

The New Norms of COVID-19

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Editorial on New Norms of COVID

This editorial outlines some steps we can take to manage this ever-changing landscape; our readiness to adapt; important preparations for future COVID waves; and ideas to overcome present challenges in the changing care landscape.

In yesteryear, working from home had to be justified. Now, for some, it is the norm. For the individual there are two main risks: the risk of getting it, and the risk of 'how bad you are once you have it'. For each country, the balance between everyone's health risk and the risks associated with depression, unemployment and financial burden for businesses are crucial. As the mental, emotional, and financial strain begins to show and the winter season beckons, 'out-of-the-box' thinking for care delivery is likely to become the new norm if we are to prevent community practices and hospitals from becoming overwhelmed once more. Restrictions and clinic backlogs in most countries are set to continue.

Steps we can take

Obviously, we all have a responsibility to lessen our exposure wherever and whenever we can. Flexibility has been forced upon Care Managers and staff alike as guidelines change and practices struggle to keep up. Planning for worse case scenarios (staffing sickness/holidays and care delivery logistics), staggered staff entry/exit times, remote electronic document signing, and expanding websites/apps to handle repeat prescriptions requests all help to lessen the load. Repeat prescriptions ordered through the UK NHS App increased by 97% in March 2020, while new EPS nominations rose from 304,000 in February 2020 to 1.25 million in March (NHS Digital, 26May 2020).

Fortunately, some parts of normal practice remain the same during lockdown. Whether remote or otherwise the care manager's key aim remains i.e. setting the overall strategy for colleagues to be the best they can be (providing support and removing obstacles).

Readiness to adapt

We can say with pride that our readiness as health professionals in different nations to adapt has been great regarding our attitude, and quite frankly 'just getting the job done'. Previously untested one day 'open air' flu clinics have greatly benefitted vulnerable patients, whilst simultaneously lessening patient contact for GPs and nurses already coping with 'lockdown fatigue' from the previous lockdown. With mass one day flu vaccination programmes accomplished, sadly the same cannot yet be said for COVID-19 vaccinations. The workforce will need to face

this additional demand when it arrives and overcome reduced capacity; continue protecting vulnerable staff from frontline work; and potentially accommodate infected staff needs or those in self-isolation. The RCGP recommend worst-case scenario planning to mitigate these risks; provide clear guidance on Governance, leadership, programme scale, and eligibility, staffing, delivery, data, and record-keeping for large scale vaccination. Clearly, non-traditional locations can be chosen but should still house 'high throughput' with more use made of pharmacies providing they are big enough to cope.

Although left with some obstacles (too few GP laptops, poor IT structure in some Care homes, initial childcare problems) a silver-lining emerged during remote working: easier work-life for those with caring responsibilities, and improved collaboration with hospitals and social care.

Important preparations for future COVID waves

As we await scientific innovation regarding vaccines, we all have a part to play to limit our exposure and therefore our viral load. There will be a clear need to adapt to a post-Covid-19 health landscape. Writing standard operating practices that can be actioned at a moment's notice is a sensible precaution. Doctor-led remote triage is likely to continue to determine service access points, and patient app use for remote monitoring may become commonplace (e.g. blood pressure, heart rate, blood sugar, mobility, falls).

Obviously, diabetes is a serious risk factor regarding COVID-19 due to the rising glucose levels at the onset of symptoms and during infection, so managing insulin protocols is critical. In China, an artificial intelligence system for COVID-19 diagnosis is reported to be equal to human diagnoses (regarding chest CTs). This shows potential and may be particularly helpful developing countries where RT-PCR kits are in short supply, but exact figures will be needed to assess the true rigor of this finding.

Ideas to overcome present challenges

Relaxation of unnecessary contractual and regulatory compliance activities and a more flexible approach could be applied to returning doctors, enabling them to devote more time to patient care. Practices have welcomed the freedom to choose the most appropriate follow-up form (i.e. face-to-face versus video call/telephone), and most importantly the ability to vary consultation length. The RCGP extended this to returning GPs, calling for a reduction in administrative requirements (e.g. keeping them on Medical Performers Lists for longer) to be in place by the end of 2020. 'Track and

trace' will continue to be a challenge as it relies on individual responsibility and integrity as on-the-ground COVID sampling companies/institutions keep governments informed of their latest findings (e.g. ONS, NHS). How to improve this is not clear. What is clear is that standard operating models for 2021 will bear no resemblance to those practiced in 2019. GP practices and community nurses will continue to provide a crucial public health role.

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