**Best Care Practice Principles for Working with People with Long COVID**

**Action Plan**

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**Developing the Action Plan**

1. Complete the SWOT analysis for each of the best care practice principles. You do not have to complete them all at once – you may choose to focus on one or two at a time to make the task more manageable.
2. Review the outcomes of your SWOT Analysis and identify the key factors in each category.
3. Prioritize the factors you have identified based on their potential impact on people with Long COVID.
4. Set specific, measurable, achievable, relevant, and time-bound (SMART) goals and objectives for your action plan. The goals reflect what you want to achieve while the objectives link the tasks you will need to complete to attain your goals.
5. Identify a set of actions that will help you meet your goals and objectives and assign them to specific individuals or teams. A helpful template for these actions is provided:

* Who? *The person or team assigned the action.*
* Does What? *An explicit description of the action to be taken.*
* With What? *Identifying the resources needed to act.*
* How Well? *An explicit statement of your success criteria for the action.*
* By When? *A time frame for the completion of this action.*

1. Regularly revisit your actions to monitor progress towards the goals and objectives. Adapt, modify, or update your action list accordingly to maintain momentum.
2. Evaluate action plan. Choose regular time points for an overall evaluation and adjustment of the action plan. This may include the formulation of a new action plan to continue with.

**Best Care Practice Principles for Working with People with Long COVID**

**Principle 1:**Understand the impact of COVID on every part of our lives.

**Clinical or Professional Terminology:**Comprehensive biopsychosocial assessment

**Thinking and Discussion Prompts**

* Comprehensive biopsychosocial assessment for patients with Long COVID should address biological, psychological, and social factors. What factors do you address in your current approach to assessment? Are there any factors or domains missing?
* Who contributes to our assessment processes? Where is supporting information collected from? How are the multiple sources of information gathered combined to provide a holistic picture of the patient’s needs?
* When do our assessments occur within the patient's process of recovery?
* Do we promote early identification of needs or issues? Does our assessment enable early intervention and to potentially head off the development of long-term symptoms?
* How do we use the findings of our assessments to develop personalized treatment plans that support the patient as a unique individual?
* How are our assessments utilised as part of shared decision-making with patients and their families?

**SWOT Analysis**

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| --- | --- |
| *Strengths: Existing positive factors and resources for yourself and your service that support goal achievement.* | *Weaknesses: Existing negative factors and resources for yourself and your service that hinder goal achievement.* |
| *Opportunities: Positive factors external to you or your service that could be leveraged to support goal achievement.* | *Threats: Negative factors external to you or your service that can be barriers to goal achievement.* |

**Principle 2:**Don’t jump to conclusions.

**Clinical or Professional Terminology:**Diagnostic / assessment error, Gaslighting

**Thinking and Discussion Prompts**

* How do you go about identifying Long COVID in your client group? What symptoms or signs are you looking for? Is this a formalised process or completed ad hoc?
* Who contributes to your diagnostic / assessment processes? Are there specific assessments utilised to identify the impact of this syndrome?
* What is the role of patients in diagnosis or assessment of Long COVID symptoms?
* Think about an interaction you've had with a person living with Long COVID. What was your response to their lived experience? What did you say?
* How would you communicate validation or acceptance of the lived experience of people with Long COVID? How is it acknowledged?
* Are there differing opinions in the treating team about the causes or contributors to Long COVID?

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**Principle 3:**Track my recovery and adjust my support accordingly.

**Clinical or Professional Terminology:**Goal Setting, Outcome Measures

**Thinking and Discussion Prompts**

* What are your current practices around goal setting with your patients? Do you have any tools or structures that guide this process?
* How are goals prioritised? Do you limit the number of goals people can work on if a large number are identified?
* What is the role of patients and their carers in the goal setting process? What areas of function or participation in activities of daily living do you generally target in terms of goals?
* Which assessments form the basis of these discussions of goals? Are they validated or bespoke? What variables do these assessments target? How are the results of your assessments fed back to patients?
* Are outcome measures repeated on a regular basis? What are your current timeframes for review (i.e., how often do you repeat your outcome measures?

**SWOT Analysis**

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**Principle 4:**Help us access and navigate the services we need.

**Clinical or Professional Terminology:**Integrated care, Care coordination

**Thinking and Discussion Prompts**

* What relationships does your service have with other supports and services? Are there referral pathways in place?
* Do you work in a multidisciplinary service or setting? If so, how does the team practice interdisciplinary care? If not, what opportunities do you have to integrate your care with other colleagues elsewhere?
* Do the patients you work with have a care coordinator or named key worker? Who takes on overall responsibility for their care?
* What services or supports are available in your local community which may be relevant to the needs of people with Long COVID? Who do you regularly refer people to?
* How would patients become aware of these services and supports? Are there any services and supports to which they could self-refer?

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**Principle 5:**Support us to stay connected with family, friends, and community.

**Clinical or Professional Terminology:**Social inclusion

**Thinking and Discussion Prompts**

* How would you identify or become aware of the social networks your patient belongs to? Is this a standard part of your assessment process?
* What role do family members, friends or other unpaid carers play in supporting the services you provide? Are they actively involved in service provision, or do you provide them with information and other forms of passive support?
* Do you consider how social networks help or hinder your patients to participate in activities of daily living?
* Do you have processes in place to manage negative aspects of social contacts (such as elder abuse, family violence or other forms of exploitation)?
* Are you aware of family or carer supports and service available in your local community? Are families and carers able to access these directly or do they need to have a referral from your service?

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**Principle 6:**Give us cutting edge support based on the latest research.

**Clinical or Professional Terminology:**Evidence based or informed practice

**Thinking and Discussion Prompts**

* Do you or your service have processes or policies in place to support evidence based/informed practice? Are these processes or policies discipline specific or multidisciplinary?
* What forms of evidence are valued or privileged in your practice? What forms of evidence are considered an ‘acceptable’ or ‘valid’ basis for practice, and are there any that are not considered ‘acceptable’ or ‘valid’?
* What resources do you have available to you or your service to support evidence based / informed practice? This could include access to online databases, university or hospital libraries or academic partners.
* How confident and skilled do you feel around evidence based / informed practice? Are there any gaps in your knowledge or skills you would like to develop?
* Are you aware of any existing evidence around supports or services for people with Long COVID? How would you go about identifying this evidence, and keeping up with the rapid developments in this field?
* What role does lived experience expertise play in your overall approach to evidence based / informed practice? How does this evidence interact with research and other forms of knowledge?

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**Principle 7:**Listen to and respect our lived experience.

**Clinical or Professional Terminology:**Co-production, person centred practice

**Thinking and Discussion Prompts**

* Who designs and develops your services? Who undertakes quality improvement activities or other reviews of service performance? What (if any) consultation is undertaken with end users before changes are implemented?
* Do you (or a colleague) have any prior experience of co-production with service users? If so, how did you experience this partnership? If not, what do you anticipate about working with service users in this way?
* Do you or your service have any explicit expectations or guidelines about person-centred practice?
* What do you think being person-centred practice would look like in your practice? How would you know you are being person-centred?
* How can you demonstrate to people with Long COVID that you see their challenges and validate their crucial role as lived experience experts? How would they know this is an aspect of your service?
* What do you foresee as the benefits and challenges of partnering with people experiencing Long COVID in all areas of service development and delivery? What adaptations might you need to make to enable their participation?

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**Best Care Practice Principles for Working with People with Long COVID**

**Action Plan**

**Date:**

**Goals & Objectives**

|  |  |  |
| --- | --- | --- |
| **Principle No.** | **Goal** | **Objectives** |
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**Action Plan**

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| --- | --- | --- | --- | --- |
| **Who** | **Does What?** | **With What?** | **How Well?** | **By When?** |
| The person or team assigned the action. | An explicit description of the action to be taken. | Identifying the resources needed to act. | An explicit statement of your success criteria for the action. | A time frame for the completion of this action. |
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**Best Care Practice Principles for Working with People with Long COVID**

**Action Plan Evaluation**

**Date:**

**Goals & Objectives**

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| **Principle No.** | **Goal** | **Objectives** |
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**Evaluation**

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| --- | --- | --- | --- |
| **Action No.** | **What did we achieve?** | **Evidence of Achievement** | **What do we need to do next?** |
|  | Refer to the ‘Does What?’ criteria in your plan. | Refer to the ‘How Well?’ criteria in your plan. | List potential further actions, and include them in a new action plan. |
| 1 |  |  |  |
| 2 |  |  |  |