Burns and Plastic Surgery Nursing during the COVID-19 pandemic: reflective account and experiences

KEY WORDS
- COVID-19
- Pressure ulcers
- Quality

Since the beginning of 2020, the COVID-19 pandemic has been a challenge faced by the world and one that all health professionals are facing. The impact of COVID-19 on patients receiving and accepting healthcare services has changed over the past few months. identified within our burns network was a change in the mechanism of burn injuries in children for example, an increase of steam inhalation burns has been seen (Brewster et al, 2020) and an overall change in the approach to burn care. This paper is an initial glance at what was identified at an acute setting during the first wave of pandemic.

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As a team of Burns and Plastics Specialist Nurses (BPSN), we never envisaged that we would be writing a reflective account on a worldwide pandemic. It is nothing new to hear about the pressures the National Health Service (NHS) has faced over the years and COVID-19 has contributed supplementary chaos, tragedy, panic and loss. By no means could we have prepared or planned for such immense devastation and, while we acknowledge and admire the work of our amazing intensive care teams in terms of responsiveness, resilience and courage, this reflective account will enable us the opportunity to reflect and focus upon the impact of the pandemic for us, within the field of wound care, and consider the direct and indirect impact for our patients, our services and our teams.

We read about Florence Nightingale and Mary Seacole pioneering modern nursing and we are aware of their well-known journey during the Crimean war. This posed them the monumental task of delivering nursing care within a defiant and somewhat disconcerting environment. Can this be likened to the challenges we are now being faced with, amidst COVID-19? Some would describe this as a war zone.

Today we can confidently document our present journey and only contemplate how our accounts and practices will, in the future, make history. Are we reliving the comparable challenges in practice then, and are we and our nursing teams replicating the forward thinking and visionary notions needed to get us through our own crisis. Are we and our teams the new pioneers in modern nursing, similar to that of our predecessors, such as Nightingale and Seacole?

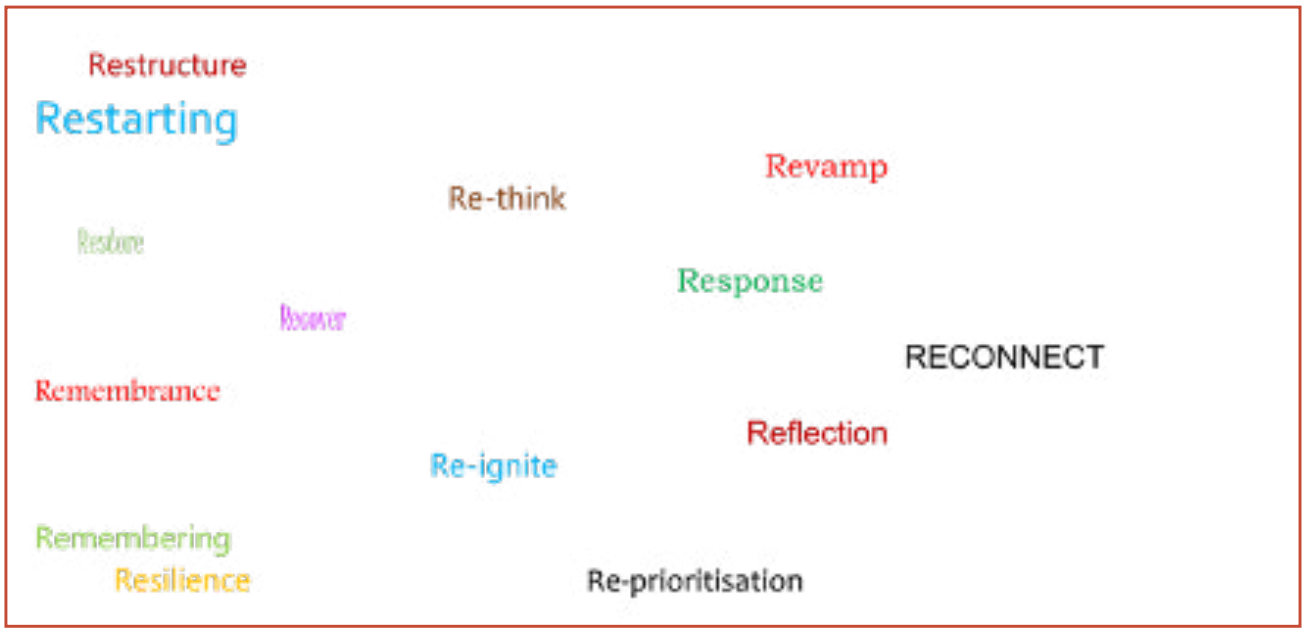
COVID-19 is reported to have claimed the lives of over 120,000 people in the UK (Gov.UK, 2021) and while this will always be engrained into our memories, among this misfortune, COVID-19 also acted as a catalyst to expedite new ways of working, along with more efficiency and more creative use of resources. In an instant everything changed and genuine concerns over colleagues welfare could not be ignored, especially in the early days, when worries about whether we would lose one or more of our colleagues to the virus were common, and with that came a new found concern to protect those most vulnerable. For managers, there was the additional pressure of wanting to make sure everything was done correctly, the need to protect everyone in the team was overwhelmingly powerful at times; it felt as though you literally had your colleagues lives in

your hands. COVID-19 seemed to bring the wider team closer, including all medical, adminstration and therapy colleagues. The first priority and question that was asked within our morning zoom meetings was to check that everybody was ok. We also began departmental zoom quizzes on a Friday night, which lifted spirits and helped us reconnect as a department. The teams attitude that they would do what matters for their patients and service even at the expense of risking themselves was just an unwritten rule and inspiring to see.

Outside of work the kindness of people was all around, suddenly strangers were doing other people's shopping for them — a member of our team experienced a complete stranger paying for their coffee at a drive through without even saying a word, just because of the status of their uniform, while doing community outreach. Grandparents were learning how to facetime to keep connected to their families, and everyone around us spoke about getting to know their neighbour's, even when they have lived close by for over 10 years. It is because of COVID-19 that these relationships have formed and flourished.

It seems our priorities in life have all been reset and perspective has allowed us to see what matters most. This reflective account is focused around our journey and our experiences throughout this unprecedented time within a Burns and Plastic surgery unit.

Our Burns and Plastic Surgery Team



Our response to fight the pandemic

OUR SERVICE BEFORE COVID-19

It will probably resonate with other health professionals that we were living life on that hamster wheel: just keeping going, struggling to keep our heads above water and managing the demands for our wound care services and patients. Maben and Bridges (2020) describe the dilemma of having a growing patient population but a reduced nursing population, which is mirrored by the pressures we faced on a daily basis. There was no time to stop and reflect, we had that vision of what needed to happen and the service restructure required to provide a modern approach, but we were too busy living in the past and the present to look forward to the future and implement our aspirations and innovations.

CHANGES DURING THE COVID-19 PANDEMIC

There were a lot of changes between April and July on a daily basis because of the pandemic. However, the things that felt most prominent, and that seemed to dominate our daily practice as BPSN's, was experiencing the distinctive attitudes of patients and the public, using the necessary Personal Protective Equipment (PPE) and the ways in which we had to adapt our services, including the shift around antimicrobial stewardship.

ATTITUDE'S

Each Thursday evening at 8pm came the familiar sound of people clapping, cheering and honking their cars horns to thank us for doing our job and then the next morning the drive to work was signposted with notices across the central reservation saying 'Thank you NHS', 'You are heroes', along with symbolic pictures of rainbows in people's houses and more thank yous. It felt as though a new respect for health professionals had been found, giving us priority in shops and allowing us discount for various things were just some of the ways that the general public portrayed huge gratification and appreciation for what we were doing. It felt as though a unity had been formed across the country and everybody played their part by staying home and ensuring we did not become overwhelmed with the amount of COVID-19 patients to care for. Many of our patients told us they did not want to add additional pressure to our team by coming to the hospital. From an alternative perspective, some patients stated they were too scared to come to the hospital, a location once deemed a place of safety.

Ironically, the fear of catching COVID-19 provided a doorway allowing us, as a wound care team, to promote self-care for our patients as well

as helping shape a willingness within our patients to embrace self-care we had been advocating before the pandemic, at that point they were not so keen to do this, however since the COVID-19 pandemic have wanted to do this. Preliminary findings of an unpublished in-house audit showed that patients were happy with their outcomes around self-care and positive results were also found clinically, for example, there were no increase in numbers of infections.

On the contrary to the positive aspects surrounding attitudes, Mabel and Bridges (2020) described the stigma some nurses experienced in that they were labelled as 'disease carriers' and sadly this stigma is something our team were also aware of, especially when telling people outside of the hospital that you are a nurse.

Paranoia surrounding COVID-19 was promient. Everyone was unsure whether the slightest symptom meant you may be positive — if you felt hot, or at times, if you coughed all eyes would look at you and the space between those around you increased. A sore throat or change in voice could set alarm bells ringing.

PPE: PAIN IN THE SIDE, PREVENTING A VISUAL FIELD, EMOTIONAL BODY LANGUAGE BLOCKER

As a nurse, PPE has played a fundamental role in protecting and keeping us safe; however, it has posed challenges of its own within the field of wound care. From a clinical aspect, the clarity of our visual field has been suboptimal at times. As wound care nurses, we celebrate our specific skills and expertise around being able to identify intricate structures and detail of the wound bed that allows us to make the best decisions for our patients, but trying to do this with goggles on compromises our visual field. Similarly, within our speciality we are often able to identify certain microbes linked to wound infection odour, (particularly the bacteria *Pseudomonas* or *Staphylococcus aureus*). This is important as it helps us choose the correct dressing, which will reduce the bioburden on the wound and the chances of it becoming infected, as smelling the *Pseudomonas* can be an indicator of a higher chance of infection developing. However, this was more challenging with a mask on.

Other extended skills that we pride ourselves on that were made more difficult included the sharp debridement of wounds including burns, along with the meticulous dexterity needed to trim and optimise skin grafts. Removing sutures from delicate areas was also a challenge.

On a lighter note, there was something quite comical about your goggles falling off whenever you looked down and steaming up every time you laughed, this seemed to put the patient at ease most of the time although it did extend the amount of time it took to do something, depending on how much of a good time you were having (how often you laughed).

On a more serious note wearing the masks and goggles created many barriers. Patients were not able to read our facial expressions and it was felt our body language was hugely compromised. As a team, we were particularly aware of the potential effects of this, especially for our patients that had learning differences and mental health conditions where a lot of our rapport is built around body language, physical contact and facial expressions. The power of touch and physical contact had been taken away, something which plays such an integral part in portraying compassion. The hardest thing to see was a patient in pain and to not be able to comfort them in the same way as pre-Covid; this was also exacerbated by the new restrictions instructing patients attend their appointment alone.

OUR SERVICE CHANGES

The flexibility and commitment shown for our patients by our nursing team has been phenomenal to witness and truly admirable. Over the course of around three days, our service model was completely different. We no longer were doing medical tattooing, or seeing 20 patients a day in our dressing clinic five days a week. Instead, we educated patients how to care for their burns and wounds and our nurses devised self-care leaflets to guide and reassure patients. We set up a virtual telephone clinic where we got patients and our community nursing colleagues to send us photographs of wounds allowing us to provide our advice remotely and decide who should be brought into the clinic and who did not need to be. This allowed us to screen the patients and safely

bring those patients to our clinic that could not be managed at home. It also enabled us to protect our staff that were deemed high risk by facilitating them to work in a non-patient facing role and remain active within our team, as opposed to redeployment.

We demonstrated creativity and the ability to change our service under pressure quickly. To minimise the risk of spreading COVID-19, our waiting area was redesigned to incorporate the two metre rule, which equated to only three people allowed in at a time. We were constantly redesigning our clinic templates and revaluating them, there was a lot of trial and error as we tried to prepare for the unknown.

As hospitals were seeking to discharge patients more rapidly, this also placed additional demands and stressors on our community nursing colleagues. Pre-Covid we were all aware of the pressures these community colleagues faced and were keen to show our respect and provide support throughout this immensely challenging time by not adding to the exacerbated workload that COVID-19 placed on them (Sher, 2020). We increased our outreach service from two to three days a week, equating to 262 visits in five months, meaning we could visit our most vulnerable patients at home, without passing the load or adding more pressure to our community nursing colleagues. As a result of these outreach visits we experienced a sense of relief and appreciation from our patients in that they did not have to come to the hospital.

We must also recognise the unsung heroes within our profession that are often not acknowledged, and that is the adminstration and clerical staff, without whom, the restructure and reorganisation within our service would have been a much larger challenge.

As nurses began to screen all routine appointments and challenged our previous routine practices, for example, reviewing every new burn at 48 hours, this was a practice we altered when clinically judged unnecessary. We also changed our standard postoperative one week clinic wound check, which we got patients to do themselves with our virtual clinic support, when appropriate to do so. The pandemic also kick started our complex wound e-referral system. In the past we experienced resistance and barriers from health professionals who would need to adapt their practice to use it, but as a result of these barriers being forcibly removed, we found that we received an increase in telemedicine referrals.

By reducing our services, it incidentally gave us time to reflect and decide how we wanted to continue in the future, and it allowed us the time to reprioritise the most complex patients and give them the extra attention required. This historically was always a challenge.

Patient empowerment and ownership of their role around their own wound care was exciting and refreshing to see. However, at times, we have felt as though certain areas of our role have been compromised as we have not had the same quality of face-to-face engagement with our patients — the fear of not knowing what will happen to them after the pandemic cannot be ignored. For example, some of them may develop psychological problems from the trauma they have experienced, but this is usually detected over time during their appointments by staff rather than the patient stating it. Although, advice and questions can be done over the phone, this is not the same as being able to assess someone in person who may not even realise they are struggling.

A large part of our role is focused around our patient's psycho-social needs, for example a patient's altered body image or them adjusting to life with scarring, as well as their wound care needs. By not having that same face-to-face engagement, we have felt the care around these areas may have been suboptimal at times. The fear of patients not wanting to attend hospital and the subsequent knock on effects of patients being too scared to come to hospital has sometimes resulted in delayed presentations of injuries, especially burns. This has meant patients have sometimes ended up with complications and poorer outcomes including scarring and often more heightened distress around their experience, both of which may leave them with negative long-term effects.

During the pandemic a more conservative approach around reconstruction of wounds and burns has been adopted. This has been guided nationally due to the reduced capacity and

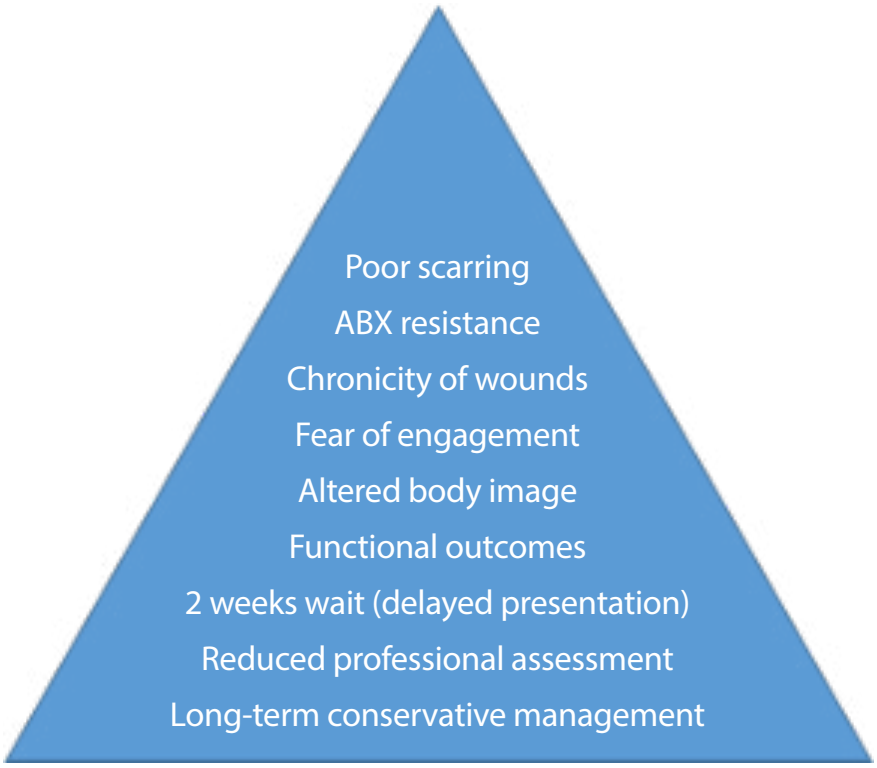


Figure 1. Consequences of the COVID-19 pandemic within our speciality

Florence Nightingale

prioritisation for theatre (Federation of Speciality Surgical Association, 2020), but also many of our patients have chosen conservative management in an effort to avoid the hospital admission they would have required if they were to have an operation. Having conversations with patients around them not being able to have surgery due to the pandemic has at times felt morally conflicting, especially when you feel as a health professional the patient should ideally be having a skin graft, which, if you know, functionally and aesthetically it will give the patient a better outcome and will also provide faster wound coverage, thereby reducing their infection risk. Trying to articulate sensitively and diplomatically to the patient that their skin graft is not a priority within the current climate has been extremely difficult, because as a nurse you are the patients advocate.

ANTIMICROBIAL STEWARDSHIP

The problem around over prescribing of antibiotics has been highlighted by Huttner et al (2020), along with the worry around advancing antimicrobial resistance. During COVID-19 we have felt there was over prescribing of antibiotics for wounds in general, and this inevitably added to the already pressing issue of antibiotic resistance. We faced a clinical dilemma, realising that we were using more antimicrobial dressings due to awareness that the dressings will be left on for longer and because we know the wound will not be cleansed by a health professional who would usually be more firm at removing debris. This is also compounded by a belief that patients do not usually clean their own wounds to the same degree that we would and therefore we have more concern over infection risk. As a result, we have opted to use more antimicrobial dressings in an effort to reduce this infection risk but at what cost? It has had a financial impact and also a possible stewardship problem. Within primary care we are aware antibiotics are being prescribed over the phone, as opposed to bringing patients into GP surgeries to try and mitigate the risk of patients catching and spreading COVID-19. Had these patients been

seen face-to-face, would antibiotics still have been prescribed? We as non-medical prescribers have always been meticulously cautious around antimicrobial stewardship, but it is difficult to know the correct solution to deal with this dilemma. We find ourselves asking if these issues are just the tip of iceberg, as shown by the wider consequences in *Figure 1* related to our specialty.

CHALLENGES AHEAD

There are still many challenges to face, we are uncertain of how will we cope capacity wise if social distancing remains the norm. Many things will remain affected, for example, our waiting areas and our working hours may need to change to fit patient demand. We, as nurses, may need to extend our services to a seven day service, instead of six. This will, of course, have wider implications for our nursing team in terms of maintaining their work-life balance and childcare arrangements. As things begin to return to normal, the new efficient ways of working may be lost due to the increase in service demand.

The harm of not operating is a major concern as within plastic surgery as BPSN's we recognise the impact and consequences of not operating for our patients, including the effects on chronicity of wounds, body function and body image. We are guided by the Federation of Speciality Surgical Association (2020) who provides a clinical guide of surgical priority, which was produced at the request of NHS England at the start of the pandemic and revised every month. For some of us the marathon is ending, but for some it feels as if it is only just beginning and the criteria for surgery has felt somewhat like survival of the fittest.

Anecdotally, within our team, we feel we have encountered more self harm, which could be due to the effects of lockdown and isolation. There is concern that we are going to uncover a huge surge in patients with poor mental health and, indeed, in crisis. We, as a team, have also discussed the impact of poor mental health on families and the increased pressure for those in which COVID-19 has imposed financial implications. More specific to our Burns and Plastics speciality, as people have been at home more, perhaps this has contributed to more accidents around the home, in particular D.I.Y and burns. Lastly, but most concerning, where are the patients who are victims of domestic violence that have been trapped in their homes with their abusers with hidden and untreated injuries.

CONCLUSION

What we have learnt is that panic is definitely spread like a tsunami and you must keep calm to keep those calm around you. We have learnt that telemedicine can be hugely beneficial but it is not a catch all, it has impacted on interpersonal skills, the ability to spend time being with a patient and express compassion in non-verbal ways, therefore one size does not fit all. There are patients that will always require face-to-face examination and treatment.

In the future, we will continue to run our virtual clinic and to promote self-care to those patients for whom it is deemed suitable. With COVID-19 there has been both pros and cons, but what has been undeniable is that strength of unity among all individuals both inside and outside the health profession. There are still many hurdles to overcome and we are still faced with the fear of the unknown. Hopefully our resilience and passion will help guide us through and will make our modern day nursing predecessors, Florence and Mary proud! WUK

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