The new normal

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It is no understatement to claim that the world has dramatically changed since my last editorial. As COVID-19 spread across the globe like wildfire, words like "lockdown", "social distancing" and "furlough" all entered the lexicon.

Although pandemics are not a new phenomenon — from the Bubonic Plague that killed 200mn people between 1347 and 1351 to the Spanish Flu that had a death toll of between 40mn and 50mn at a time when the world was reeling from the First World War – mass lockdowns certainly are. As of April 3 2020, half of humanity was on lockdown. "Unprecedented" became the adjective of choice.

At the time of writing, there had been more than 4.3mn coronavirus cases worldwide and the virus had tragically killed more than 295,000 people (World Health Organization, 2020). The impact of the virus, quite aside from the personal tragedies, has been rapid and all-encompassing on healthcare systems. The pandemic has upset the usual day-to-day running of hospitals and disrupting routine services.

This disruption led European Wound Management Association (EWMA) president Alberto Piaggesi to film a series of video tutorials along with his team at the Diabetic Foot Section of the Pisa University Hospital, Italy, designed to provide useful tips to clinicians during the pandemic. The video can be accessed here: https://ewma.org/covid-19/short-video-tutorials-adapt-your-hospital-routine-towards-covid-19/

The unwanted arrival of COVID-19 onto the scene has caused a shake-up of daily practice, with the pace of the change disorienting for many clinicians. Specialist services in hospitals and community are struggling due to being understaffed as nurses are redeployed to COVID-19 wards and critical care areas. In addition, some members of staff who are classed as vulnerable are being shielded at home, while others self-isolate.

At the same time, Jacqui Fletcher, an independent tissue viability consultant nurse in the UK, explained to me that pressure ulcer numbers appear to have reduced but this does not mean they are actually going down, just that reporting is viewed as being less important when placed in the wider COVID-19 context. In actual fact, clinicians are seeing an increase in both numbers and severity, particularly when patients do not present to emergency departments for fear of catching the virus.

Quite apart from Personal Protective Equipment (PPE) shortages across Europe (Sanchez Nicolas, 2020), skin damage caused by PPE is also a huge problem. There have been some alarming photos in the media of clinicians around the world suffering from PPE-related pressure ulcers. Joyce Black's ten top tips in this issue (on pages 8-9) shines a light on the measures that can be taken to prevent pressure ulcers under face masks.

Meanwhile, organisations in many countries, including the National Pressure Injury Advisory Panel (NPIAP), have created some valuable COVID-19 resources, including an NPIAP position paper on preventing pressure injuries with N95 masks, an infographic and some pressure injury prevention tips for prone positioning (NPIAP, 2020). The UK's official advice was updated in April 2020 (NHS England and NHS Improvement, 2020).

On this latter point, clinicians are increasingly encountering pressure ulcers in intensive and critical care settings due to the use of the prone position, which some healthcare professionals are not familiar with and which needs to be maintained for a minimum of 16 hours. The importance of a pressure redistribution surface has been amplified, as has the avoidance of friction and shear when repositioning.

As we all navigate living with the 'new normal', the lasting legacy of the COVID-19 outbreak may be streamlined processes, such as rising demand for telehealth and helping patients self-care, arising from the need during the pandemic to find minimal contact solutions in health care. It may have been under uniquely trying circumstances, but perhaps long-term change will be for the better. WINT

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