gov.uk, Local care policies, Headspace app.

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

Laptop. Mobile phone, video consultation apps.

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Please give any individual examples, quotes or other information.

I think if Covid-19 have taught us anything it is that to truly provide holistic care within a patient's own home, we need to take a MDT approach and be able to work with other providers in a more seamless way and build bridges rather than barriers.

Only then will we be able to say that a patient has had 'holistic' care needs met, something that I am positive will happen moving more forward, especially at BDCFT.

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Rachel Woodington