How is COVID-19 changing the experience of healthcare from both sides of the bed?

Taking care podcast transcript

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Susan Biggar: Welcome to Taking Care, a podcast of Ahpra and the National Boards. I am Susan Biggar and today we are talking about how COVID-19 is changing the experience of healthcare from both sides of the bed. How are those normal non-COVID healthcare experiences becoming different for patients and for their families, and for healthcare practitioners that are caring for them? We begin today with a personal story from Kath, a woman who speaks from her recent and relevant experience.

Kath: So, earlier this year before COVID-19 hit I was diagnosed with brain cancer. I went in and started treatment fairly quickly because I was so sick. I had had all these symptoms prior, such as falling over, slurred speech, fevers but I just made an excuse for everything because things like that don't happen to me: they happen to other people. When it got to the point where I just couldn't function, I went and had all the tests done. I had four rounds of chemo. Each round of chemo went for five days, so every twenty-one days I started a new treatment. The first couple were okay because family and friends' visiting hours were just normal so people could come and go anytime between 10am, I think it was, right through until about 7pm. However, then they started the restrictions. Initially the restrictions were two people, twice a day for two hours… I think it was between 12 and 2pm and 5pm and 7pm. So even that you could sort of deal with it, and then when COVID really hit they went down to one visitor per day for two hours. That was really hard because I was really sick. There is not a lot to do, you can only watch so much television. They had really good wi-fi so I was able to Zoom and that was okay, but it's still not personal. It's been really hard on people, and even my friends have had to Zoom in and it's not the same. It's impersonal and, as nice as it is to see people and have a conversation, it's not the same as sitting down and having a cup of coffee with someone. I found it really difficult to cope with. It's just one of these awful times in life. The loneliness was the worst part, I could deal with the treatment, but the loneliness really does your head in.

Susan Biggar: Well, it has certainly been a lonely journey for Kath and I know there are many other families and patients who are experiencing similar loneliness and other challenges as well in their healthcare experiences during this pandemic. Changes to visiting hours and access for friends and family is one obvious change but there are others that are impacting on healthcare. Here to shed more light on some of these issues are my three guests Dr Carmel Crock, Director of the Emergency Department at the Royal Victorian Eye and Ear Hospital in Melbourne, Ashley Scoular a nurse who works in case management and discharge co-ordination in a busy Melbourne neo-natal intensive care unit, and Professor Harvey Newnham, Director of General Medicine and Program Director, Emergency and Acute Medicine at the Alfred Hospital.

Susan Biggar: Carmel, can you tell us a bit about how routines and experiences are changing in your context at the Eye and Ear?

Dr Carmel Crock: The Eye and Ear is a very busy little emergency department and how it has been changing for us is in the last few weeks we have been giving all patients and carers masks. They are sitting in the waiting room all wearing masks. We are trying to limit the duration of our consultations. Our specialities that work here are ophthalmology and ear, nose and throat so they are two of the high-risk

specialties. Our doctors are obviously wearing PPE which we have never done before. Our doctors are wearing a mask and face shield for every patient in ear, nose and throat. Obviously when you are testing for COVID, you have a nose swab done and then a throat swab. There is high virus load in those areas of the body. When the pandemic kind of broke in Australia, the first thing when I went in on a Monday morning, on the weekend my young doctors had already set up breath shields on the slip lamp so that there was an extra barrier between the doctor and the patient so that your breath wasn't passed on. The doctors are very innovative in changing and moving what needs to be done in the pandemic.

Susan Biggar: Yes, I bet they are needing to. Ash, you work in neo-natal care, I wonder if you can tell us what are some of the new unexpected issues that have emerged in that context?

Ashley Scoular: In the neo-natal context I guess a lot of it does pertain to visitations and who else we are letting in and visitors and things like that. So, we are only allowing parents in at the moment and the unit ordinarily operates on very family centred care. We would normally have siblings and grandparents and involve all those people in the care so that has definitely changed things. And we can't take the approach that we ordinarily would, so there have been babies that are months old and have never met their siblings or extended family. So I think just in general the strain on staff and parents which is already stressful (a) being a parent in the NICU and (b) as nurses caring for these families. So, it differently adds strain and stress.

Susan Biggar: And Harvey, what about you in general medicine? What are you seeing in the areas that you work in the Alfred Hospital?

Professor Harvey Newnham: The clinical work that I have been doing is mainly general medicine which is acute patients coming through the ED who are unwell. And a lot of them have symptoms that are potentially ascribable to COVID,, so they get labelled as a COVID suspect which of course means then they have to be isolated and that causes a huge change in the way we deliver care. General medicine particularly is a team sport. We have doctors, nurses, allied health pharmacists and we thrive on team work and that gets quite disrupted in that isolation environment. It becomes really challenging because typically where you can only have one staff member see the patient because you are trying to minimise the contact and the use of the limited PPE that we have go. So, that staff member is then seeing the patient on behalf of the whole group which can mean that some of the other staff members are looking after patients that they haven't actually spent any time with or developed a relationship with and that's completely foreign to what we usually do. And negotiating people who have a little bit of a hearing impairment or don't speak English very well, you are wearing PPE, they can't see your lips, they can't hear you properly and, by the way, if you need an interpreter, whether it's a telephone interpreter or a video interpreter that's all compounded by all the PPE that we are wearing. So, we don't have that easy way of striking up a relationship with the patient, getting their trust, it's.. even you can't sort of hold their hand. It's all that kind of stuff. It's really tough to strike up that easy-going conversational relationship in which people generally open themselves up to the healthcare team so easily, usually. So, it's just all a bit foreign and everybody's a bit worried.

Dr Carmel Crock: And so, similarly, we go to call a patient out in the waiting room and we are wearing a mask and a face shield and often the wrong patient will come in with you because you are completely muffled.

Ashley Scoular: Harvey, you were talking about the challenges wearing PPE and delivering information and building rapport with patients. I have definitely found that this week alone we have had a number of families that I have been in meetings with,discussing either quite extensive medical care and delivering bad news, which is particularly tricky when you have got half your face covered. And again with the interpreters that has been a challenge for everyone as well.

Susan Biggar: In your interactions with the patients' families, are they changing their expectations about healthcare in this pandemic? I mean, should they be? What do you think, Carmel? Do you have any thoughts on that?

Dr Carmel Crock: Look, we have found that patients are incredibly responsive and respectful to us in this period. They have been really happy to wear masks in our waiting room, they can see that we are doing the most that we can. We have done unusual things, like offered patients at triage if they wanted to wait in their car, we will call them on their phone and take most of the history from the phone. And again, patients have been really flexible in all of this and they have also been really flexible. Like we are getting much better at introducing ourselves behind the masks because we really go out looking like some sort of an astronaut when we go to see them. So, we introduce a little bit of humour in the situation, because the

doctors are really stressed. We can see that the patients are really stressed but in an interesting way it has almost broken down some of the barriers between healthcare workers and patients because we are all so much in this together.

Susan Biggar: I wonder about people accessing care when they need it. Do you find that there have been some reports in the media of people who maybe aren't going to hospital when they needed it? And at least for you, Carmel and Harvey, you are treating people who have other ongoing chronic conditions or co-morbidities. Do you have any comment about that?

Professor Harvey Newnham: Susan, a lot of our patients are elderly and have chronic disease and receive a lot of support at home. You know, council workers coming in and other people visiting to support them. And a lot of that just couldn't be done once COVID was out there and the lockdowns were in place. So, the various supports that had been keeping people going, keeping them independent in their own homes fell away. And they struggled the best they could and then, quite often, delayed doing anything or didn't have the means to actually make something happen to get them out of that situation. So, they presented when they were sicker as a result; they deteriorated at home without the supports and then came in quite sick. And I think that was quite a common occurrence for the vulnerable people out there.

Susan Biggar: I can imagine that the implications are enormous. Ash, would you like to comment on the way that has changed your experience or your colleagues' experience of providing care?

Ashley Scoular: There has certainly been a bubbling sense of anxiety, particularly at the beginning which I think definitely impacted the morale in the unit where I work. So, having to adapt to that and also to support each other and the patients through it has definitely been challenging.

Professor Harvey Newnham: I would agree. I think that the staff have really risen to the task. There is a job to be done and they get there and do it, despite whatever the constraints are. So, that has been, I think, amazing to witness and makes me proud to work with them all. I think the other issue is the imperative to look after themselves and the others around them. You know, just as much as you are trying to look after yourself, you are trying to make sure that you are not going to spread the virus to either your working colleagues or your patients or, for that matter your family, your friends, your loved ones or anyone you know who is immunome suppressed that you might have any contact with.

Dr Carmel Crock: I asked one of the doctors the other day who has got a toddler at home and who had just finished nights, she had done four nights, and I said 'How do you manage at home because, how do you sleep during the day?' and she said initially she was just sleeping in a room at home and the toddler would come and bang on the door constantly. And so she now goes to her parents-in-law who have a room all set up for her with an electric blanket on and she goes in and she curls up there.

Ashley Scoular: The majority of our workforce in the unit are women with young families and so you have got nurses and doctors are, like, working twelve or fourteen hour shifts and then also going home to care for children who might otherwise be in school. There has been a really common narrative about home schooling as well. So, then on their days off there is sort of no reprieve from working really. So, that stress, plus any other stresses, like partners losing jobs. So, it's sort of a unique time and highlights the importance of looking after each other.

Susan Biggar: Well, that is interesting. It makes me think about this whole concept of taking care of oneself. We have mentioned many probably negative impacts of COVID for health practitioners; I wonder if there are any positive ones that you can see emerging from this, in terms of the ways of working or looking after one another?

Ashley Scoular: Yes. It sort of creates a level of comfort to express your health needs to your colleagues and bosses. And I sort of hope it changes that culture of having to toughen up and come to work. I think we are pretty good at that as nurses anyway because you're not just coming in because you don't want to spread anything at the best of times, but changing the culture around that. Plus, mental health as well, so I think that a lot of people have been able to voice their anxieties and things like that to each other and to their bosses, and I think that's a good thing for a cultural shift in this.

Dr Carmel Crock: I want to also say that we are not really used to noticing when we have a slight cold, a tickle in your throat or a blocked nose and it wouldn't cross our minds not to go to work with those sort of symptoms on a normal day. So, I have had four or five of my doctors come up and say, 'Oh gee, Carmel I've got a sore throat today' or 'My nose is blocked, What do I do?' And, of course, I have to say, 'You have to go and get tested.' And even myself, I had really minor symptoms and I said it to a friend, an ophthalmologist, 'I've got a blocked nose today'. And she said 'That means you have got to go and get

tested.' So, we have almost had to learn to verbalise with each other when we have got mild symptoms and have the responsibility to know that that makes us a danger to our colleagues and to our patients. So, that has been an enormous change for us.

Professor Harvey Newnham: Yes. I think for those of us that do have loved ones at home...I think it's hard if you live alone, particularly in this environment. But for those that do have family and supports at home, I think this has allowed greater focus on the family. You know, the time off seems to be without as much pressure and social distractions or the school sport or the parties and all that sort of stuff. So, I think some of my colleagues have focused a lot more on those sort of core, central family issues and actually feel that they have benefited as a result.

Dr Carmel Crock: I was going to say one of the other strange benefits is that we have been able to have some robust disagreements on occasions and you have had to get off things very quickly. So, in the early days there was some disagreement about which PPE to wear and what circumstances and that changed quite rapidly. We have had all to kind of get used to guidelines changing. Normally guidelines will stay in place for, you would hope, day or weeks or months rather than changing so regularly. But the sort of principles that we have around patient safety, like having a robust safety culture where you can speak up, where you don't blame each other, where you are self-aware, these kind of things. We have had to really live them day by day, moment by moment, that's my view.

Professor Harvey Newnham: We still have a manual journey board which is a whiteboard and we sort of plan the care around that, next to the patients' names. And the challenge has always been to get somebody from every team at that journey board meeting. How do you get the physio, the OT, the speech therapist? It is very hard to do in a physical sense. But now that we have the digital support with the communication, everybody can be involved. And they can be even more involved because they can be listening to this at the same time as they have the screen open on the electronic medical record and they can be going into the patient's record and actually contributing to the conversation directly from what they can see in the record, which of course, you can't do if you are sitting at a physical journey board. So, you can actually enrich the team input in this particular situation because of the communication.

Susan Biggar: And very reassuring for patients to hear about. As people who have spent a lot of time in hospital, we are often frustrated by communication also, and so it sounds like much of that is leading to improved care. Even bringing our minds back to Kath and what her comments were. I wonder if Harvey, you or Carmel, want to comment on what it is like for patients when they can't have their loves ones with them?

Professor Harvey Newnham: Yes, I think that is huge, isn't it? I think we have all heard the story about the chap who couldn't visit for five weeks and then visited on the day, I think, when his mum, I think it was, died. I can't remember but that is just so common. Lots of things are being done. You know, we have tablets on sticks that you walk in to the room and you try and make it easy for people to communicate but it is still hugely challenging to get that working anything like the real experience. And I think the other challenge is the changing continuity of care. You know, when you come in as a suspected virus patient, you are usually managed in the suspected area or ward by the suspected team and then as soon as you are cleared, which might be at The Alfred, at the moment it is as little as five or six hours. You then go to another team pretty smartly. So, you have got the ED team, then you have got the COVID team and then you go to your regular ward. Then you are ready to go home and then you get the outpatient team. So, we have to really think about how we integrate that care and reduce the opportunities for discontinuity of care as much as we can. And that is a real challenge in our system. And it is particularly a challenge around hospital discharge at the moment. The better we can integrate what happens in the hospital with the community, the better we will be.

Dr Carmel Crock: Our patients, a lot of them are elderly and obviously vision impaired and/or hearing impaired. Normally they will come with their son or their daughter who might be translating for them or who will be their eyes and their ears. I think it has been really really difficult, especially for the elderly in our hospital.

Susan Biggar: It is really difficult because we have always said that patient care, person centred care involves having the family present, having the people that you love present. It sounds like patients and families are being quite understanding, but that doesn't take away from the fact that it is still very painful for them and presumably painful for you as health practitioners watching that experience. I wonder, as a final question, if I could just ask any of you to respond to what would be your message then to patients and families in this time? What advice would you have for them or a word for them?

Ashley Scoular: We need to make patients and families feel safe to keep asking the questions and that that's ok and we don't mind them asking questions and we will be as transparent as possible with them and we have got their safety in mind. That we as nurses feel safe to deliver care at the moment, so that they too should feel safe coming into the hospital and attending appointments. And also just to take the advice of the state and Premier seriously and we can get through this.

Dr Carmel Crock: It is safe to come to hospital. As we said before, we have seen a lot of people delay emergencies and present late. So, if you need to come to hospital, we will keep you safe there.

Professor Harvey Newnham: We can't provide the best care without the input of the loved ones around the patient and we want you to speak up. We know it's more difficult for you to do so, but please don't let that stop you.

Susan Biggar: So, I want to thank our guests today: Carmel Crock, Ash Scoular and Harvey Newnham, for their expertise and thoughtfulness and empathy. We are travelling down new roads with this pandemic and these are exactly the characteristics that we need to get through this as we all adapt to these new healthcare experiences and norms for patients, families and health practitioners.

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