Lessons learned from COVID-19: Building a 'new normal' in tissue viability

Like many sectors, tissue viability services have been affected by and had to learn lessons from the COVID-19 pandemic. The pandemic has had an impact on service delivery and patient communication, and there has been some debate over whether this will permanently change the ways in which care is delivered. A group of specialist nurses and academics working in wound care met online via Zoom on 15th June 2021 to discuss how care has evolved since the start of the pandemic, and what this might look like as we move forward. This builds on a previous discussion that took place one year earlier (18th June 2020), in which a similar group discussed the challenges of delivering care at the height of the pandemic, which was published in Wounds UK in September 2020 (Fletcher et al, 2020).

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The group agreed that a lot has happened in the year since the last meeting. The impact on delivery of some services is ongoing and staff are still facing a lot of uncertainty, which can be very challenging. Clinics are starting to resume face-to-face appointments and home visits, but services are still in flux, and it remains to be seen which new measures may become an ingrained part of service delivery.

It was agreed that it is important to use this time to look forward and use the best new developments in care to improve services for patients. While the COVID-19 pandemic has presented many challenges in care, it has also provided a unique opportunity to assess services and how they are delivered, which should not go to waste.

TECHNOLOGY AND REMOTE CONSULTATIONS

Use of technology helped to facilitate patient contact during the pandemic. Even where face-to-face appointments were still running, many patients were reluctant to come to the clinic or to have a clinician visit them in their home due to shielding or fear of nurses visiting.

It was generally found that telephone appointments worked more efficiently than using video technology. However, this may vary depending on the care setting and the individual patient. It has been reported that some ward rounds in care homes conducted via video worked well.

Preferences vary, and this may depend somewhat on the wound/condition/individual patient, but in general it was found that video consultations did not work smoothly. Connectivity issues, especially in rural areas, caused problems, and some patient groups did not have the access or the skills/dexterity to be able to show their wound properly on the camera. In general, it has turned out to be easier simply to pick up the phone.

Some patients have anxiety around using technology, which can then make them more anxious around their wound and the care they are receiving. These issues can make it difficult to unpick the patient's anxiety and how this can be alleviated, particularly when there are lot of different elements involved. Now that the risk has reduced, many patients seem to be keen to get back to face-to-face visits, while some are less so.

However, it is worth noting that, for some patients, there is also anxiety around going to the hospital or seeing a clinician in person (e.g. travelling, parking, factoring the time involved), so there is not necessarily a 'perfect' solution.

Many clinicians are keen to return to face-to-face appointments as some nurses have missed the reassurance of patient contact as

much as their patients have. Building trust and relationships between patients and clinicians is important, and clinicians may also miss the satisfaction of close contact with patients and seeing first-hand how they progress.

LIMITATIONS OF REMOTE CARE

Remote consultation has been found to work 'when things are going well'. If patients are on a pathway to healing, remote consultation is generally sufficient and works well. However, if there are complications or uncertainty, face-to-face contact is needed and provides more reassurance to the patient. There can also be serious issues regarding patient wellbeing (see section below on 'Patient wellbeing and safeguarding) that may be at risk of being missed.

It was also noted that remote consultations tend to work better when conducted by confident, experienced members of staff. Long-term staff tended to be confident working over the phone when necessary; however, without face-to-face contact and experience, it is difficult for newer staff to develop this level of confidence.

While in some ways, remote consultations can save clinician time, they can be more difficult to document effectively, as it is easier to take notes simultaneously in person. Practical issues such as these mean that it remains to be seen whether remote consultations save time or money in practice.

HEALING RATES

While there is no specific comparison data for how healing rates have changed during the pandemic, there is anecdotal evidence that the pandemic has impacted on healing rates for patients in various ways.

The pandemic, particularly during the first wave, had a negative effect on many patients who did not have support in place, so became isolated and saw their health deteriorating. Some patients who were reluctant to come to clinics or appointments delayed seeking help, so their condition worsened.

It has been suggested anecdotally that there has been a 'huge' increase in pressure ulcers due to care issues during the pandemic, some of these being COVID-related, although there is currently no evidence to support this.

However, it has been reported that self-care appears to have resulted in reduced rates of wound infection. It is acknowledged that this may be because they have not been seen by a clinician, but it may also be that patients' hygiene is better at home, or patients have become more aware of how to identify and manage their own infection risk better, there has been an increased level of hand washing and hygiene in general has become a public priority. This is an area that requires more evidence and exploration.

PATIENT SELF-CARE

During the pandemic, some patients have not been able or willing to have face-to-face visits, so self-care has been a matter of necessity. In other circumstances, it has been necessary to decide which patients could benefit the most from increased self-care.

Any self-care regimen requires clinician support and is about achieving the right balance. It was found that some patients were largely able to manage their own care with a weekly call from their clinician, while some have largely managed their own care but with a face-to-face visit every 4 weeks.

Stratifying patient capability and capacity, plus the support they have available, is key. Just as clinicians have a range of skills and expertise, so do individual patients. Some patients are 'the expert self-carer' and are well qualified to manage their own wound and symptoms (particularly in terms of recognising infection); whereas some require more support and education.

Patients also have varying levels of resilience. As clinicians, we have become accustomed to seeing huge numbers of wounds of varying severity, but a patient or their relatives/informal carers will not have this frame of reference and may be fearful of dealing with a wound.

However, many patients who have had to self-care during the pandemic – who may not have chosen to do so otherwise – have now built a level of confidence that enables them to want to continue managing their own care. It is important to keep this momentum going and consider self-care for all appropriate patients, while reassuring them that support is available when they need it.

In some cases, inappropriate patients have been asked to self-care, which may have been used as a way to abandon 'difficult' patients. It must be emphasised that they are the ones who are often more vulnerable and need contact more than anyone, in order to build the patient-clinician relationship and achieve better outcomes.

In wound care, patients can struggle to access the right service or clinician for the care they need – as has always been the case. There is a need for relationship-building and gaining the patient's trust in order for them to get the most out of their treatment. In many cases, patients still trust in physical contact and this is vital. However, self-care models have also instilled increased confidence in some patients, who have become much more knowledgeable about their own care and when they need to ask for help. This increased autonomy means that patients are able to be on their own schedule rather than the clinician's, which can be empowering – for example, in choosing when to change their own dressings or have a shower, rather than having to wait for an appointment.

On a practical level, there is a need for some hands-on care, such as checking compression bandaging and being able to see the patient's dressing. New technology that helps to monitor the wound and healing conditions (e.g. moisture, pH level) may change this, but with standard wound care, physically seeing the wound tends to be important, particularly in the presence of any complications. It is important to remember that, when seeing a trained clinician, patients get more than 'just a dressing change'.

PATIENT WELLBEING AND SAFEGUARDING

In all consultations, human contact and communication is of paramount importance. This enables us to see how the patient is reacting, how the information is landing with them, their level of understanding and any concerns.

During a holistic assessment conducted in person, the clinician can pick up on a lot of information about the patient, from seeing (and smelling) the wound, and from meeting the individual. In person or home visits allow the clinician to pick up on patient cues and assess the patient's environment. These are factors that could be missed unless patients are seen in person.

Clinicians in the group gave examples of patients who may be dehydrated or malnourished, may not have the appropriate care or support at home, or who may have communication issues. These may present safeguarding issues that would not have been picked up unless the patient was assessed in person.

Patients are sometimes reluctant to share information, which can stem from not wanting to appear to be a 'difficult' patient, so picking up on these cues is vital. During remote consultations, it can be easier to appear to the clinician that they are doing well, if the patient chooses to do so. This means that environmental issues, lack of support or self-neglect can be missed.

THE ROLE OF CARERS

It is important to consider the role of carers and relatives, as their role has changed, and this has been difficult for many people. Some family members have been 'thrown in' to caring for their relatives without being prepared for it, which may have affected family relationships and had a wider cultural impact on family dynamics. There are huge cultural differences in terms of how different families look after one another, which creates disparity among individuals.

Considering the family and how this may have affected the individuals involved is crucial. As clinicians, we need to think about what we ask of carers and how individual attitudes and capacities may vary.

THE IMPACT ON CLINICIANS

The COVID-19 pandemic has had a significant impact on clinicians and their own wellbeing. Many clinicians have been overstretched, while dealing with challenging and sometimes upsetting situations. Clinicians may now be experiencing burnout and 'change fatigue', having had to adapt their services and not always being able to deliver the services they would like.

Personal protective equipment (PPE) has been a huge issue in practice. The approach has sometimes been counterintuitive – with a lack of PPE at the beginning of the pandemic and now an ongoing requirement for full PPE even as conditions have improved and vaccination rates and access to lateral flow testing have increased.

It continues to be challenging to protect staff wellbeing under the ongoing conditions; for example, being unable to have a fan on hot days due to infection control. Some clinicians have experienced additional challenges, such as the discomfort of experiencing menopausal hot flushes while wearing PPE.

This has also been an issue in terms of communication, such as the difficulty of telling patients bad news while wearing PPE. These challenging conditions have had a huge effect on staff as well as patients.

There is frustration among some clinicians at the prospect of things going 'back to normal' and staff not having a voice in how services evolve and which successful measures could be kept as we move on. There may also be fear of a possible 'blame culture' within the NHS, which will require staff to justify how decisions were made during the pandemic. It was noted that many services were preparing for a 'tsunami' that in some cases never came. Decisions may have been made differently in hindsight, but it was impossible to know what to expect.

Staff have faced these challenges and continued to provide care, working flexibly and with huge commitment to providing what was needed however possible, which may be at risk of ebbing away as services return to 'normal'.

It is important to keep communication open within teams and to encourage members of staff to talk to colleagues if they feel anxious or depressed. Staff mental health needs to be approached in a way that is not just 'a box-ticking exercise', so it is suggested that this can be more meaningful if addressed on an individual team level. For example, in team meetings, staff could be asked to rate their mood/wellbeing on a scale of 1 to 5, to facilitate team discussion. There is also a need for organisations offering anonymous independent support for staff if anxiety is an ongoing issue.

MOVING FORWARD

Services are largely moving back to being in-person. However, there are still some ongoing issues relating to this – such as patients still having to wait outside in the car park and other logistical issues. There is some disparity between different departments and care settings, and access to face-to-face GP appointments is still a significant issue. This needs to be discussed and consensus reached to stop patients and clinicians from becoming confused and frustrated.

In general, clinicians are keen to see patients again, but also to gauge how new developments that were made through necessity during the pandemic may be able to improve ongoing practice. There is still a lot of uncertainty, and a feeling that it is important now not to go backwards, but rather to use this time as an opportunity that should not be wasted. There is a danger that services will automatically fall back into ritualistic care, and we should make sure to avoid this happening wherever possible. This is an issue that is much wider than wound care and should be considered in all care settings.

EDUCATION

The pandemic has highlighted the need for education in general. Generalist staff need to have greater knowledge to reduce the need to rely on specialists. Education and support are needed for clinicians such as GPs, as the close connection with specialists has been lost. There is also a need to gather information from patients and from front-line staff, to gauge experiences and shape how services could evolve, without making assumptions.

Online education is useful and future conferences could have a hybrid approach (online and in person), in order to increase access but also bring back networking and learning between colleagues.

It is also vital to reignite clinicians' clinical curiosity and enthusiasm. In many cases, practice has been chaotic and sometimes emotional, with too much for staff to deal with, so time needs to be made for practice to be carried out, such as thorough assessments and documentation, enabling meaningful practice.

We need to invest in the future workforce and support less experienced staff. There is a need for education aimed at novices in a specialist role, as well as generalists, as currently a gap exists. Clinicians need to build their clinical acumen and confidence: building clinical, business and personal skills, and learning the nuances around clinical decision-making.

There is a need to build on the relationship between the NHS and industry, with creative ideas from industry as to how care can be delivered and sustainable changes can be made. Commercial companies are keen to play a part in supporting NHS staff, with agreed objectives and innovation. There is a need to work in partnership and for staff not to be fearful of utilising the skills and offerings of industry partners.

CONCLUSIONS

Staff have continued to provide care to patients in a challenging time under huge amounts of pressure. It remains uncertain how care will evolve as a result of this, and some challenges in practice currently remain.

There is an opportunity to improve practice and not automatically go back to ritualistic care, as services develop going forward. Services need to find the right balance, which is an issue wider than wound care – not lagging behind but not rushing to return to 'normal' and all that entails.

We need to reflect and learn lessons in handling the workload in the most appropriate way and ensuring that patient care – and clinician wellbeing – are at the heart of service delivery.

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REFERENCES

Fletcher J, Atkin L, Murphy N et al (2020) Learning from COVID-19: Developing a more efficient tissue viability service. *Wounds UK* 16(3)