

EDITORIAL

Research nurses rising to the challenges of COVID-19

Covid-19 has profoundly changed the landscape of clinical nursing research and the profile of research nurses in hospitals and health services. For the purposes of this article, we define “research nurses” as a broad group of nurses within health services and universities who have a major research remit as part of their role. They may be clinical research nurses employed by health services or funded/supported by National Institute for Health Research (NIHR, UK) or similar bodies, nurse researchers or academics employed by universities or specialist nurses who have dual roles or joint appointments with a large research component. Processes and protocols once deemed to be sclerotically immune to change have been streamlined almost overnight. Empires and silos that were once accepted as solidified examples of “just how the world is” have dissolved in favour of unprecedented levels of collaboration and cooperation across disciplines, sites and even countries. Permissions and authorisations that would once have taken months are now happening in days or weeks. Ethics consideration and other approvals are being expedited. As one research nurse observed: “Now, we’re getting information on a Monday and by Thursday we’re opening the study and recruiting patients” (O’Neill, 2020).

Given the thousands of people who have died from COVID-19 and the vast health, economic and social damage the virus has wrought, any “benefits” it has brought to research have already come at far too high a cost. There are, however, health system and research improvements that have arisen in response to COVID-19, not because people willed or managed these changes, but rather because people and health systems have had no other choices. We have seen examples of markedly improved cooperation and collaboration across professions, sectors and indeed entire health systems (Toh, 2020). Old tribal practices and system-wide demarcation lines that were historically deemed too difficult to breach or dismantle, have disappeared. Where once research and research nurses may have been seen as a nice-but-hardly essential bauble sitting atop the essential patient flow work of a health service, we are now witnessing a previously unimagined level of integration and collaboration between research nurses and clinical areas. Research is no longer viewed as icing on the cake, it is part of the bakery. Research nurses are no longer a luxury but an essential element of a nursing and health service team. Not only are they researching but also “rolling up their sleeves” to support clinical colleagues with direct care when necessary (Evans, 2020). Research nurses, despite perceived role misconceptions (Hernon et al., 2020), ARE “real nurses” after all!

We recognise of course that such long overdue flexibility and genuine teamwork is often limited to COVID-19 related trials and vaccine studies while other important research has been disrupted

or even halted (Hernon et al., 2020; van Dorn, 2020). This is only to be expected but research nurses will not simply acquiesce in losing all of these gains when COVID-19 is finally defeated. The pre-COVID-19 world may have been normal for research nurses and their clinical colleagues, but this is not a “normal” to which we should ever return. Nobody would wish to relive the appalling circumstances of 2020 and for this reason alone, no gains made should be squandered away at a later date.

There may be a sense among some research nurses that they are not doing what they set out to do, but for many others they are doing exactly what research nurses should be doing; making research happen, raising the profile of how research supports and enhances practice, engaging with colleagues around research ideas and studies, and working collaboratively with all colleagues – both within our organisations and externally. The fact that “almost 80,000 people have been recruited into 43 different Covid-19 clinical studies since the start of May” (Duffy, 2020) speaks volumes. Research nurses have never had a problem in understanding that when it comes to clinical research and nursing practice, we are assuredly “All in this together”.

Clinical cultures too have also changed and often for the better. There cannot be a research nurse anywhere who has not, at some point wondered if and when research, evidence and inquiry would come to be seen as every bit as crucial to nursing and quality care as “clinical skills.” Would research and evidence ever be valued as an integral dimension of patient care and not as some academic nicety to be added at some point when every other “problem” in the world had been solved? Would clinical research nurses ever be accepted and valued as genuine clinical colleagues and members of the team, rather than as “egg-heads” who had “given up nursing” by moving over to the dark side of research? It seems that the COVID-19 crisis may have answered these questions for all of us.

Research nurses are now omnipresent colleagues in the clinical and research landscapes. Many nurses have moved into clinical research for a variety of reasons such as “shielding” and more, while other research nurses have temporarily moved into clinical roles. What is remarkable is how research nurses and their clinical colleagues have responded to this dramatic rise in research awareness and urgency. Clinicians are thinking more and more about research questions, suggesting clinical issues to be studied, asking how to prepare proposals, seeking research grants, finding out how and where to find support for research ideas and more. New research nurses are thriving in their clinical roles and helping drive the concerted research effort involving some “50 different COVID-19 treatment trials” in addition to vaccine development, staff safety and wellbeing studies and more (Evans, 2020). Never again, we hope, will nurses

have to endure being press-ganged into mandatory training “workshops” where some proto-adult management consultant “reveals to them,” the “secrets and strategies” of flexibility and adaptability in the workplace.

While much has improved, all is not rosy for research nurses and clinical academics. In addition to the numerous additional COVID-19 stresses that many nurses are experiencing (Alharbi et al., 2020; Hu et al., 2020; Maben & Bridges, 2020; Nie et al., 2020; Pearce, 2020), the understandable focus on COVID-19 research means that numerous other important studies are now on the back burner or have been cancelled. There is a danger that research nurses could burn out due to the sheer pressure of the many COVID-19 studies that are now “priority items” occurring simultaneously with freezes on replacing positions and other funding strictures. Research nurses can no longer be sustained only by their altruism (Fisher & Kalbaugh, 2012). Clinical research academics in the university sector have been drawn away from their research roles by the pervasive pressure to get all of the university's programmes and activities online. While a reduction in bureaucracy and speedier, more responsive processes are always welcome, caution is warranted that clinical research does not become a “wild west” of research nationalism where egos and the desire to be “first with the vaccine” trump all other concerns.

In the post-COVID-19 future that research nurses must help shape, many processes will change. For example, many more cancer patients will be reviewed remotely where possible because such home monitoring technologies are already proving to be “feasible, acceptable and usable” (Jonker et al., 2020). There will be far fewer hospital-based clinics, far more patients will be seen in community settings and in their own homes – exactly what many have been requesting for years. Research nurses will need to develop workable online and virtual alternatives to “face to face” ways of accessing and recruiting patients to studies, and to digital assessments. It is also vital that these processes receive the support and encouragement of funding, ethics and other approval bodies and become “the new norm.” The NHS in the UK, and other countries' health systems have often been glacially slow to adopt digital and virtual technologies, often for good reason (Gawande, 2018). The COVID-19 crisis has shown, however, that digital and virtual technologies can improve and free up research and clinical processes, provided that the “previous unjustifiable regulatory barriers can be blown away” (Webster, 2020). Research nurses will need to capitalise on the current borderless ways of working and to establish and hardwire new ways of working across disciplines, departments and other boundaries, including the worlds of public and private hospitals.

It is easy to become caught up in any research culture positivity engendered by the COVID-19 crisis. We can admire the new landscape of co-operation and intense research activity and be lulled into imagining that this could become the desired “new normal” for health services worldwide, but the forces who would readily see this new research landscape “slip back into old habits” (Bleasdale, 2020) and crush this “new normal” have not disappeared. The hard won gains that are now celebrated could be so easily rolled back when the virus dissipates or is defeated by a successful vaccination programme. It

is inevitable that reactionary voices in politics, policy and health service management will seek to claw back some of their previous power and to return nursing and research to their pre-COVID state. Researchers and research nurses must know that this is a strong likelihood and prepare now to defeat these inevitable calls.



We should not need to re-learn the lessons of “Rosie The Riveter” (<https://youtu.be/eDIGmUhwn-Q>) to know how this will be done. “Rosie” showed how the role of women during and after war-time could be systemically and dramatically altered. Women, before World war II were deemed to be primarily suitable for matrimony, child rearing and domestic chores but during wartime they were “enabled to” run the factories, transport systems and indeed most of the country. At the war's end, however, men were returning home and expecting to take up their “rightful place” once again and so, through extensive propaganda and social policy, women were forced back to the home and kitchen. The same playbook will be predictable to anyone involved in research or health care. There will be inevitable “clinical crises” or “unprecedented” service or educational demands leaving Deans and service managers with “no choice” but to redeploy nurses from research roles to clinical or teaching roles to “support their colleagues” and to demonstrate their “flexibility and adaptability”. There will be “unforeseen financial and budgetary pressures” making it “impossible” for health services to support research nurses and clinical research that they “simply cannot afford.” There will be proposals that clinical research is not “core business” or “mission critical” for health services, but rather the preserve of the academic and university sectors. There will be demands for a “tightening up” of processes and procedures and for more “appropriate oversight” from managers or “external auditors”. These “regrettable but tough decisions” will, of course, be “kept under regular review.”


Clinical research nurses and midwives need the support of everyone in nursing and midwifery, and that of our clinical colleagues, to ensure that the gains and welcome changes forged in the teeth of this COVID-19 crisis are not dissipated or wound back. The most welcome and valuable aspects of the new “clinical research normal” deserve to be maintained and enhanced even further to improve all aspects of clinical research culture and patient care long into the future. Anything less would be a betrayal of the suffering and loss wrought by this pandemic.

CONFLICT OF INTEREST

No author declares any conflict of interest in relation to any aspect of this paper.

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