COVID-19: From fear to opportunities in community care

A story about fear, challenges, strengths and opportunities during COVID-19 in community care

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COVID-19: From fear to opportunities in community care

A story about fear, challenges, strengths and opportunities during COVID-19 in community care

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'I really thought it was fun to do, because it was completely different, and we also visited clients where we normally never went because they live in a different neighborhood.'

My name is Sophie, I'm 31 years old and work as a community nurse at Buurtzorg in The Netherlands. In this story I will tell you everything about my experiences while working as a community nurse during the corona crisis. During the first wave, we experienced a lot of new opportunities and challenges which will be described in this booklet. Starting from the point that the World Health Organization (WHO) declared this outbreak of corona to be a pandemic, I will tell you everything about our experiences from that first moment we came into contact with corona. I will be honest; we were pretty anxious at the start and so were our clients, but as professionals we know how to cope with challenges while working in self-managing Buurtzorg teams through which inventive solutions were devised. The first challenge was our lack of knowledge, which forced us to search for sources of knowledge. We made plans together with our other colleagues from other Buurtzorg teams to develop corona routes, through which we were able to guarantee the quality of care and safety of our patients as much as possible. Working during this pandemic made communication an essential aspect of our work. In the story below I will take you through our experiences of collaboration with other health care providers, communication with clients and the role of telemedicine. In addition, I will share experiences of the protective measures and finally what it means to work in a Buurtzorg team during a pandemic. Let's hope we can give you some interesting facts about our work during a crisis, stay safe!

'As a nurse you notice that they are getting lonelier. And then it is sometimes difficult that you are not allowed to sit in a chair to have a chat, for example. Because you can see that they really need it. That is difficult sometimes.'

Introduction

Currently, all countries in the world are facing a pandemic caused by the Coronavirus, with the spread continuing at a rapid pace. In January 2021 more than 95 million confirmed cases have been registered across 190 countries. The number of deaths from corona is well over 2 million (WHO, 2021). The pandemic creates a heavy workload for both hospitals and home care. Medical care personnel are obliged to work in an unusual way, which means that more independence and creative solutions are expected.

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Objective

Currently, during the Transforming Integrated Care in the Community (TICC) –project, home care organizations in Belgium, France and the United Kingdom (UK) are implementing integrated nurse-led care at home based on the Buurtzorg model within their organization. This means working in self-managing teams of 12 staff working at neighbourhood level (Interreg 2 Seas Mers Zeeën, 2017). But, what does it mean to work in this COVID-19 crisis time as a nurse according to the Buurtzorg model? How does the model adapt in a real crisis? The way to anticipate this new situation is a challenge as new insights and practices arise. This may also allow community care nurses to learn from the current crisis for future care. Which brings us to the objective of this booklet: to explore healthcare staff's experiences with providing care during the COVID-19 pandemic. Ultimately, strengths and areas for improvement of the Buurtzorg model during the COVID-19 pandemic will emerge for an international context. These aspects can be given extra attention during the implementation by the TICC partners, so that the model can be implemented sustainably and successfully. Also, learning from these experiences may be valuable for Buurtzorg Nederland as well.

Participants

Between September 2020 and October 2020, seven community nurses, one project employee, one assistant nurse and one nurse in the community working at Buurtzorg Nederland, were interviewed using a semi-structured interview by one researcher (IB). The respondents were identified by the TICC project manager at Buurtzorg. Before the interview with the project employee started, the researcher was not familiar with the fact that this respondent was not working in the community as community nurse. Therefore, the researcher produced questions on the spot that seemed relevant to ask, also fed by experiences from other interviews which could yield interesting perspectives. Analysis was conducted by one researcher by reading and coding transcripts and summarizing striking stories in a semi-structured way. This causes the reliability of the results to be diminished, but are suitable for the practical objective this booklet intents. Table 1 shows that most respondents have a lot of experience working at Buurtzorg Nederland.

Table 1. Participant's characteristics

Resp.nr	Work exp. (Years)	Years at Buurtzorg	Position	Contract hours
1	38	12	Community nurse	36*
2	18	8	Community nurse	32
3	31	13	Community nurse	32
4	10	7,5	Community nurse	28
5	25	8	Community nurse	24
6	45	12	Community nurse	30
7	32	13	Community nurse	24
8	26	11	Project employee	24
9	6	4	Assistant Nurse	30
10	4	3,5	Community nurse	30

* 36 hours is fulltime

The Storyline of Buurtzorg nurses

The results described below have been drawn from topics and themes that emerged from the interviews. Themes are described in chronological order as much as possible following a storyline from the start of the corona crisis to the moment the last respondent was interviewed.

In December 2019, the first reports of people becoming ill were known, from what was later called corona virus (2019-nCoV) (World Health Organization (WHO), 2020-a). Due to the alarming levels of spread and severity, on March 11th, 2020, the coronavirus was officially labeled a pandemic infecting people of all ages (WHO, 2020-b). In the Netherlands, home care continued where possible. In some situations, clients received less care than usual, or care was organized differently. For example, care at a distance, using telehealth innovations, became more valued. When care was organized differently, this was discussed with clients and their informal caregivers (Ministry of Health, Welfare and Sports, 2020). This is also the case at Buurtzorg Nederland.

Fear of the unknown

Especially at the beginning of the corona pandemic, there was fear of the unknown among both clients and employees. In addition, there was a lack of information available yet, which meant that a lot had to be researched by community nurses themselves. This sometimes made the work situation quite difficult. The fear was often fueled by a lack of knowledge about the coronavirus amongst care staff and the distance created using protective measures.

> ***There was a lot of fear among the clients and there was also a lot of knowledge lacking about how we should deal with it at that point. And uhm, it has actually continuously put a lot of stress on your entire work as a community nurse. We still notice that now, because on the one hand you are afraid that you will transfer the virus to clients, and on the other hand, not really afraid that you will get it yourself, but that you will take the virus home. So, it has had a major effect on both client care and your private situation.***

Need for knowledge

So, where did those Buurtzorg community nurses get their knowledge from? As said before, in the beginning of the corona pandemic that was quite a challenge. From the start there was a lot of collaboration between colleagues. News items and the internet became frequently used information sources. The question that was frequently raised was: 'When is someone suspected of being infected with coronavirus?'. Shortly afterwards, communication from Buurtzorg started and a corona crisis team was soon set up. This corona crisis team arose quite naturally, resulting from the self-managing organization that characterizes Buurtzorg. Project employees with a role in infection prevention were inundated with questions from professionals working in the communities and decided to create fact sheets that would enable them to inform and advise colleagues across the country on how to act in the crisis. An email address and telephone number were created to keep an overview and to distribute workload among several project employees, who from that point became the corona crisis team. In the beginning, this platform was quite reactive, but then the approach became increasingly proactive. The challenge experienced by the interviewed project employee is the combination of being a member of the corona crisis team whilst continuing the other tasks

that are expected of a project employee, which started again after the first wave of corona. At the busiest times, this corona team met daily to discuss the advice they distributed. After that period these meetings became weekly or less. Due to all the sources of knowledge as described below, both nurses and clients felt more supported and informed. Fear subsided as the next quote shows:

> ***I actually communicated the information back continuously, and I noticed that precisely because I could provide so much clarity, that it also gave a lot of people peace of mind.***

In short, some sources of knowledge used by Dutch community nurses and project employees:

- Nursing Journals and scientific journals; for example the Dutch Journal of Medicine (NTVG).
- Buurtzorgweb: a corona crisis team was started up which made sure information on Buurtzorgweb was frequently updated following the latest news from the government, NHG (Dutch general Practitioners association), RIVM (National Institute for Health and Environment) and WHO.
- Buurtzorg has set up a corona crisis team that was available for questions (mail and phone).
- Nurses who already had experienced the coronavirus (becoming ill, or family became ill) were seen as fertile sources of knowledge.
- The corona crisis team has also developed a care pathway[1] for corona patients (cooperation with other care providers) which is experienced as very supportive by some nurses. The care pathway also raised awareness among GPs, for example, about the possibilities of care staff working at home care organizations. This 'Care Pathway Community Care Covid-19' can be found on https://www.wijkverpleging.org.
- Website or contact via phone with the National Institute for Health and Environment.

Corona route-method

After all the information that was spread about corona, many teams started making plans for a separate method, called the corona routes. This was an adjusted division of tasks for when corona patients came into care. Teams started corona routes on their own initiative, sometimes together with other Buurtzorg teams or after the team coach gave the team advice to start such a route. Colleagues from (mostly) several teams were deployed on a voluntary basis, to form one corona route over an area in which several Buurtzorg-teams normally work. In this way it was ensured that healthy patients could not be infected by healthcare workers who also visited corona patients, because in these routes only corona patients were included. A difficulty while forming those corona teams was that not all colleagues wanted to work voluntarily in a corona route, given a home situation with children or caring for elderly family members. Not all teams eventually used corona routes during the first wave, because luckily there were few clients infected with the coronavirus. Two respondents worked together in a corona route stated the following:

> ***I really thought it was quite fun to do [...] we had to consult a lot of other teams to get information about those clients and yes, it was really a hassle at some point, but in the end, I really enjoyed doing it.***

> ***Of course, you will go there completely packed (with protective measures) and ready to go, so it is not really personal. However, because we were with only two caregivers(nurses) in the corona route, it becomes personal for people because they also get to know you. And I really liked that we could do it that way.***

1 Clinical pathways (CPWs) are structured multidisciplinary guidelines in which the steps in a course of treatment or care, are described. CPWs are often used to translate guidelines or evidence into local structures and standardize care for specific groups of patients (Lawal et al., 2016).

Some dos and don'ts when working in corona routes from the respondents:

- When two colleagues with many contracted hours are deployed in a corona route, this means that other colleagues with small contracts must absorb the hours that these colleagues cannot spend in the normal routes. So, when organizing a corona route, keep in mind the contract hours or choose colleagues working in different teams.
- For some teams, the team coach acted as an advisor while preparing corona routes. She advised setting up a corona route and to collaborate with other teams when preparing for corona routes so you can divide tasks.
- Be aware of the loneliness that is present in some home care situations that will become more intense due to the corona crisis. Working in corona routes raised awareness about loneliness.

Changes in communication

Communication emerged as a separate and broad theme after reading the transcripts of the interviews. During the interviews, respondents spoke about communication with clients, communication with and information coming from the management of Buurtzorg, the transfer of client information, team meetings, communication with other care providers and the opportunities to use telemedicine as a way of digital communication. Most respondents spoke positively about the support from Buurtzorg management at critical moments. Communication was top-down at the beginning of the corona crisis. Even though respondents indicate often that they enjoy working in an autonomous team, this top-down support gave the necessary confidence at the important moments. As mentioned before, Buurtzorg started a corona crisis team with whom care staff could communicate by phone, email and through the Buurtzorgweb. This corona crisis team was formed by being self-organizing, but did inform the managing director of Buurtzorg about the plans they had:

> ***We had a certain fixed group (for the corona crisis team). And at one point, Jos (managing director) joined that meeting every day.***

Physical team meetings were almost immediately changed into weekly team meetings which was supported by the availability of an online platform for video calling. Team meetings were experienced differently by different respondents.
Some positive things about online video calls were:

- There is less noise or disturbance from chatting colleagues, because you are not physically sitting next to each other;
- It was observed that normally only a few people are speaking/taking the lead, while during an online meeting several colleagues are speaking.

However, physical team meetings were normally also used for the transfer of client information amongst colleagues and video calling is not the best way to share information about clients from several respondents' perspectives. Another difficulty with video calling with an entire team is that there was regular noise because colleagues were talking intermittently. One of the respondents said that organizing a mix between online and physical meetings could be a promising idea for the future, because there are both positive and less positive aspects about video calling. This way colleagues who cannot or do not need to be physically present can attend meetings via video calling:

Yes, that is the first thing that comes to mind, because we are talking about the moment that we can easily meet physically again. But for the colleagues that are not working we say, 'then you can be present online', so you don't have to come to the office, because people also live outside the city. But also, from within the City, if you must come to the office it will cost you very quickly 45 minutes extra while you can just participate from home, we talked about keeping that.

Collaboration with stakeholders

Very shortly afterwards, the care staff from Buurtzorg became one of the few people who still visited patients and communication with other care staff became more important. Collaboration with other stakeholders such as GPs and other home care organizations to coordinate care for corona patients arose but were experienced differently by each respondent. One respondent mentioned a very collegial collaboration with GPs and other home care organizations:

We also contacted general practitioners and other home care organizations; we all work together on a collegial basis. Via video calling we sat down together and discussed what we could do for each other, whether everyone thought he was going to make it, supposed it was going to happen. Well, that was a reasonably good collegial atmosphere and that also provided a good basis to deal with all those uncertainties.

Cooperation with GPs sometimes meant that GPs shifted more tasks and observation questions to nurses in the community. However, this meant that the nurse's judgement became very valuable and action was taken when necessary. The use of photos to visualize wounds, for example, was used more for communication with general practitioners and is something that should continue. When care was scaled down, the continuation of care relied often on informal caregivers. But there are also known cases in which collaborations were established with other care providers who visited a client, who could provide part of the basic care:

Some clients received care for washing and dressing seven times a week in the morning. We often reduced that to three times a week, or the informal caregiver did a little more. We also have situations, that turned out to be very helpful which became a facilitating factor where social work came and took over part of the basic care needs. So, if they visited the clients' home, we wouldn't come and if they weren't there, we came. We continued that.

Communication with clients & tailor-made changes

The moment that corona became a pandemic, and the Netherlands went into a so-called "intelligent" lockdown, was also the moment when Buurtzorg teams informed their clients, often in the form of a letter, about the care provided from that point in time. The care continued, but as a result of that letter, some clients and their informal caregivers nevertheless opted to take care of the care needs by themselves. This therefore seemed to be a moment to take a critical look at the care that was provided and could therefore also function as an evaluation of that care.

And we also, uhm, took a good look at what should be done and what could be less. Showering three times a week, is that absolutely necessary? Or can we do that twice? That has been looked at a lot. We have been very critical about that. And a letter preceded this as well.

So how did this work:

- Clients sometimes received a letter from the Buurtzorg team in which was described how the care would continue during the corona crisis;
- In practice, among the respondents, there were only a limited number of situations in which care could be scaled down. In these cases, informal caregivers took over the task of the community nurses;
- In some situations, it was even necessary to increase the time available for clients. Other care providers often stopped coming, so they were the only caregiver visiting the client. So, community nurses sometimes gave themselves some extra time for advice, information and education;
- A situation was mentioned in which the community nurse scaled down the care visits, because a social worker could take over part of the basic care. Afterwards, it was evaluated how this collaboration could be continued;
- Regular phone calls became an important part of the nurses' work. Contact was maintained, often by telephone, with clients whose care had been scaled down, to evaluate the process.

Telemedicine & ICT

This highlights the following theme: telemedicine & ICT. Did, for example video calling, become a more frequently used part of care given to patients? The answer to that question from respondents to this research is 'No'. Yes, nurses called their clients more often in many situations, especially with clients where they went less often; to evaluate the situation and to make sure they were still ok with the situation. However, a few respondents did mention possibilities for future care with video calling. Some statements by respondents about remote care and video calling:

> ***No, we actually don't use remote care at all. No it happens sometimes that we have someone who we then call or something like that. So we didn't actually use that at the time. I: And, in your opinion, would that be something that could be used more in such a situation? R: I don't really know, because I also think that a lot of older people don't like that, that's my idea. That they would rather see someone. And we usually have that too, because when you are with someone and you really see them, then you get more information.***

> ***Well that could be a good idea (video calling), especially if you have scaled down care where loneliness already plays a role, then I can imagine that video calling is a good way to maintain visual contact with the client, but we did not do that. With us, care was scaled down for patients where family moved in or already lived there and took over the care, but I can imagine that this could work for other teams.***

> ***No, we tried video calling with a few clients for example when family was present, but just using a normal telephone. And not through the, from Buurtzorg there were Ipads available for video calling, but we did not use them. But you know, the largest part of clients we visit is 80+, so that is difficult.***

Using protective measures

Where community nurses kept providing care, protective measures were necessary. Face masks are occasionally experienced as a hindrance. The non-verbal communication is less visible, making it more difficult for care providers of (for example) foreign origin to understand patients and vice versa. Also a mouth mask is oppressive. Gloves do not work well if, for example, you must put on compression stockings or someone must shower, and the water runs into the gloves.

Some practical experiences which worked quite well:

- Protective equipment was often distributed by team coaches;
- If the atmosphere in which to give feedback is good, you can point out to your colleagues the correct use of protective materials;
- Some teams were a central collection and distribution point for protective materials. This made the distribution of the materials noticeably clear and accessible.

In very few situations, healthcare continued to be scaled down. In most situations, the care was taken over by the Buurtzorg Team again when the corona crisis became a more stable situation. One nurse said the following about that:

> ***The moment we got into a calmer situation with corona, informal caregivers often said: 'Nationwide it is calmer, I notice that it is very difficult to take care of my beloved one, do you want to take over again?' Yes, care changed in that period and it was difficult for everyone.***

Working in a Buurtzorg team during a crisis situation

After all this information about the approach of Buurtzorg teams during the corona situation, it is important to also reflect on working in a Buurtzorg team during a crisis situation. What are the advantages and disadvantages of working in a Buurtzorg team during a crisis? What should you use and what should you perhaps not use?
Below you can find some statements from the interviews:

- Working in an autonomous team was often experienced as pleasant: "that you can decide for yourself how you want to do it and that there is not some sort of guideline which said 'you should do it like this or that'. I actually like that very much."
- Working in a small team creates shorter lines for communication.
- It is important in times of crisis to also assign a task regarding communication. This way, the most valuable information is collected and distributed succinctly to the rest of the team. That way everyone is on the same page.
- A division of tasks can arise quite naturally and on very short notice: "Someone took the chairperson's role in those meetings right from the first day. He made sure things were written down and always arranged an agenda where we could fill in the things we wanted to bring forward."
- The collaboration that started between project employees during the corona crisis, will continue within other projects besides corona.
- For some teams, the team coach was given a more supportive role. Protective equipment was distributed by team coaches and questions were asked by teams about the right way to approach when new corona patients came into care.
- It is a challenge when several colleagues call in sick due to corona symptoms. It then becomes quite a challenge to complete the schedule and the task associated with personnel management becomes quite a challenge.

Some final advice

This pandemic has changed and will continue to change healthcare provided in the community. Some things will have more impact than other things. But at the end of this story we will provide you with some final summarized advice from everything written above:

It seems to be very helpful to organize a group of project employees (or other volunteers from the organization) who can fulfill the task of a corona crisis team.

Take a look at the 'Care pathway Community care – Covid-19' at the website mentioned above, it can probably be translated it into other languages to learn from it.

Organize a corona route, but keep in mind the contract hours of colleagues working in the same team or choose colleagues working in different teams.

Team coaches can act as advisors when preparing Corona routes and support in other tasks (for instance the distribution of protective measures).

Be aware about the increasing loneliness of people living at home.

Discover the opportunities to use telemedicine for clients and interdisciplinary contact during and after Corona time.

Top down support at the beginning of a crisis is pleasant and clarifies a lot!

Take the opportunity to look critically at the amount of care supplied by your team. Informal caregivers may be able to take over care, but cooperation with other health care providers during a crisis is also worth investigating.

When you scale back care, make sure you stay in contact with your clients.

A central collection and distribution point for protective materials can be practical and efficient.

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More relevant information from the TICC project will follow in the near future.
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