Caring for Patients and Families Affected by COVID: meeting the psychological needs of those we serve

6 May 2020
WebEx Quick Reference

• Please use chat to “All Participants” for questions
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• All lines will be muted during the presentations, please chat in questions and comments to All Participants
Thank you – for all you do everyday
Thanks to Year 4 HIAE Members and partners in Europe

http://www.ihi.org/Engage/collaboratives/Health-Improvement-Alliance-Europe/Pages/default.aspx
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Anna Dinsdale
Clinical Nurse Specialist GUCH) Team, Joint Lead Nurse for the Hub
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A Harvesting tool; a nimble structure to learn; a mechanism for curating and moving to scale up

Harvesting Tool: COVID management and improvement approaches now, and into the future

Only a couple of months ago (it’s April 2020) our definition of ‘normal’ daily life in personal and professional ways differed from our experience today. It’s important to have a mechanism to systematically capture what we’re learning in real time, as memory is fickle and often unreliable. There are many sources of optimism – how innovative and collaborative professionals and society at large have been; the displays of solidarity seen daily; how bureaucracy has given way to agility. Learning is always dynamic and failing to capture it ‘live’ and envision ways to incorporate new practices towards a better future may not allow us to leverage the opportunities afforded by the intensity of the changes driven by the urgent COVID response. In some ways, going back to pre-COVID practices may be desired, whilst in others it may be unthinkable. The socialisation of ideas to imagine a better future will help organisations learn and adapt in line with their local nuances – shaping the new normal.

The basics of the effort should include:

- A designated Organisational Learning Lead, who will coordinate and facilitate the org
- A senior executive to oversee and sponsor the effort
- Local Learning Leads, who will be responsible to collecting local learning in creative w (wards, units) and/or meso systems (departments or directorates). These may include
  - Online / virtual forms
  - Learning logs
  - Daily or Weekly conversations
- An approach that
  - Clearly communicates in a compelling manner why the organisation is doing it
  - Develops simple mechanisms for collecting the learning, such as the ones des
  - Starts small, testing the learning collection mechanism with one person and c desired areas
  - Fosters conversations to reflect on the learning as it is collected, creating a se

The following template serves as a data collection tool for the local learning leads and the org common themes and trends, and curate information in terms of specific practices to propose decide whether to focus on both preparedness and management, or just one of these dimen: ‘what we did’ and ‘level / topic’ columns, to ensure local relevance.

I. COVID Preparedness

Core question: what would we do differently if we could turn the clock back to the beginning of COVID-19 preparations?

<table>
<thead>
<tr>
<th>What we did</th>
<th>What we would do differently</th>
<th>Why (what could be better about the new way? Include any anecdotal or hard data you may have)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID Testing:</td>
<td>Physical infrastructure changes:</td>
<td>Human Resource re-deployment:</td>
</tr>
<tr>
<td>Surge Planning:</td>
<td>Elective activity:</td>
<td>Non-COVID Management:</td>
</tr>
<tr>
<td>Staff Physical safety:</td>
<td>Staff Psychological safety:</td>
<td>Patient and family communication care needs</td>
</tr>
</tbody>
</table>

II. Management Practices to manage COVID19: improvements and innovations for a better future

Core question: what are we doing differently to manage COVID19 daily that would be valuable to incorporate into the ‘new normal’ of how we manage, improve, innovate? (complete sections that are relevant to you)

<table>
<thead>
<tr>
<th>Level / topic</th>
<th>What new management and improvement practices would be useful to continue beyond COVID?</th>
<th>Why should these be adopted? (what is better about the new way? Include any anecdotal or hard data you may have) How would we incorporate these into practice in the future?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>Department or Directorate</td>
<td>Team</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>(specify area)</td>
<td></td>
</tr>
</tbody>
</table>
It starts with me....

....treat yourself like someone you are responsible for helping!
The power of stories
“The greatest waste... is failure to use the abilities of people... to learn about their frustrations and about the contributions they are eager to make.”

W. Edwards Deming
Out of the Crisis
Intelligent Kindness: reforming the culture of healthcare (Ballat and Campling 2011)
1. Always focus on what really matters now and for the future for the person

2. Be intentional

3. Feed your soul by feeding the soul of others
Caring for Patients and Families affected by COVID-19

Dr Seema Srivastava, Consultant in Medicine for Older People
Dr Stephanie Eckoldt, Consultant in Palliative Medicine
North Bristol Trust, Bristol, UK
New Challenges to Communication

Staff
- Considerable re-organisation of a large acute hospital in an incredibly short space of time
- Rapidly changing workforce with redeployment, sickness, shift patterns
- Variation in continuity within wards
- Anxieties about what we may face during the pandemic

Patients and Families
- Being forced to shift from a culture of “open visiting” to significantly restricted visiting
- Families and carers unable to visit because of their own health issues.
- Families left with a “knowledge gap” about their loved ones, particularly in context of deterioration.
- Constantly engaged phones adding to anxieties
Coronavirus (COVID-19):
Visiting restrictions

In line with the Government’s strict new rules announced on Monday 23 March to help reduce the spread of infection, we have suspended visiting to our adult wards with immediate effect.

Visitors are not permitted within the hospital
Impact...

Changing the way we communicate...

Switch from face to face discussions to communication by phone

Realisation that our communication with relatives is largely **REACTIVE** rather than **PROACTIVE**.
Maintaining a ‘Lifeline’
Maintaining a ‘Lifeline’

- Physical Separation
- Emotional Gap
- Information Gap
Maintaining a ‘Lifeline’

- Physical Separation
- Emotional Gap
- Effective Communication
- Information Gap
Communication with families during the COVID-19 pandemic

- Co-ordinated approach to sharing information
- Communication Toolkit to support Staff
- Development of a Family Liaison Team
- Use of Technology
Communication with families during the COVID-19 pandemic

Phone communications during admission:
1. Admission call
2. Daily update call
3. Deterioration call
4. Discharge/Death call

Communication
Toolkit to support Staff

Development of a Family Liaison Team

Use of Technology
Communication with families during the COVID-19 pandemic

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Communication with families during the COVID-19 pandemic
The future...

• Changing culture to support the ‘new normal’
  – Amazing opportunity to fundamentally impact the way we communicate with families/ carers
  – Communication toolkits to support any type of conversation with families/ carers

• The value of virtual visits

• Ensuring sustainability
  – supporting staff to be facilitate new processes
  – development of stable workforce
THANK YOU
St Bartholomew’s Hospital Covid Enquiry Hub

Henna Roberts, Senior Improvement Manager
Anna Dinsdale, Specialist Nurse (GUCH)
### Aim:
To centralise and streamline information dissemination to St Barts COVID19 patients’ families, between hours of 8am-8pm.

### Measures:
- Calls out/day
- Calls in/day
- Number of COVID19 patients/day in Barts
- Time of calls

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#### Primary Drivers

1. **Estates and equipment**
   - 1.1 Room, toilets, staff room access, whiteboards
   - 1.2 PCs, 2nd screens
   - 1.3 Phones, single number/loop, headsets, answerphone for OOO
   - 1.4 Hub email address
   - 1.4 Issues and improvements logs/posters

2. **Staffing and training**
   - 2.1 Recruitment (initial and on-going) A&C, nursing, medics
   - 2.2 Staff contacts and rotas
   - 2.3 Reporting sickness/isolation
   - 2.4 Paying for OOO and weekends
   - 2.5 Induction
   - 2.6 Psychological support for staff

3. **Information flow – internal (with ITU)**
   - 3.1 Central number for families, direct line for ITU
   - 3.2 Daily ITU handovers
   - 3.3 ITU information centralised on CRS and clear for enquiry hub staff
   - 3.4 Hub notes for ITU on family

4. **Information flow - external (with families)**
   - 4.1 Family updates – arrival, daily, deterioration, EoL, death, onward transfer
   - 4.2 Single point of contact with family, passwords, identifying one person
   - 4.3 Fielding reactive calls
   - 4.4 Call data recording and information board
   - 4.5 Chaplaincy and other external support for families e.g. Samaritans
   - 4.6 Scripts and logging on CRS, daily SOPs
   - 4.7 Complaints
   - 4.8 Website and switchboard

5. **End of Life**
   - 5.1 Notification of EoL/death (supporting ITU)
   - 5.2 EoL visitor meet and escort (hospital letter for access)
   - 5.2 Link to EoL flow/support
   - 5.3 Handover/link to Bereavement flow
Enquiry Hub Team

- Made up of administrators and nursing staff
- Nursing staff are Senior Specialist Nurses from Cardiac and Cancer services together with Intensive Care nurses
- Individuals need experience of communicating with patients via telephone and having difficult conversations
- Staff redeployed from previous roles where services were greatly reduced
- Psychologically demanding role, psychology support available
Daily Operations of the Hub

- Nursing staff attend handovers on ITU to get clinical updates of patients from preceding shift
- Admin staff contact relatives of new admissions to explain how the Hub works and set up a key contact and password
- Nurses proactively ring all key contacts with an update of the patient’s condition and the medical plan for the day
- ITU medical staff used the CHOCK acronym to assist hub staff with information giving
  - C - Consultant in Charge of care
  - H - Headline (Progress over 24hrs)
  - O - Oxygen and ventilator requirements
  - C - Comfort levels
  - K - Key plan for the day
- ITU medical staff periodically ring – end of life
- Additional roles – collating bedside photos and messages for patients, assistance with video calls, and escorting relatives in end of life situations
Discussion

- Please continue to chat in your questions and comments
Where to find resources from this call series?

- Visit the IHI Europe Team webpage at http://www.ihi.org/regions/Europe. Then click on ‘Resources’ listed in the left sidebar.
Next week’s webinar

13 May at 16:30

QI Approach to Tracking the COVID Pandemic: the Power of Control Charts