Safer Care Victoria

COVID + Learning Network Webinar Questions

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The Royal Melbourne Hospital COVID-19 Community Navigator Service

Questions and Answers

Q1: Is there a cost to your patients for hotel quarantine or CIRF (COVID-19 Isolation and Recovery Facility)? Or is the service covering that?

A: There is no cost at CIRF as this is fully funded by DFFH/DH. The Integrated Intake Assessment and Triage Service (IIATS) provides members of the community with support for isolation and quarantine. See more information here.

Q2: Why were nurses not included in the team?

A: The reason why we started the COVID Care Navigator (CCN) service was to offload the nurses and clerical staff who were spending a lot of their time on discharge planning. Emergency Departments are under a lot of pressure so having designated staff responsible for discharging patients that have become experts in discharge planning is really important.

Q3: How did you manage to find the staff for the CCN roles? Through adjustments in usual operations and redeployments?

A: The CCN positions were advertised to allied health professionals as an opt-in opportunity. In the beginning, staff didn't know exactly what their role was going to involve, and it evolved right up until the day it was started. It has always been something that our team can opt-in to do and we have had over 30 different staff on the roster at one point and feel very supported by all the allied health staff. Those that have been able to do this role for a couple of weeks have been able to take away some knowledge and implement that on the wards or another service. Overall, it has really helped to up-skill allied health professionals.

Q4: Are all admitted covid patients being referred to these clinics or those with specific identified issues? i.e. need LTOT due to pulmonary dysfunction/fibrosis?

A: At this point in time, it is not blanket referral approach to the outpatient clinics. Patients are referred as needed by a medical practitioner (i.e. Hospital medical officers, GPs) to the Respiratory Medicine outpatient team. This is something we as a health service are looking further into as we have noted a number of ED presentations for patients who are no longer in the acute inflammatory and infectious phases and do have ongoing residual COVID-19 symptoms.

Q5: What would you see your future role in a hospital service, and do you think this is something that every hospital in Victoria should have? What would your vision be for the future?

A: From a CCN standpoint we have seen the efficiency of having a designated discharge team particularly in spikes, peaks and troughs of COVID-19. What we are seeing in the near future is the post-acute covid clinics. Our focus is the patient and wherever the demand is in terms of the service.

Right now, the focus is on acute and post-clinics to enable patients to stay at home and self-manage. However, in terms of ongoing patient flow and something we've done really well is education and educating the patients and also our colleagues. At the same time, a lot of this is unprecedented and hard to plan for without knowing exactly what things are going to look like. What we will always do is continue to see what the demand is for our patients and then continue to evolve the service towards that.

Furthermore, we do see more complex people presenting and having longer lengths of stay and there could be a role for our service to help with complex discharge planning Monday to Friday. We are looking into this and it's something we have discussed with our director about how our service might be able to assist with complex patients and improve patient flow.

Q6: What do you do if you have a client in ED who requires a specialist assessment for example a gait aid/shower stool etc. Who would assess and provide these? Was it the CCN or was there other AH?

A: The CCN's don't replace the usual allied health staff working in ED i.e. physiotherapists, occupational therapists, speech pathologists and social workers.

If someone requires a gait aid or a shower stool, the CCN's can refer or link the patient back to the treating team to provide the appropriate support. Some examples include referrals to addiction medicine, Care-Co colleagues and ED social work.

In the beginning it was really important that our scope of practice was really clear and that although we are physiotherapists and occupational therapists by background, we can't be everything to everyone and weren't providing mobility assessments or providing gait aids.

Q7: In previous webinars we have talked about having a credit card available to staff to help enhance discharge processes. For example, purchasing a taxi home. Do you think this would be useful?

A: The CCN resources built over time and along the way we tried to think of different ideas to make things more streamlined or to add to our service. For example, we didn't have food packs to physically provide to patients. We found out that the food vouchers weren't substantial and someone did a food shop for a patient who had nothing at home. We thought about how we could adapt the processes by making food packs available that were vegetarian, gluten free and halal friendly without adding to the CCN workload. We also wanted to encourage and empower patients to independently manage at home and link them into existing resources.

Q8: Was there a standardised approach to linking patients in with GP's? How did you communicate complex discharge arrangements and support requirements to GP's?

A: Through our Electronic Medical Record system, the GP gets a discharge summary within 24 hours of the patient leaving the hospital. The 3-day follow up call was also useful to determine if patients did call the GP. If someone didn't have a GP they were provided with a new one for their COVID management, sometimes there was some hesitancy to make contact. We sent patients text messages to make sure they had the GP details, and the social work team would call on day 3 to check in and see if they have booked their GP appointment. We were able to emphasise the importance of having a GP so that patients understood that from here, the person they need to follow up with is their GP unless they become really unwell and need to present to ED. We have a list of about 6 GP's who are happy to take new positive patients and a lot of our messaging was around calling them and we provided the patients with a

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script to use and say that they are a new, covid positive patient and that they need organise a telehealth appointment with a GP in the next 24-48 hours. There were a lot of people receiving this information as this was the main pathway that people went home with.

Q9: What was the role of the social worker in patients discharge home?

A: The ED social work team still have their normal roles which can be around complex psychosocial presentations, homelessness, family violence, drugs and alcohol. We could speak directly to them if we felt that a patient's issues would impact on someone's discharge. Our rapid follow up clinics social work input was around emotional support, if they have young children at home or follow up from a non-critical point-of-view that wouldn't change their discharge plan and where we got consent to do so, we would place a referral to a social worker before they went home for follow up the next day. We still utilised our social workers as we would on the wards and some people had really complex discharge plans. Sometimes patients waited to see a social worker face to face. We were not replacing social work in any way.

Q10: What are the main points covered on you discharge checklist?

A: The discharge checklist was very practical. It included information such as: address, phone number, updated GP details, how they plan to get home, what transport is required and if it is booked, do they have access to groceries and usual medications and if not, how will they access these, if they are linked into another service, have oximeters or thermometers, need a translator and their ability to use telehealth. We asked them anything that could potentially come up as an issue later on and it was all about their practical needs to get them home to isolate safely.

To tie in the discharge checklist and social work, we were asking patients if they wanted further emotional or psychosocial support. At times where we knew there were flags that raise that, we were able to ask a few more prompting questions to hand over to our ED social work colleagues who were often already referred in the first place. If they needed that follow up, we would get patients permission to place a referral and explain what that referral meant. In most cases, patients were more than happy to be called and have a social worker follow them up.

Q11: Is it possible to share the screening tool that you are using for these patients?

A: The resources from this webinar will be available on the COVID Clinical Shared resources SharePoint site. If you would like to have access to these resources, please contact: centresofclinicalexcellence@safercare.vic.gov.au

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