

## **RCN DCN Forum Covid-19 Survey Results.**

As the RCN District and Community Forum Steering Group, we are extremely proud of the care provided by community nursing staff in very challenging circumstances. We asked Forum members 10 brief questions to enable us to capture the challenges currently faced. 80 responses 7/4/2020. Guidance regarding PPE from PHE was amended during this survey to include PPE for all patients (mask, apron & gloves).

### **1. What is the impact Covid-19 on both patient acuity and demand for visits in your caseload?**

Larger more complex caseload with increased requests for visits, alongside some inappropriate referrals. An increase in demand due to earlier discharges (some are dangerous with little information and these visits will not be picked up for several days). Vulnerable patients are being supported and monitored by telephone calls. There have been some increases in visit requests due to primary care withdrawing services, eg. GPN and AHP services and GP requests for home visits for self-isolating patients. Some GPNs visiting at home but other referrals are having to be refused. Only urgent, essential calls or those RAG rated 'red' are being maintained but this changes on a daily basis and there is little clear guidance, eg. insulin, syringe drivers and Clexane. The timing and length of visits is having an impact and there are challenges for urgent visits, eg. blocked catheters.

Teams have encouraging self-care, they are 'critically cleansing' their caseloads and have discharged patients wherever possible. Some patients are less able than others to do this which has, on occasions, led to suboptimal treatment in response to increased demand and reduced staffing capacity. Some patients are reluctant for nurses to visit, this has prompted more to manage their own care where they have often been unable to for many years. There are questions about whether carers/nurses should be let in; PPE for carers. Some want nurses to visit rather than GPs. Treatment rooms have closed which has led to increased referrals of these patients who are now self-isolating.

Increases in palliative patients as they are being discharged sooner from hospital; this is expected to be the biggest acuity jump. The provision of personal care at EoL has been taken on by many teams due to reduction in care packages. Many patients are deteriorating very quickly. Some areas are waiting for the tidal wave to arrive and feel they are still in the preparatory phase. Staff sickness has created gaping gaps in rotas and in some areas teams have merged. The effective use of triage is essential.

Teams are anticipating that demand from those who have overcome COVID-19 and are debilitated and require support to rehab and recover will be great. Some Covid-19 EoL patients are being discharged home without relatives being able to visit. Support is being provided for dementia patients by phone, which is challenging. There are referrals for additional support due to reduced packages of care, day centres have closed so there is no carer respite. Specialist services are on standby to take additional DN visits.

Some patients still don't understand that nurses can't do the call outs we used to for catheters etc. but demand is the same currently. Trying to prevent hospital admission with increasingly complex visits. Teams have, however, reduced visits to care homes. GPs care now contacting patients by phone and posting DNARs.

Prior to this caseload were at breaking point. Now there is staff sickness, no tests available and the strain is just too much for some. A reduction in 'routine' work but unsure of the impact on healing and a lack of prevention. But we have formed stronger PCN's and are deploying the best skill to the people most in need.

## **2. Do you sufficient Personal Protective Equipment available? What are the issues with this? What guidance do you have for when to use PPE? Do you feel that this is clear?**

During this survey, Government guidance for the community changed to a mask, gloves and apron for all visits.

Teams are following government guidance, but this is challenging as other agencies and Trusts are not and are using PPE more frequently than the current advice which is a concern for staff. The Government advice changed just last night to include a 3rd mask type for all vulnerable patients however, this type of mask is not something some teams have access too. Staff and patients feel safer with staff having a mask on. There is changing guidance and staff not trained, with no FFP3 masks available. Following all the media coverage, staff feel that higher levels of PPE are required which is causing undue stress.

Teams have some PPE but they need more; this monitored daily & counted. Some teams do not have sufficient and others are trying to purchase PPE themselves. Teams reflect that they have almost run out at times so PPE is rationed. Patients are seeing nurses as 'spreaders' and challenging staff. Some teams have accessed PPE from elsewhere eg. building companies.

Tensions and anxiety are very high. Advice from PHE, Trusts and infection prevention and control teams seem to differ. Many staff not happy with national guidance as it differs from WHO guidance. There are no visors available and in some areas hand sanitising gels are now centrally held per locality. There is limited PPE: one team was told by their line manager to only give nurses 1 visor & mask for single use only for Covid-19 only. If used, staff have to come back to base to get a replacement. Only reverse barrier patients have surgical mask apron and gloves and there are no gowns available at all for any procedure in some areas. All PPE is locked in cupboard and administrators have the key; supply is tightly controlled. There is not enough hand gel or Clinell wipes. There is rationing of PPE supplies; collected from central store and availability is limited. Staff upset and would feel happier to have more PPE in cars for confidence they are protected.

of Friday, 03/04/2020 we are wearing PPE for all visits, ie gloves, apron and fluid repellent masks. Guidance has previously been very vague & equipment in very short supply. However, there is a shortage of aprons and gloves and fluid shield masks; strict instructions, in some areas, to use fluid shield masks only when performing aerosol generated procedures. There is video training for donning and doffing but nothing to say when to do this, on/prior to entering, especially if greeted at the door, before/after leaving. No guidance on hand hygiene when leaving the home. Some have been told can wear surgical mask all day or store in bag between patients. If there is a risk of body fluid splash to wear eye protection. There are delays in delivery of dressing packs from suppliers. All households are a risk as it is not a controlled environment. Some nurses are feeling very unsafe going into patient's environment without knowing if they could already be positive. No clear guidance and left up to us to risk assess. Conflicting advice; we were advised that masks were to be worn by staff until moist and between patients.

## **3. Are you having queries from patients and relatives/carers about your use of PPE?**

Patients and carers are raising that we should be wearing additional PPE. Some patients/carers have purchased their own PPE for them or for the nurse to wear. Others are declining visits that teams would deem necessary. Patients feel they are more protected if staff are wearing a mask. Other patients have asked for no call or to ring before the call and to meet them in the garage or shed, where they expect care to be delivered. Patients and carers are worried that DNAs may be causing them more harm. Patients want to know why the nurses are not wearing masks at all of their visits and can become quite abusive and aggressive; others nurses have been denied entry without a mask. Some have questioned why delivery drivers are wearing more PPE than DNAs. Some staff have been verbally abused in the street for wearing uniform outside of the hospital

despite being community nurses. Patients concerned when carers are using public transport between visits. Some patients want PPE provided for them as well, to protect them from the nurse.

#### **4. How do you determine the Covid-19 status of patients you are visiting? Are referrals for visits detailed enough in relation to Covid-19 status, isolation, etc.?**

All patients being verbally screened, they are either triaged by phone and on the doorstep prior to visits and asked about symptoms, including a new persistent cough or temp above 37.8. This includes the patient and anyone co-habiting. Also, nurses are asking if they have received a letter regarding shielding. Some patients are not able to understand or confirm this and, on occasions, others have lied to get someone to visit.

This is time consuming and concerning to staff as some patients who have been found to be positive have not overtly displayed these 2 symptoms. Some are temperature checking prior to entering the house. Challenging as positive Covid-19 patients can be symptom free. Most referrals from acute trusts or GPs have been reasonably clear regarding confirmed or suspected cases whereas others have reported that referrals were not detailed enough. Any non-urgent visit requests for self-isolating patients are being refused. Some have a separate Covid-19 caseload to ensure known status and allocated staff. Staff are still reporting visiting and discovering someone quite ill rather than this being reported when triaged. However, some report that they are finding patients that are symptomatic but have put it down to a bug or cold.

#### **5. Have any patients said that they will self-manage and will not require visits during this time?**

For some this is a few, for others a significant number. The reasoning has been to reduce risk; many are very frightened; some nurses have been turned away on the doorstep. This has resulted in some having suboptimal treatment, eg. 2-layer bandaging not compression. Concern about the implications of suboptimal care. In some cases, family members have asked if they can take over care; a few don't want nurses in their house anymore and just want phone call for support. In some cases, this has been quite surprising as the family have refused to be involved with care in the past. Some increase in care is due to family being off work so they are now available to manage this level of support. This has included hands on care and medication administration. Care Homes are helping out and managing some care that would have been delivered by the DN. Teams have encouraged self-care and have taught family members key procedures and medication administration. Many families with a member with dementia families do not want visits and have reduced their care packages as well.

#### **6. Are patients worried about you being an infection risk when visiting?**

Patients and relatives are very worried, and some are refusing entry. Many are complaining about lack of PPE and some are purchasing PPE for nurses or them to wear during visits. Chemotherapy and immunocompromised patients and those with PICC lines are especially worried about the risk that staff pose to them. Many think nurses are carriers; some have been verbally abused and called disease spreaders. One colleague had to demonstrate how to give an injection through the living room window to a patient who was too scared to let the nurses in. However, some patients are having numerous carers in their house as well, they have worryingly just accepted the risk. Patients are worried about us carrying the virus on uniforms and are asking whether we have been tested. Some patients are wearing masks to protect themselves and others go to more extreme lengths to protect themselves from the nurse. Some nurses have had comments made by the public when on the street. Deployed staff and newly qualified are worried. Many patients are lonely and grateful for the visits. Nurses themselves are concerned

about their need to self-isolate with vague symptoms. Patients will refuse entry unless the nurse is wearing a mask.

**7. Do you have staff members self-isolating, socially distancing, etc? Have you had any staff deployed to your team?**

Many have staff members shielding for 12 weeks, some are having to self-isolate due to them or household members having symptoms and others have staff off due to conditions unrelated to Covid-19. For one team, current staff in post are down up to 75%. Staff have been deployed to teams including Health Visitors, treatment room staff, etc.; this in itself presents training demands.

Teams have also been asked to supply details of potential staff to move to critical care; there are concerns about where these vacancies would then leave teams. Staff trying to socially distance in clinics although often office space is small and does not allow for this. Staff morale is low as not returning to base or having any team support is challenging. Huddling and handover via Microsoft Teams is going well. Pregnant staff members doing office work/phone calls. Some staff are having challenges with childcare as schools only operating 9-3. Staff are socially isolating when off duty to reduce risks. Teams are not travelling to double up visits in the same car. Some teams have staff deployed; some are waiting for staff to arrive. Some staff who are home working are triaging and telephoning patients ahead of visits.

**8. Have you been challenged by members of the public for wearing your uniform as you travel between visits?**

This has been variable. Public and patients have challenged nurses as they feel that nurses are carrying the infection from each house. One nurse called into the shop before starting work to get a bottle of water and was told she was spreading the virus. One nurse was called a 'Virus Rat' but community nurses have to wear their uniforms. Some teams have had car seat covers donated. There are incidents of verbal abuse and intimidation from the public; others report positive comments from the public. Challenging to get lunch or petrol, however coats are worn to cover uniform. Some report people crossing the road to avoid them. One HCAs had a bottle of water thrown at her and she was sworn at and another reported that a member of public shouted that she was an infection spreader going house to house like that.

**9. How are you managing clinical waste?**

Advice on clinical waste is unclear. Varying advice including double bag, leave in the patient's home and ask them to wait 5 days before moving to their household bin, if they are symptomatic. Leaving waste for 72 hours in patients' home before disposal into normal rubbish. Some are double bagging and leaving outside for 72 hours then put into normal black bins. Staff are using gloves to put keys back in key safes etc, but there is not always somewhere to put these used gloves afterwards.

Patient's bin or if suspected Covid-19, double bag and leave in clinical waste bin at base with a Covid-19 sticker on. One team stated that they use the orange bags provided and carry these in their car and then dispose in clinical waste bin at base; however, nurses do not want to carry waste in their cars. Some have transit boxes and dispose of it back at base. One team putting in yellow bag at the patient's home for 1 week then bring back with us and dispose in clinical waste at clinic.

**10. What can we as a Forum do to help? What issues do you want us to raise?**

1. A need to promote the most up to date and consistent guidance for PPE.

2. Raise the profile of District and community nursing in this pandemic; highlight the role, skills and expertise. Community nursing feels that they are forgotten about or are dispensable. The work of community nurses doesn't seem to be a priority. We need to ensure the voice is heard.
3. There is nothing to protect cars and there is a risk of contamination, uniforms are worn throughout the day with positive patients and then to immunocompromised patients with just a plastic apron as protection.
4. More PPE is needed and clear, unambiguous advice. More suitable masks with enough for every visit and clear guidance on donning and doffing in the community.
5. Publicity that nurses have to travel in uniform.
6. This service feels like they have a responsibility to pick up everything that other teams no longer feel that they can cover.
7. Support for staff mental health and burnt out staff. Annual leave being cancelled which is having an impact.
8. Testing for staff to be able to return to work promptly.
9. When this situation resolves, we need to maintain self-care, independence and self-management and encourage care homes to deliver basic care for their patients.
10. Teams need access to clinical waste bags and labels to adhere to the correct disposal of waste for suspected/positive patients. Staff should not be transporting clinical waste in their cars. There are challenges for adequate handwashing facilities.
11. Representation of community in strategic plans.
12. Robust clinical supervision or counselling for those doing the EoL care.
13. Implementation of advanced care planning; retain patients in the community for EoL care, reduce the burden on hospitals and families want loved ones to die at home.
14. Keep pushing community forward, we will not be forgotten!
15. Capacity to meet the current challenges.
16. Challenges to socially distance on Out of Hours and double up visits.
17. Risks of the impact of suboptimal care, eg. pressure area checks and two-layer bandaging.
18. Risks to family members from staff returning home in uniform, etc.