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Staff wellbeing in times of COVID-19

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Abstract

In the last 10 years, there has been increasing interest into the psychological wellbeing of healthcare providers. Within critical care, increasing attention is being paid to the concept of 'burnout' – a cluster of symptoms that adversely affect the health of critical care providers. Publications and statements from the major critical care societies have all addressed this syndrome and emphasised urgency in tackling it. The current COVID-19 pandemic has fundamentally changed the way we work, communicate and learn. Even before the pandemic, there have been growing concerns and acknowledgement that healthcare practitioners in intensive care are at increased risk of burnout and burnout syndrome. There has never been greater pressure on intensive care or indeed healthcare as a whole to look after so many patients during this pandemic and yet there is global acknowledgement that key to overcoming these challenges is to look after the care providers – both physically and psychologically. In this paper, we review the issue of burnout amongst healthcare practitioners during current pandemic. We present the impact of burnout on the individual and the system as a whole but perhaps most importantly, we provide a review of steps being taken to mitigate against these adverse outcomes in the short and longer term.

Keywords

Wellbeing, burnout, resilience, COVID-19, pandemic

Introduction: The current context

In the last 10 years, there has been increasing interest into the psychological wellbeing of healthcare providers. Within critical care, increasing attention is being paid to the concept of 'burnout' – a cluster of symptoms that adversely affect the health of critical care providers. Publications and statements from the major critical care societies have all addressed this syndrome and emphasised urgency in tackling it.[1]

Burnout is a psychological syndrome that was developed by Maslach and colleagues in the 1970s. She observed it in healthcare workers, and described three key features: depersonalisation, loss of a sense of accomplishment and emotional exhaustion.[2] The Maslach Burnout Inventory developed by her team has been the gold standard for assessing burnout. Maslach conceptualises burnout as a continuum rather than an end point and at the opposite end of the spectrum to engagement with work.

In the psychological wellbeing of healthcare providers, there is also interest in other important potential adverse impacts, such as post-traumatic stress, depression, anxiety and general work-related stress. Researchers have tried to ascribe 'resilience' to the ability to recover from adversity; however, many argue it is poorly defined. Studies on the topic devoted to health care practitioners are still in their infancy and there is uncertainty in the relationship of individual resilience in preventing or mitigating burnout.[3]

Factors that have been identified as contributing to burnout have been categorised into individual and environmental factors. A difficult work environment, lack of access to support and an individual tendency to self-criticism have been suggested to increase burnout risk – hence the phrase 'The flame that burns twice as bright burns half as long'.[4]

The scale of the problem

The recent Medscape Lifestyle report of American physicians showed a 42% prevalence of self-reported

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burnout amongst all physicians, with the highest proportion (48%) being intensivists, who were also the least happy at work.[5] Within the UK, a recent survey by the Royal College of Anaesthetists showed that 85% of anaesthetic trainees were judged at risk of burnout.[6] A recent survey by the UK Intensive Care Society has shown that approximately a third of intensive care healthcare professionals – doctors, nurses, and allied health professionals – were at high risk of burnout.[7]

Furthermore, post-traumatic stress has been found in approximately 18% of critical care nurses and depression in almost one-quarter of intensive care consultants.[8] There are a myriad of consequences to psychological distress arising from work, from individual ill health to poor work functioning and risks to patient safety. It can lead to career change, profound psychological morbidity and some incidences of suicide.[4]

The COVID-19 effect

COVID-19 disease resulting from novel coronavirus infection has significantly changed the environment that healthcare professionals work and train in. Many have been working under pressure in unfamiliar environments, having been redeployed to expanded critical care areas. These staff have been welcomed, but there are significant impacts for the individuals to work well as a team without prior knowledge of each other.

The necessity of increasing critical care capacity, for example in theatre recovery areas, required rapid change and reorganisation to allow the safe flow and isolation of infectious patients. Managers, alongside clinicians, have had to work tirelessly to manage staffing, capacity and patient flow effectively, safely and efficiently.

A pandemic has far reaching psychological impacts for healthcare workers. We anticipate that many staff will struggle with burnout, exhaustion, fatigue, moral injury, depression, anxiety and post-traumatic stress. Estimating the prevalence in the UK will be difficult; however, in a meta-analysis of 61 studies of the psychological impacts of viral pandemics on healthcare workers, 45% experienced anxiety, 38% experienced depression and 31% experienced acute stress disorder.[9] Early data from China and Italy have shown significant amounts of post-traumatic stress, anxiety, depression and distress amongst healthcare workers involved in the care of COVID-19 patients.[10,11]

The authors of this review argue that COVID-19 may represent a more serious threat than previous pandemics due to factors such as concerns about the availability of PPE, impaired systemic resilience and social distancing requirements. The prolonged nature of the pandemic and the likelihood of further waves of increased cases are also likely to present a significant continuing threat to many staff. Undetected and untreated mental health problems such as PTSD and depression are likely to have a significant long-term impact on workplace functioning and increased sickness-related absences.

Effects

As COVID-19 is spread via surface contact and through aerosols, HCPs have had to learn new procedures for maintaining hygiene – the most significant of which has been adapting to personal protective equipment (PPE). Different areas have had different protocols, requiring rapid learning and adoption by staff. This has brought a new degree of anxiety to performing the already stressful job of providing healthcare, as now performing one's duty is associated with a risk to the healthcare worker's life – and that of their loved ones as well.

PPE is also a physical burden. The extra weight of additional clothing, the need to conserve such clothing – leading to prolonged periods of time in a single set – and the complicated donning and doffing procedures have led to an increased physical load on staff. Dehydration, fatigue and headaches are commonplace. Pressure sores, particularly on the nasal bridge, from prolonged mask wearing are also common.[12]

Despite PPE, sadly many HCPs have become ill themselves and indeed, some have died. A UK unit had a third of intensive care doctors develop COVID-19 symptoms requiring time off work (Personal communication).

The sheer volume of patients with disease has been overwhelming in some areas, resulting in a dilution of normal staffing ratios. Team leaders have been left with the dilemma of considering compromising professional standards and what might be considered 'doing enough'. Many healthcare practitioners have experienced moral distress due to the need to lower standards under these difficult circumstances.[13]

COVID-19 has a high mortality, and staff have witnessed higher levels of patient death than before. Due to the lack of visiting, staff have had to hold a higher level of emotional distress from patients who have not had the comfort of their relatives and loved ones. Staff who would normally use the family interaction as a way of understanding the patients they care for may have experienced an enhanced form of depersonalisation of their patients. This level of disconnection is one symptom in the process towards burnout syndrome. [13]

The impact on providing suboptimal care due to lack of resources, staff and medication is a profound change for established ICU staff, used to working in optimal conditions. Also, the impact of breaking bad news and end of life discussions over the phone or on a video call can be extremely distressing for patient's families, with a significant loss of the ability to gain physical closure during the dying process. The effects

on the families can heavily impact staff on ICU who may have had to experience several of these conversations during this pandemic. The loss of families at the bedside during end of life care adds to the emotional labour of the treating clinician. Debriefs after these cases may help but are not universally supported by evidence.[14]

In order to cope with the increased workload, rotas have had to change – often drastically. Many intensive care units have moved to resident consultant cover, with an unsustainable frequency of 'on call'. Trainee, nursing and HCP rotas have had similar changes. This has wide ranging effects, from fatigue at work to impacting ability to switch off.

Home life has been impacted. Some HCPs living in rented accommodation have been asked to relocate, due to concerns about infecting other residents (personal communication). Those with partners who are non-HCPs have faced a significant loss of income due to the lockdown. Those with children have had to face prolonged periods apart from their children and families, and challenges with childcare.[15]

The psychological impact on the lockdown on medical professionals working long hours, separated from their loved ones is not to be underestimated. Many in acute care are living in separate accommodation to their families to protect those more vulnerable. Those with underlying personal and life problems aside from work and mental health issues may well be exacerbated during the COVID outbreak.[15]

Evidence that HCP health has been seriously impacted by the COVID-19 crisis was demonstrated in a recent survey by the British Medical Association (BMA). The BMA carried out a snapshot survey of more than 6000 doctors after receiving mounting evidence of the disturbing toll the COVID-19 pandemic, and related issues such as the lack of PPE, was having on doctors up and down the UK. More than 4500 doctors responded to the questions around mental health; 44% of the doctors surveyed said that they were currently suffering from depression, anxiety, stress, burnout or other mental health conditions relating to or made worse by their work. The survey also showed that more than half of doctors (51%) did not feel personally supported by the Government and confident that everything possible was being done to help them to keep patients safe, despite pledges that more PPE was being delivered to the front line.[16]

What can we do?

The individual

Traditionally, there has been a large focus on individual strategies to reduce burnout and promote resilience; however, increasing data suggest that individual strategies have a minimal effect – especially when significant system issues are present.[4] A combined approach of giving individuals tools to help them cope, while also providing a system that supports and nurtures, is recommended by the authors of this article.

Individual strategies revolve around principles of self-care. Attention to basic needs such as adequate nutrition, rest and exercise is highly encouraged and supported by literature.[17] Connecting with others is a powerful tool for wellbeing, and we encourage people to remain connected with their loved ones as much as possible. Social media and video calling apps can allow people to remain connected even when self-isolating or shielding. Breathing exercises may be helpful during times of significant anxiety or stress.[18]

The system

As the demand on all healthcare systems continues, it becomes even more important that strategies to support staff delivering care are put in place. Leadership, and the attitudes and approach of management staff are vital in the management of wellbeing at work.[19] Each Trust should have wellbeing lead, but this person should be suitably experienced and qualified, ideally with a psychology background. Preserving and protecting the health, safety and wellbeing of staff are critical for any healthcare organisations' response to the COVID-19 outbreak. There is general agreement and appreciation that staff wellbeing needs to be looked after; however, this needs to translate into tangible and meaningful measures.[20]

Recognition is key – often it is the people around the individual affected that notice the signs of burnout before the individual him/herself. Hence, employers will need to be proactive rather than reactive to staff fatigue and burnout. Employers have a moral and statutory duty of care to protect employee's health and safety and provide a safe environment to work.

It is critical that employers support staff by listening to concerns, responding appropriately and reinforcing the need to follow the latest PHE guidance. Also, the effects of COVID-19 on wellbeing could be long lasting. Trusts need to support staff in order to help reflect, learn from the experience and possibly look for signs of PTSD and other psychological impacts of the work. Regular team discussions are invaluable, particularly after difficult cases. The role of a Clinical Psychologist may also be important in helping the team to facilitate this.

Employers also have a responsibility for ensuring staff do not work excessive hours and that they get enough rest. They also have a responsibility to ensure staff are appropriately remunerated for the hours that they work.

Employers have the same duty of care to their staff during a pandemic as in other circumstances and should take steps to safeguard the health and safety of their staff. This includes supporting adequate nutrition, hydration, skin care and childcare wherever

possible. NHS organisations must consult with their health and safety leads, public health colleagues, occupational health colleagues and staff unions to develop a local plan to support the workforce. Trade union safety representatives should also be involved and consulted on, in line with the statutory duty to consult them on matters relating to the health and safety of members they represent. Employers may want to encourage staff to use their representatives as a route for flagging up concerns. PHE's infection prevention and control guidance principles should be applied and reflected in local plans.

Fatigue can lead to additional risks, so organisations should encourage staff to raise any concerns they have with their line managers and consider increased breaks and adjustments to shifts where required. The Health, Safety and Wellbeing Partnership Group's guidance on shift working provides helpful information.

In addition to following key PHE guidance, employers will need to be mindful of staff with disabilities and review support and adjustments as needed. It is important for employers to ensure employees have access to basic wellbeing provisions, to enable staff to maintain their own wellbeing.

One of the authors has developed a series of wellbeing resources for the UK Intensive Care Society, which can be used as a starting point for developing local services. Further resources are to follow, available at https://www.ics.ac.uk/ICS/Education/Wellbeing/ICS/Wellbeing.aspx

Conclusion

The experiences described in this manuscript of the authors' individual workplaces are not unique, as supported by published data from other countries.[21–23] The COVID pandemic has made ICU feel like a warzone for some. Constant battles with risks to one's own health. Doctors and nurses have stepped up with gaps in the rota giving additional discretionary effort and a sense of solidarity. With more consultant presence 24 h a day, in many Trusts, there is increased levels of support for patients and staff to provide better care. With close knit groups of doctors and nurses working together under extreme scenarios, this can bring the best out of each other, with a bond and camaraderie being formed. As trainees are not rotating currently, there are more opportunities to work together to build team relationships and rapport which can only help boost morale and patient care. Being supportive of one another during this time is crucial, and a knock-on effect from the pandemic has meant that ICU teams are now stronger than ever.

The psychological impact of the work is an ever-present challenge for the critical care practitioner. Managing it and preventing further psychological harm in staff require a multidimensional approach involving the individual and the wider organisation/working environment.

COVID-19 can thus be viewed as a double-edged sword. On one hand, it can, and has no doubt exacerbated a difficult situation for the workforce. This is despite the heroism, dedication and selflessness we have all become accustomed to see in the people on the front line in times of adversity and pressure. On the other hand, it may just be the cathartic condition which finally leads to burnout being recognised for what it is – which is the symptom of a mismatch between the requirements of the system, the less than optimal deployment of technology, the aspirations of the population and the capacity and capabilities of the workforce. Ultimately, it is the result of a mismatch in expectations and reality.

We have solutions – but have we deployed them? COVID-19 forces us to do so.

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Appendix

Account from Emily Wayling, a Band 6 ICU Nurse

Coronavirus has certainly taken its toll on people of all levels respectively.

Working as a Sister in a busy General Intensive Care Unit, I undoubtedly felt an unyielding fear and anxiety as we as a team began to prepare for the carnage we were soon to endure.

My job as a nurse is my life. I strive to do it well, act as a role model and ensure I am there for my colleagues in a professional and personal manner.

I was so afraid. Inside I felt powerless to them, especially the most junior members of my team. And they too were so afraid.

The workload was unbelievable and the fear of not getting to a patient in time due to being caught up with another was awful. Our high standards of care had been taken from us and we all felt vulnerable in an unknown world.

Watching the normal routine procedures and therapies we would provide on a daily basis failing on Covid-19 patients was not only frustrating, it was frightening. I felt helpless. I could not sleep, and when sleep came, I would have nightmares.

This became normal over the 1st two weeks until something in my mind clicked and I felt anger. I watched my dear colleague fight for his life from the very start and when he died the numbness turned into complete failure.

As a team we all grieved for our dear friend and colleague, but we all came together and continued to support and love each other keeping morale as high as possible throughout an awful situation.

The weeks have gone on and the coronavirus cases have lessened. I have encountered many different experiences from this pandemic; both positively educational yet mentally exhausting.

I am now fighting my own battle against Covid-19!

Account from Eibhlin Moore, a critical care outreach nurse

The first COVID-19 room I entered filled my body with fear and anxiety. My fear exacerbated by my inexperience of this virus and what I could offer with my lack of knowledge to a relatively unknown pathogen. But as I tried to psych myself up, I knew I must also convey leadership and hide my fear which could be just as contagious as the virus to junior nursing staff and medics who have requested my assistance. Outside the isolation room I apply all essential PPE, even making humour to colleagues whilst doing so, in hope not just to ease their anxiety, but mine also.

I have met so many patients affected with this disease process and I remember them all for different reasons. I commenced one man on CPAP who contracted the virus after working in a care home. I was scared of the aerosol generation and the risk to me but as I spoke with the patient there was nothing more deafening than his fear. His eyes bulging and asking if he was going to die, how can I answer that? But I stay positive despite knowing the last two patients admitted to ICU with COVID-19 have already deceased. I offer a videocall to the family for the patient and I hold the iPad whilst doing so. Some family tell the patient he will be fine, and they will see him soon, others can't hide their fear and sorrow and want to make sure they say all the things they want to say in case they never see him again. They pray together whilst I stand there respectfully, I cannot leave to give privacy, PPE is in short supply.

When the intubation team enter the room, I have a feeling of impending doom. I hope the patient does not feel the same. I stay in the room to assist with intubation and hold the patient's hand throughout. I look down and having been in the room for what felt like an eternity I can see the sweat through my gown and gloves. I wish I wasn't wearing this mask on my face so the patient could see my facial expressions and I could offer a smile for reassurance. Instead there is a faceless team standing over him and it dawns on me this could be the last thing this man will ever see. Suddenly my original fear for myself is overcome with my empathy to this man and his family, who could not be there to give a heartfelt hug or kiss to reduce his fear and anxiety. Intubation is successfully completed, and focus turned towards facilitating a safe transfer to ICU for continuing treatment.

All the time I have spent in this one room I have been unable to see other patients in the hospital who also need my help. I have a responsibility to prioritise my workload but in the middle of this pandemic it is hard to know who has the greater need for my service, my decision is only as good as the information I receive via a bleep referral. COVID-19 is a disease seen by some as a direct need for ICU admission and it feels there is a desire for me to be aware of all the COVID admissions, the referrals have been overwhelming.

After months of caring for COVID-19 patients my fear for myself has dissolved significantly. I have watched patients and colleagues who have turned into patients; survive; be intubated and are still awaiting their outcome or die from this virus. The most shocking experience from this disease is the volume of death. I have learnt so much. Not just about the disease process but about the power of human interaction and to never take this for granted and the importance to remain positive throughout. I have experienced a desire to be at work on my days off because of the forever changing policies and environment in the hospital setting and not wanting to miss a decision on something that could impact how I work

tomorrow from today. I never really switch off, even as I return home to my 'normal' after 13 hours a day or night of these conditions. I hope this desire will also begin to dissolve and I can return to my normal day-to-day life but I am grateful for my team who have become my closest friends and allies throughout this pandemic and to all the healthcare professionals who have similar stories as mine because they have had to become so much more than just the patients clinicians in their time of need and isolation.