

# Responding to COVID-19 in Psychiatric Rehabilitation: Collaboration Is Vital

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In March 2020, the UK saw a steady rise in infections of SARS-COV-2 (COVID-19), with London becoming the national hotspot of virus transmission. Uncertainty about the best way to respond led to delays in protecting the most vulnerable people. Longer term care facilities were considered high risk at the outset. We share our experience of the pandemic from our rehabilitation unit.

Heather Close is a rehabilitation unit situated in a south-east suburb of London. It has 24 inpatients with long-term psychosis and many of them have multiple medical comorbidities. The patients are older and frailer and with complex needs compared to acute psychiatric inpatients. They score highly on risk and vulnerability measures, have functional deficits and difficulties engaging with their care.

Our first patient developed symptoms of COVID-19 on 15th March 2020, a week prior to the UK lockdown. There was little formal guidance on managing COVID-19 infections, even less for inpatient mental health settings and hardly any for longer term settings like rehabilitation units.

Our multidisciplinary team recognised the high risk of transmission on our ward and adapted our response

by getting the basics right. We developed a daily screening tool to detect symptoms, initiate isolation early and mitigate spread. It included monitoring vital signs—temperature, pulse, oxygen saturation, respiratory rate and heart rate. Any patient developing a temperature of above 37.7 or a new persistent cough (as per UK government guidelines) were immediately isolated with their own bathroom facilities, barrier nursed and a COVID-19 swab was sent.

We undertook COVID-19 risk and vulnerability assessments for all patients on the ward. All known risk factors, age, gender, ethnicity, co-morbidity, ability to adhere to COVID-19 restrictions and capacity to understand were used to formulate individual risk profiles.

For high-risk patients, we coproduced care plans with the multidisciplinary team and patients. The plans were shared commitments, with everyone working together to reduce risk of infection. Patient involvement ensured an improved adherence to social distancing and isolation.

The care plans addressed modifiable risk factors and highlighted risk enhancing behaviours to change. We tailored community leave and found ways for patients to remain connected with families, including providing a ward iPad. We changed face-to-face ward rounds to virtual reviews using telephone and video calls. Care co-ordinators were able to join us by

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telephone or software such as Microsoft Teams to continue community engagement.

We communicated our plans by creating brightly coloured posters with simple flowcharts and holding daily morning and afternoon meetings to review and detect new cases. We encouraged staff to rigorously adhere to these measures. The messages focused on safety and protecting each other by looking after mental and physical health.

Our attempts to flatten the curve of COVID-19 at Heather Close have been successful so far. We had a total of 3 confirmed cases and 5 further suspected cases. There were no new cases since 2nd April 2020 and no patient deaths. Antibody testing became available for staff from 2nd June 2020.

As with all preventive measures, there is an inevitable trade off. By prioritising infection control and safety, we lost some of our most vital rehabilitation activities. Our daily planning meetings were suspended; activities such as breakfast club, walking group and bingo were put on hold. Like the rest of the country, our patients had to endure the social exclusion of lockdown and anxiety of potential infection whilst living communally.

Our initial concerns had been around (1) limited and sporadic supply of PPE; (2) restricted testing facilities; (3) staff commuting from all over London; (4) staff travelling between multiple sites; and (5) patients continuing to use community leave. We also realised that the guidance provided did not address the needs of long-term inpatients facilities. This is also

reflected in longer term residential care homes, where mortality has been high.

It is difficult to estimate the true costs of suppressing the virus in the short and long-term. Patients experienced increased anxiety, poor sleep, frustration and worsening mood. Discharges were delayed and social inclusion activities and family contacts were disrupted. Patients were cared for by staff who were suffering from their own personal challenges. The majority of staff at Heather Close are from higher-risk black and minority ethnic groups (BAME). As many staff members became unwell with COVID-19 symptoms, we also experienced staffing shortages.

This pandemic will have a lasting impact on how we support rehabilitation and recovery for people with enduring psychosis. The future has to be one where safety and enablement go hand in hand. Rehabilitation teams need to continue delivering person-centred interventions, facilitate social inclusion and support individuals towards independence while mitigating COVID-19 risks. Rehabilitation practitioners are creative problem solvers and are adept at navigating complex and uncertain situations. Rehabilitation approaches should be enhanced to protect vulnerable people in these unprecedented times.

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**Compliance with Ethical Standards**

**Conflict of interest** None.