**Keywords** Coronavirus/Covid-19/Public health/Inequality

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## In this article...

- Skills and knowledge needed to equip nurses for public health emergencies
- Why people living with disabilities need special consideration during the coronavirus crisis
- How nurses can advocate for and support marginalised groups during the pandemic

# How should the role of the nurse change in response to Covid-19?

Nursing Times Journal Club

## Key points

**People living with disabilities are less inclined to access health services and experience poorer outcomes**

**Education on physical, mental, intellectual and sensory disabilities should be a mandatory component across all pre-registration nursing programmes**

**The health protection content of undergraduate education should be enhanced**

**Nurses will have a critical role in ensuring the success of any coronavirus vaccination campaign**

**Nurses need time to build relationships with community institutions to help disseminate information**

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**Abstract** The UK nursing workforce has made a substantial contribution during the Covid-19 public health emergency and we now need to evaluate its current skills and knowledge and what it needs to cope with future potential outbreaks. This article discusses several approaches that warrant urgent consideration from the UK government, nurse leaders and policy makers to ensure long-term investment is made to support the profession and that nurses are well equipped to effectively respond to outbreaks, with a particular focus on meeting the needs of vulnerable groups and advocating on their behalf to reduce inequity in access to healthcare, health protection and cultural sensitivity.

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During the coronavirus pandemic, a full lockdown has been imposed, including closure of workplaces, schools and universities as a means to protect population health. The population was instructed to leave home only to shop for basic necessities or to exercise once a day, and to seek medical help only when required (Cabinet Office, 2020). The success of these outbreak control measures rests on inclusion of all societal groups in the outbreak response (*The Lancet*, 2020). During this global public health crisis, consideration of populations disproportionately exposed to risk is crucial. Often termed 'vulnerable populations', this group includes not only older individuals, those with disabilities, ill health and comorbidities, but also those from any socioeconomic group who might have difficulty in coping mentally, physically or financially with the pandemic (*The Lancet*, 2020).

Failure to consider vulnerable populations may not only exacerbate the barriers to healthcare these populations already face, but may act to deepen health inequalities (Ahmed et al, 2020). During this unprecedented time, policy makers must ensure that strategies to address the pandemic do not further marginalise vulnerable populations. This article challenges the nursing profession to address inequalities by tackling the social determinants of health, and supporting and advocating for those at the highest risk of the effects of Covid-19 in society (Box 1).

### Box 1. Social determinants of health

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. (World Health Organization, 2020c)

*"Nurses must be provided with the time, autonomy and knowledge to act as patient advocates"*

## The role of the nurse

Nurses make up the largest workforce within the NHS, and are among the first people present to provide care during periods of crisis (Buchan et al, 2019). In January 2019, the Nursing and Midwifery Council introduced a new set of standards (NMC, 2018a; NMC 2018b), which set out the skills and knowledge required to build the next generation of nurses. Interestingly, the term 'advocate' was cited only once within the *Standards of Proficiency for Registered Nurses* (NMC, 2018a), and was not mentioned within the *Standards Framework for Nursing and Midwifery Education* (NMC, 2018b). In all of its forms, advocacy acts to "ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, defend and safeguard their rights, and have their views and wishes genuinely considered when decisions are being made about their lives" (Royal College of Nursing, 2017).

As nurse advocacy plays a crucial role in reducing health inequalities, it must remain a central component of nursing practice and, more importantly, nurses must be provided with the time, autonomy and knowledge to act as patient advocates (Hemingway and Bosanquet, 2018). In light of this, a number of creative but considered approaches are discussed within this article and summarised in Box 2, which aim to strengthen the UK nursing workforce and its capabilities in responding to the Covid-19 crisis and future potential public health emergencies.

## Meeting the needs of people living with disabilities

Within the UK, approximately 13.3 million people (21% of the population) live with a disability (Department for Work and Pensions, 2019). In general, people living with disabilities including physical, mental, intellectual, or sensory disabilities are less inclined to access healthcare services, demonstrate greater health needs, have poorer outcomes, and are affected by discriminatory laws and stigma (Armitage and Nellums, 2020; UN News, 2020). Preliminary findings from a recent survey by Inclusion Scotland (2020) on the impact of Covid-19 on people with disabilities in Scotland, revealed the coronavirus pandemic had exacerbated existing disparities. Measures such as social distancing or self-isolation were found to have disrupted service provision for people living with disabilities, who often rely on assistance for food delivery, medication and personal care (H. Fisken, personal communication, 14 April 2020; Inclusion Scotland, 2020).

Preliminary findings from the survey found many people with disabilities in need of priority shopping have reported failing to access food, because they are not deemed 'clinically high risk'. People who are deaf and hard of hearing have voiced fears of being admitted to hospital, due to the lack of expertise found within these settings. This fear was further compounded due to the inability of healthcare staff to provide British Sign Language support or alternatives for people who were reliant on lip reading, due to social distancing and the use of personal protective equipment masks. In light of these findings, it is not surprising people living with disabilities have reported feeling 'left behind' during the Covid-19 response (*UN News*, 2020).

In 2018, only 41% of adult nursing courses reported teaching the Accessible Information Standard (despite this standard being mandatory in all health and social care settings in England). The standard aims to ensure that people who have a disability, impairment or sensory loss receive information that they can read or understand. Moreover, 86% of courses reported teaching on reasonable adjustments. Given that reasonable adjustments are pivotal to ensuring people living with disabilities receive equal access to healthcare, this presents a worrying picture. (Royal Mencap Society, 2018).

These figures demonstrating the gaps in nurse training on the care of people living with disabilities indicate the urgent requirement for training on physical, mental, intellectual and sensory disabilities to be a mandatory component across all pre-registration nursing programmes, instead of being restricted to the learning disability nursing discipline (De Castella, 2018; Royal Mencap Society, 2018; Ward and Banks, 2017; Kuenburg et al, 2016). Alongside this, training in British Sign Language could be offered as an accredited optional module/continuing professional development activity.

### Box 2. **Recommendations**

**Recommendations for governments, nurse leaders and policy makers**

**All pre-registration nursing programmes should include:**

- Training on physical, mental, intellectual and sensory disabilities
- The option to undertake training in British Sign Language as an accredited optional module/continuing professional development activity
- Training in health protection

**A register should be produced nationally of:**

- Nurses able to assist with specialist care to deaf and hard-of-hearing individuals
- Bilingual nurses who can assist in eliminating language barriers during the provision of care

Nurses should be provided with the time and autonomy to build on relationships with community institutions and religious groups to ensure the provision and dissemination of evidence-based information

**Recommendations for nurses**

- Advocate to ensure governments prioritise the information and communication requirements of vulnerable groups
- Prioritise the delivery of multiple forms of health communications in accessible formats – Braille, large print, text captioning for hearing impaired
- Develop and disseminate educational materials on basic hygiene practices and infection prevention
- Use digital technology to overcome issues related to social distancing
- Support bilingual nurses and nurses with experience of different cultures to provide culturally sensitive language translations for the purpose of communicating health information
- Build on relationships with community institutions and religious groups to ensure the provision and dissemination of evidence-based information

As more than a quarter of hospital trusts in England report having no access to specialist learning disability staff, these approaches would enhance the level of support provided to people with disabilities, both in routine care and during periods of crisis (Royal Mencap Society, 2018). They will also help to secure a nursing workforce with skills and knowledge to advocate for people living with disabilities, ensure their health needs are identified through appropriate assessment, adequately recorded in patient records, disseminated to the appropriate services, and met during routine care and periods of crisis.

## Nursing and health protection

Historically, the role of public health nurses focused on the management of sanitation and infectious disease. Over the 20th century, as the dangers of infectious disease diminished, the role shifted to address new challenges including the effects of deprivation, and non-communicable disease (Royal College of Nursing, 2020). This emphasis on the management of non-communicable disease was reflected in nursing programmes, which currently provide very little, if any training on infectious disease management (Ward, 2011).

In 2004, under the Health Protection Act, the Health Protection Agency was established (now respectively Public Health Scotland and Public Health England). Made up of multidisciplinary health protection teams – formed of nurses, practitioners, doctors, surveillance and administrative staff – these teams provide local specialist support to prevent and reduce the impact of infectious diseases, hazards and major emergencies. Following the Ebola outbreak in 2014, the measles outbreak in 2018 and more recently Covid-19, health protection has been given an increasingly high profile and recognised for its specialist knowledge and skills. In spite of this, health protection training continues to be reserved for those nurses who choose to pursue this specialty as a career in health protection post-registration (NHS Education for Scotland, 2017).

The World Health Organization has recognised the need to bridge this gap, highlighting the requirement for infection prevention and control knowledge, and its application in healthcare settings to secure outbreak preparedness and response (WHO, 2020a).

When outbreaks occur, it is crucial that nurses are able to liaise with health protection teams to commence next steps including pathogen identification, appropriate treatment, and prevention of further infections (Corless et al, 2018). In order to do this, nurses need to have knowledge about notifiable infectious diseases, their symptoms, modes of transmission, and ways to break the chain of infection. This education should commence in pre-registration nursing programmes (Burnett, 2018). An enhanced understanding of the skills and competencies which underpin health protection would advance the nursing contribution during epidemics and pandemics, and allow nurses to protect themselves, as well as the communities they serve.

As health systems in many countries are overloaded with managing the coronavirus pandemic, mass vaccination campaigns against a number of diseases are already coming to a halt. Twenty-three countries have already suspended their measles campaigns, which will mean 78 million children globally will not receive the measles vaccine (Roberts, 2020). Measles infection resulted in more than 140,000 deaths globally in the outbreak in 2018, with the poorest countries hit the hardest (WHO, 2019). These findings, combined with the highly contagious nature of measles infection, present an alarming picture (World Health Organization, 2019). The rapid integration of health protection training within pre-registration nursing programmes would support the nursing workforce in managing the potential increase in infectious diseases as Covid-19 forces suspension of vaccination campaigns. In addition, with a number of coronavirus vaccines now in development, urgent health protection training for the nursing workforce will ensure they are prepared to lead on the delivery of the anticipated vaccination campaigns.

## The nurse advocate

Providing nurses with the skills to identify vulnerable populations and their diverse healthcare needs, alongside increased knowledge on the fundamentals of health protection, will mean they are well placed to act as advocates, uphold the rights of these vulnerable groups to maintain their dignity, safeguard against discrimination and protect against inequities in healthcare provision. The means to achieve this include ensuring the delivery of accessible, accurate and evidence-based health information during periods of crisis (Inter-Agency Standing Committee, 2020). Throughout the Covid-19 response, an array of health-related information about Covid-19 has been presented in various media channels, including social media, television broadcasts, radio, postal and text message alerts (Ofcom, 2020). The failure to deliver this information in readily accessible and understandable formats to vulnerable groups, including people living with disabilities, refugees and migrants, older people, and people from black and minority ethnic (BME) backgrounds has been deemed a human rights concern (Human Rights Watch, 2020; *The Lancet*, 2020). International human rights law asserts that governments are responsible for providing essential information to support the promotion and protection of rights, including the right to health. Respecting this right during the Covid-19 response involves ensuring accurate and up-to-date information is provided about the virus and is readily available and accessible to all (HRW, 2020).

People living with disabilities may have inequities in access to public health messaging due to specific communication needs (IASC, 2020). Refugees and migrants may have problems with access to publicly available preventative information and health and social care services due to their legal status, discrimination or language barriers (IASC, 2020). Similarly, people from BME backgrounds may not speak English as a first language and information provided may not be culturally sensitive, which may impede the person using any health-related advice provided (Hickey et al, 2018). Data suggests that 34% of critically ill patients with coronavirus in England, Northern Ireland and Wales are from BME backgrounds and this highlights the need to prioritise culturally sensitive language translations (Intensive Care National Audit and Research Centre, 2020). Some older people, who are the most vulnerable group for Covid-19, may have difficulty understanding information or be unable to follow instructions provided, issues that are further exacerbated by social distancing, which may inhibit their ability to seek assistance (IASC, 2020).

The health literacy of these groups also warrants consideration. Older individuals, those with limited education, long-term conditions and those who do not hold English as a first language are more likely to demonstrate low levels of health literacy (Hickey et al, 2018). Low levels of health literacy are strongly associated with the inability to engage in complex disease management, self-care, increased hospitalisation

rates and higher mortality. This underpins the rationale to ensure the delivery of accessible, plain language health-related communications, presented in easy-read formats using algorithms and simple sentences (Hickey et al, 2018).

In ensuring the inclusion of vulnerable groups during the Covid-19 response and reducing the health inequalities they may be subject to a number of approaches can be employed by the nursing profession. Nurses can first advocate to ensure governments prioritise the information and communication requirements of those in vulnerable groups. They can highlight the need for multiple forms of communications in accessible formats such as Braille, large print and text captioning for hearing impaired (IASC, 2020). Further actions include the development and delivery of educational materials on basic hygiene practices and infection prevention. With advances in digital technology, such as social media, nurses can use these communication channels to overcome issues related to social distancing.

## The culturally sensitive nurse

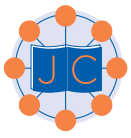
With approximately one in eight NHS staff reporting a non-British nationality, some may be able to translate/interpret health communications during periods of crisis – a role historically undertaken by interpreter/translation services (Public Health England, 2018). The diversity that exists within the NHS should be harnessed during this critical time.

The creation of a register of bilingual nurses and other healthcare staff who can act as interpreters and translators could help to eliminate language barriers during routine care and critical events, and secure the provision of culturally sensitive and patient-centred care (IASC, 2020).

In addition, nurses must be provided with the time and autonomy to take advantage of and build on the links they hold with community institutions and religious groups during periods of crisis. Community and religious leaders are primary sources of support, guidance, comfort and healthcare for the communities they serve (WHO, 2020b). They can provide spiritual and pastoral support during public health emergencies and advocate for the needs of vulnerable groups. In the 2018 measles outbreak, communication and collaboration with community and religious leaders was key to the dissemination of evidence-based information and outbreak control (PHE, 2018). By communicating transparent, evidence-based steps to prevent Covid-19 to religious and community leaders, nurses can promote the dissemination of helpful information, reduce fear and stigma and promote health-saving practices in formats that individuals can understand and are more inclined to act on and share (WHO, 2020b).

## Conclusion

The inequitable response to Covid-19 is already clear. Covid-19 mitigation strategies must be inclusive of vulnerable groups to ensure the maintenance of their human rights and reduce inequities, rather than exacerbate them. Nurses, as advocates, play a crucial role in this process. Investments to enhance the knowledge and skill sets of nurses will not only present positive outcomes now but will secure preparedness for future outbreaks. If any lesson has been learnt from this public health emergency, it is that the costs of inaction are immense. The world will most likely see another pandemic in the future. Efforts must be made to ensure Covid-19 does not become a fading memory, as was the case with the 2014 Ebola outbreak, and that lessons are learnt. **NT**

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