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COVID-19 Management

Delivering Acute Cardiac Care During a Pandemic: Seeds of Opportunity Within a Crisis

In this article, we discuss some of the potential opportunities for positive changes in service provision that may emerge from the COVID-19 public health crisis, with a particular emphasis on changes enacted in our own service.

Introduction

"The Chinese use two brush strokes to write the word 'crisis.' One brush stroke stands for danger; the other for opportunity. In a crisis, be aware of the danger, but recognise the opportunity."

John F. Kennedy

The COVID-19 pandemic represents the defining crisis of our time, heralding unprecedented changes across healthcare systems globally. The resultant large-scale turbulence can provide an impetus for transformational change and allow emergent strategies to form which can result in improvements in healthcare delivery.

The environment we are currently operating in during this pandemic is radically different to our established norm. This has required a shift in our assumptions and a re-orientation of established practice. In this article, we detail some aspects of our practice that have changed positively in response to the COVID-19 restrictions. We then go on to discuss potential opportunities for growth and positive change that may emerge from the current crisis.

Increased Utilisation of Outpatient Management

Given the projected surge of COVID-19 inpatients, efforts were made within our service to minimise medical admissions where possible. This has led our department to re-evaluate our previous admissions policy and consider whether care can be safely delivered on an outpatient basis. Our experience has been that the majority of patients are happy to go home if their initial investigations are reassuring and they have a defined plan for follow up. In addition, changes in service provision like expedited access to computed tomography coronary angiography has resulted in a quicker turnaround of patients. It is important to remember that patient safety must be paramount to this process and it is crucial that the patient is comfortable with their management plan.

Establishment of Virtual Clinics

Due to lockdown measures, we have been unable to run our normal outpatient clinic service. Instead, 'virtual clinics' have been rapidly implemented, with telephone conversations replacing face to face assessment. This has been embraced by staff in our department and has enabled us to monitor the clinical progress of our patients remotely. If further investigations are required, these can be organised and patients with concerning symptoms can be reviewed in hospital in an 'urgent review' slot if necessary. Telemedicine has long been mooted as a potential solution to improving access to healthcare and our initial experience has been largely positive. Our experience has also led us to reflect on the number of patients who receive annual 'check up' appointments in our clinics. Many of these patients have been clinically stable for many years and the value of bringing them in for annual face to face reviews is questionable. Virtual clinics, where long term patients are contacted remotely to screen for concerning symptoms or change in clinical status may be a more efficient way of providing long term cardiac follow up to this cohort. In addition, there may be benefits to this approach for our patients, as they can remain in their own homes and do not need to travel to the hospital and wait for their review. Looking toward the future, it is important that patient feedback is also sought in this regard as some patients may not be comfortable with virtual review and may prefer traditional appointments. In addition, the value of clinical examination and the patient-physician relationship should not be underestimated.

Improved Communication With Primary Care

As mentioned earlier, we have endeavoured to manage patients as outpatients and avoid emergency department admissions where possible. Another observed feature of the current pandemic is an increase in communication between our service and general practitioners (GPs) in the primary care setting. Where before, patients with cardiac symptoms may have been referred directly to the emergency department, we have noted an increase in GP's discussing cases over the phone with our service in an effort to avoid an emergency department attendance. In order to respond to this, we have developed a rapid access assessment clinic each morning where up to four patients can be reviewed and receive investigations and clinical assessment as required. This streamlines patient care and fosters development of communication channels between primary and tertiary care. In many cases, these interactions and assessments avoided an unscheduled hospital admission. Improving communication channels with primary care may be an effective strategy to avoid emergency department attendances and improve access for patients and their primary healthcare providers to cardiac investigations and specialist assessment.

Crises as Opportunities for Change

The constraints of the current pandemic have led to a need for creative solutions to continue to deliver high quality care. We feel that the dangers presented by the COVID-19 crisis laid the foundations for rapid change within our service. The forcefield analysis model conceptualised by Lewin in 1951 provides a framework for conceptualising this (Lewin 1951). Established customs and practice can provide a powerful impediment to change. Therefore, unless resisting forces are reduced or driving forces increased, a system will remain in a steady state. "Unfreezing" from this status quo during the COVID-19 crisis allowed a service infrastructure to emerge that is radically different to our previous status quo. In our service this was manifested by the rapid establishment of virtual clinics, a reduction in

our reliance on inpatient hospitalised care and enhanced engagement with primary healthcare providers in our community. Together, these developments have allowed us to continue to deliver highly specialised cardiac care in order to meet the needs of our patients.

Many of these adopted processes have involved the streamlining of previously proposed strategies for redesign of services. A strategy can be defined as a deliberate or emergent process which is dictated by real world conditions. Deliberate, planned change can frequently spark resistance within an organisation and stifle efforts to evolve. We feel that the seismic shift in environmental conditions created by the COVID-19 pandemic opened a window of opportunity for these new practices to emerge in our service. When a service is found to be out of sync with its environment, it can be shocked into a cultural revolution. This can side-step much of the resistance that may otherwise be encountered and strategy can thus be formulated rather than formed in response to an evolving situation. Actions that emerge can be legitimised and adopted to allow the organisation to embark on a new direction. This allowed us to take a "quantum leap" with the radical redesign of certain services in a short period of time (Mintzberg 1987).

Story-telling is important throughout any change process and the clear and imminent threat posed by the COVID-19 pandemic created sufficient societal turbulence to cultivate commitment across the hospital to achieving delivery of healthcare within an onerous set of circumstances. This had the effect of creating a highly motivated workforce with greater congruence of employee and organisational goals. We attempted to communicate a clear vision of how this would be achieved which proved highly compelling to win over "hearts and minds" and to foster a sense of empowerment out of the crisis.

The concept that strategy should purely be the domain of a single, all-knowing leader is a fallacy and a noted feature in our institution was that strategy emerged across the grass roots of the hospital. Processes emerged organically within the crisis and those that improved workflow were nurtured. Co-operation and co-production in this regard allowed a sense of collective ownership and organisational pride to develop. We feel that this helped overcome traditional hierarchies within the organisation and created a culture of empowerment, self-direction and commitment (McGregor 1960).

Conclusions

While COVID-19 presents a significant challenge to healthcare providers worldwide, the discontinuity presents an opportunity for positive change. Strategies can be enacted which not only meet the needs of service delivery within the current climate but that also align with the long-term vision of the organisation. Nurturing these new processes may offer a promising new direction for service provision for the future. We would urge all healthcare providers to consider the 'seeds of opportunity' within this crisis and to reflect on how they can be used to improve patient care. ■

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Key Points

- The COVID-19 crisis has heralded unprecedented change across healthcare systems globally.
- This change can also be viewed as an opportunity to change the way in which healthcare is delivered.
- Our department has instituted several changes due to the coronavirus pandemic.
- Crises can often provide a window of opportunity for new practices to emerge, bypassing institutional resistance to change.
- We invite our colleagues worldwide to look for the seeds of opportunity within the COVID-19 pandemic.

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