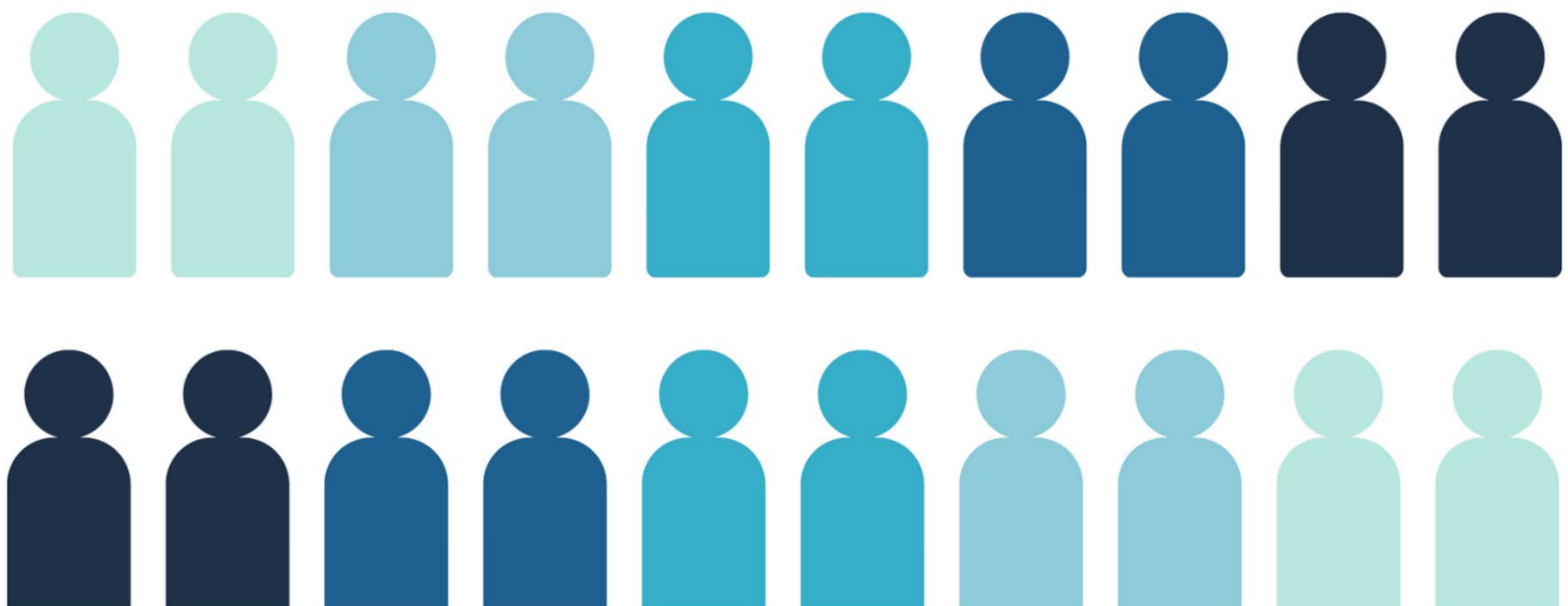


Intensive care as a positive place to work: Workforce wellbeing best practice framework



Endorsements



Intensive Care as a Positive Place to work:

Workforce Wellbeing Best Practice Framework

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Document version 1. This is a UK document and the above are representatives from across the UK. The Society took into consideration the needs of all individuals to ensure the framework can be applied to every area of intensive care

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Introduction:

The purpose of this document is to provide a best practice framework to guide commissioners and budget holders, senior hospital management and the intensive care team on ways to provide the best possible employee experience within intensive care. The aim is to support and improve recruitment, retention, job satisfaction, unit culture but also to have an impact on clinical outcomes and patient safety^{1,2} and there is a significant return on investment when employers spend money directly on the mental health of their employee.³

Wellbeing⁴ is considered a dynamic state in which an individual is able to reach their potential, be productive and creative, build positive relationships and contribute to a wider community and find a sense of purpose. Work has an important role in shaping a person's overall wellbeing through the interaction of the environment (including the people in that environment), the nature of the work and individual attributes as well as the interaction with life outside of work. Work can have negative effects on psychological wellbeing and work-related stress is defined as the adverse reaction people have to excessive pressure or demands. Burnout is one identified impact and is a psychological syndrome with three key features: depersonalisation, loss of a sense of accomplishment, and emotional exhaustion⁵.

There has been increasing demand upon intensive care over recent years, with improved technologies and more call for intensive care beds, and higher expectations of what intensive care can achieve. The critical nature of the work, the acuity of the patients, the speed with which one needs to work, and the need for rapid feedback and decision making clinically is often at odds with usual hospital management systems. These increasing demands have the potential to impact on our employee's experience of work, which then impacts their ability to carry out their work and the quality of care provided.

The research indicates that at least 30% of intensive care staff experience burnout⁶ and post-traumatic stress. In 2016, the Critical Care Societies Collaborative Statement called for action on the management of burnout in critical care professionals.⁷ The nature of the clinical work in witnessing trauma, the potential for repeated exposure to the tragic circumstances of patient illnesses and deaths, as well as liaising with and supporting distressed family members adds an additional emotional burden to the work of intensive care staff. The potential for exposure to the emotional aspects of work, in addition to the high level of technical skill required, means that it is likely to be beneficial to employee wellbeing to focus on both the practical aspects and the emotional aspects of work.

Intensive Care Staff Wellbeing in the COVID-19 Pandemic and other Surge Conditions

During the pandemic, the demands placed on intensive care have significantly increased and there is emerging evidence of high levels of psychological distress in staff⁸. At the time of writing, intensive care units are facing the impact of the second wave. There has been an incredible amount of learning on the go, and there were some triggers for ongoing stress and anxiety in staff that where possible should be carefully considered in any further waves of the COVID-19 pandemic. The pandemic has also offered valuable lessons of what can happen in a surge.

Redeployment: People were quickly redeployed, and this was difficult to manage. In the future, where possible, this needs to be carefully managed based on a person's skills set and normal roles. People choose their core profession for a reason and need to work to their preferences and abilities.

Change: Many people needed to adapt the way they worked and required acknowledgement and support to do so. Standards and ratios were often compromised, and junior staff have reported that they were frequently put into positions of responsibility which risked patient safety and caused anxiety for staff.

Equipment & space: Personal and Protective Equipment (PPE) both style, availability and the impacts of wearing for sustained periods were ongoing stressors for staff, especially nursing. Some units were in a position of needing to use equipment that was different to those they typically used in everyday practice (e.g. anaesthetic machines, pumps, locations). The unfamiliarity risks the potential for human error.

Units experienced limitations on space or different and unusual locations to care for patients and frequent moves within units as an expansion of bed numbers occurred. This was particularly challenging and anxiety-provoking.

Interactions with families: As families were often unable to visit their relatives, during the pandemic, conversations and withdrawal of care took place virtually. Both nursing and medical staff found these interactions difficult and, at times, upsetting.

Support: To meet clinical demands, some units were unable to maintain educator and shift co-ordinator roles despite redeployed staff. It is key to maintain skills for staff and to provide ongoing clinical support where possible, so that staff feel safe in the delivery of care.

Staff are uncomfortable with rapid changes and uncertainty. It is important both within the intensive care unit, and within its external supports, that time is given to sense-making and reflection on lessons learned and that staff have safe confidential spaces to offload. Evidence from the ICS WARE project suggests staff are using our multiple methods and spaces⁹. Embedding professional psychologists is an important ongoing and future component of supporting this approach.

Improving wellbeing in intensive care

The following are ten core themes for proactively improving the experience of work in intensive care and the sustainability and wellbeing of the workforce. Examples are given throughout.

1. Intervening for wellbeing should be preventative as well as responsive

It is important when considering workforce wellbeing that the overall system takes an approach of what maintains the workforce's ability to be well at work. Often approaches to wellbeing have focussed on peripheral or tokenistic offerings and post-hoc interventions. Instead, every intensive care unit (just like every workplace), should consider what are the needs of the workforce to have a positive experience of work. When designing your local workforce wellbeing offering, an overarching primary principle of workplace wellbeing is to consider the level of intervention:

- **Primary preventions** are aimed at modifying or eliminating stressors in the work environment and target the organisation or whole-systems level. They set the core conditions for being well at work (e.g. leadership training).
- **Secondary interventions** are focussed on an individual's response to stressors as they are occurring and are aimed at reducing the effect of the stressors, but do not target the issues themselves (e.g. wellbeing training programmes). Awareness training, in the absence of primary intervention, can often land badly and may risk higher staff turnover.
- **Tertiary interventions** are focused at treating the resulting ill-health and focus on recovery responses (e.g. offering psychological intervention).

Where possible it is important to focus on primary preventions.¹⁰

Recommendations 2-8 (below) provide a framework of how to deploy primary preventions in intensive care units.

2. Effective leadership is fundamental to staff wellbeing

Relationship with managers, and having the right leadership approach, is the strongest predictor of workplace wellbeing¹¹. Interventions and initiatives to develop leaders are largely considered to be a primary level of intervention. Leaders should create conditions for setting the core purpose and direction of the service. It is important for belonging that staff feel they can make some contribution to shaping this direction.

The strongest evidence base for effective leadership style is the transformative and compassionate based leadership research¹². One way to ensure this compassionate approach is to select leaders for their values, behaviour, and attitudes as well as their technical performance. Anecdotally it seems that some staff who become leaders in an intensive care environment may have developed coping mechanisms to mitigate the demands of the clinical work, which are not helpful when trying to support the emotional demands of their workforce. Leaders should be supported to develop their self-awareness and emotional intelligence, which should include their knowledge of psychological trauma and staff wellbeing.

For Example

- New leaders should have access to training, coaching/mentorship and 360-degree leadership evaluation such as the NHS Healthcare Leadership Model¹³. Staff can also learn how to be adaptive in their coping mechanisms and recognise their own maladaptive or unhealthy coping styles¹⁴. The evidence base for some frameworks such as Mental Health First Aid is limited¹⁵
- Senior Management interviews should include questions set by Workforce/Organisational Development and Psychology teams. Some units have made use of additional methods of assessment, such as stakeholder groups where a separate group spends time in discussion with the candidate and offers their view to the interview panel.

Organisations should make a commitment to employee wellbeing and this should be driven by leaders and not tokenistic.

For example

- Having a nominated ICU Wellbeing Lead, with protected time to focus on wellbeing, would be beneficial. A wellbeing lead with a mental health qualification, such as a Practitioner Psychologist, is ideal.

Leaders should support the team culture through a willingness to set the scene for psychological safety, inviting continuous feedback. They should also ask and listen at every available opportunity - ensuring visibility and availability of support.¹⁶

For example

- Put learning on every team meeting agenda
- Take opportunities to walk through the unit and ask, "Is everything as good as it can be today?"

The senior/executive management understanding of intensive care makes a key difference to its functionality. Intensive care is a unique environment and senior leadership teams should aim to understand the complexities of intensive care, the impact it has on service delivery and the high impact caring for sick people has on their staff. The critical nature of the work, the acuity of the patients, the speed with which one needs to work, and the need for rapid feedback and decision making clinically is often at odds with usual hospital management systems. Therefore, the intensive care unit benefits from the functionality of its Clinical Director, Matron/Lead Nurse, and Operational Manager, and the ongoing relationship between this triumvirate and more senior hospital management.

3. Staff need clear communication and opportunities to feel engaged with the work.

For many researchers, engagement is considered the opposite end of the spectrum to burnout¹⁷. Therefore, a key mitigating factor in workforce wellbeing is how leaders should engage and include all staff. Staff should be kept informed and involved in all changes, and specifically, those that will likely affect them, although the pragmatics of this will vary depending on the size of the unit and the time available to the management team. There should be a “collective leadership” of the unit by taking a network rather than top-down approach to communication and engagement. To welcome new staff, the induction for all new staff members should also explain how the department is managerially structured, and how its processes are supposed to be functioning. A sense of belonging is key for any team, and one way is to allow opportunities to put individual’s ideas into practice to develop and innovate the team.

For Example

- Try a regular staff newsletter and include urgent matters in the safety briefing.
- Set-up an email for staff to send through positive ideas for innovation.
- Consider regular senior staff walk-throughs to invite ideas from the clinical floor.
- Ensure staff are aware of and engaged with the department’s strategic direction and make use of Collective Leadership tools¹⁸ to help staff feel part of the change.
- Use of useful frameworks for innovation such as Learning through Excellence¹⁹ alongside the use of DATIX / incident reporting.
- Consider the principles of Just Culture and take an approach of “what” went wrong not “who” went wrong²⁰.

4. Job design & access to job-related resources (especially staffing) impacts people's ability to care for patients, and therefore staff wellbeing

A core part of the experience at work is the way the working day is designed, and the balance of demands and resources. A useful framework for understanding is the Job-Demands-Resources model²¹. When job demands exceed the resources, there is a risk of work-related stress. In addition, scarcity theory indicates that when resources are low in any area, it becomes an additional burden of focus and reduces cognitive capacity. For example, if staffing is stretched, staff inevitably become focussed on staffing levels, and reduced in their ability to consider other issues, impacting on innovation at least and potentially leading to clinical error²².

A recent report on the mental health of nurses and midwives concluded that they strive hard to ensure that their working conditions, and any stress they may experience, does not adversely affect their patients. Nonetheless, they are at particularly high risk of moral distress if institutional pressures and constraints stop them from pursuing what they believe to be the most appropriate course of action for their patients²³. A recent report on the mental health of doctors across the UK concluded that workload, work conditions, schedules and rotas have a significant contributing impact on doctors' wellbeing and their ability to deliver safe patient care. When they are unable to deliver this care to an appropriate standard, they too experience moral distress²⁴.

One of the greatest resources in an intensive care unit is its staffing, and for patient safety, high staffing ratios are set. Staffing and staffing ratios should adhere to national standards set in GPICS V2; Units should audit against GPICS V2 standards and the results should be disseminated to the workforce. Staff turnover in larger units can be high and, as such, units should maintain a workforce tracker to plan future workforce demand (including succession planning).

To manage the demands of the work and allow sufficient rest, staff rostering must comply with Health and Safety Executive recommendations for sleep and rest. The working day should also be organised to balance workplace demands and allow for downtime. Staff should be able to find meaning and purpose within their role and have some choice and autonomy at work. Work job plans need to be flexible and consider an individual's changing needs over their career.

The opportunity for professional development and autonomy influences staff retention²⁵. With staffing pressures, some mechanisms for maintaining this may slip, but it is important to ensure meaningful staff appraisals are undertaken annually and linked to both behaviour and performance such as the values-based appraisal approach. This also offers further opportunity for engagement and belonging and encourages talent and new opportunities.

For example

- Consider group job planning for band 7s & consultants linked to the aims of the unit.
- Link the job planning of senior team members to the core purpose and direction of the service to enhance a sense of belonging in the team.
- During the COVID-19 pandemic, one unit trialled changing the Band 7 rota to cover 7 days a week using long days to be more visible to support staff.

5. Access to education and opportunities for progression improve people's experience of work, sense of purpose and development

Education is fundamental to staff recruitment and retention²⁶ but, with staffing pressures, some units struggle to protect this vital resource. The Education team should be (at least) at the minimum ratio set by GPICS V2 and should include the training of established staff, as well as more junior or newer staff. Staff should stand a fair chance for progression, and engagement with formal and informal education is an element of this. Therefore, we recommend a clear, open, and transparent structure for how all individuals can apply and be allocated funding for education or attendance at meetings.

For example

- Some units use protected learning days as a way of bringing the team together to learn, improve and build better relationship
- Allocate time for mandatory and unit-specific training.
- Some units have an application form for funding within the department to make the process of applying transparent and systematic.
- Paediatric Intensive Care has a useful framework, Learning from Excellence²⁷, to encourage an innovative environment.

6. A safe and fit for purpose physical environment with both sufficient facilities for staff and infrastructure for patient care are essential

Ensuring the good provision of adequate facilities for staff helps to highlight the value placed on them by the department, and by the wider organisation. Clean, comfortable and well looked after social areas are important to foster the team and the individual, but also offer informal spaces for conversations which allow the emotional processing of elements of clinical work.

It is fundamental that adequate rest and showering/changing facilities are provided. All users of the service (patients, visitors and staff) need access to natural light, formal and informal spaces to come together (staff rooms and education/ meeting rooms, family rooms), and formal and informal spaces to retreat (offices as well as rest facilities, and hospital cafes and canteens).

7. Relationships with peers and unit culture should be actively shaped by leaders

Workforce culture can be defined as “how we do things around here” and is the collective values and beliefs influenced by the core nature of the work, history, leadership, and key individual²⁸. The 24-7 nature of the ICU can disintegrate the sense of team, so we need to encourage teams to spend time together to build relationships and develop a culture of talking and spending time together.

A key part of this is psychological safety: being able to show and employ one’s self without fear of negative consequences of self-image, status or career²⁹ and that the team is safe for interpersonal risk taking³⁰. Freedom to speak up about clinical errors^v, fairness and a “just culture”¹⁸ – *what went wrong, not who went wrong* - are enabling factors in psychological safety so that errors are considered learning opportunities rather than taking punitive action. Formalised Peer Support models can create a cultural shift towards caring for each other³¹.

The transient nature of clinical rotations, carried out by doctors in training and some allied health professionals, may make it harder for them to feel comfortable in accessing support or developing relationships within the work environment. Junior nursing staff may also feel less able to access the support of senior nursing staff due to the nature of management hierarchy.

For example

- Discussing the impact of the day in huddles, simulation programmes, formal meetings such as Quality and Safety meetings.
- Regular unit meetings, with remote/dial-in access, and sharing unit news
- Some units use buddying and mentorship schemes.
- Coaching may be useful in developing staff to take on leadership roles³².
- Some units have a new staff member welcome where they meet staff on duty, and introductions made with refreshments.
- The Intensive Care Society is developing an intensive care Peer Support Programme. This creates a culture of caring for one another through schemes such as Peer Support, where individuals are trained to offer psychologically informed conversations with their peers. Such frameworks need departmental buy-in and a governance structure. Peer supporters should be supported by a clinical supervision framework³¹.
- Deanery based support systems should be highlighted to doctors in training
Some units report a nursing supervision team for new starters every 6 weeks to embed them into the unit.
- ICUs have reported creating time for social spaces at work and for staff to engage in fun activities such as charity walks.
- Preston, UK shared that staff have the ability to send a “thank you” to staff to other staff such as following a difficult shift. This is done on the hospital intranet and you can also make comments. The staff member receives an email, and this can be included in their appraisal.

It is important to proactively deal with strained relationships and bullying: healthcare is low-resourced, with high-demands, and this can create tension and competition in relationships. Repeated bullying behaviour should be dealt with through local Workforce/Human Resources procedures.

For example

- An internal “Freedom to Speak Up Guardian” may be helpful³³ - which is a National scheme.
- Using resources, such as from the Civility Saves Lives campaigns³⁴ which is from Coventry (UK), can help to raise awareness.

8. Monitor & measure wellbeing and factors which are influencing it

Consider an annual wellbeing measure in your unit (e.g. HSE Management Standards Indicator Tool³⁵) and act on the findings of that tool. It is worth having a Wellbeing Lead, with dedicated time and expertise to deliver this measure, and consider embedding wellbeing within continuous improvement cycles.

For example

- Some units run annual or bi-annual staff surveys to compare employee wellbeing over time

9. Understand and mediate the staff stress and trauma response

These are considered both primary and secondary level interventions.

The clinical nature of caring for the intensive care patient shapes the staff, their relationships with each other, and with external departments. Working with high workload³⁶, with high acuity, complexity, sometimes limited options for treatment, high death rates³⁷ and trauma shape the natural coping tendencies of intensive care staff. Staff are then vulnerable to psychological and moral distress, and sometimes mental health problems.

Staff will sometimes utilise avoidant methods of coping to manage high exposure to psychological trauma³⁸. This avoidance can then influence relationships with colleagues.

Often intensive care staff report that staff outside of the unit do not have insight into these experiences, which can lead to fractures in interdepartmental relationships.

However, it is also important to note the definition of work-related stress where demands exceed resources and not lay the locus of disturbance in the individual alone. The integration of an ICU Practitioner Psychologist can provide this awareness training in-house and facilitate these conversations. However, only 19% of UK ICUs are reported to have direct access to Psychology³⁹.

Staff benefit from learning how to manage the demands of their role and recognise the way stress may manifest for them, including recognising symptoms of post-traumatic stress and offering systems to process trauma through individual and group conversations. If someone has clinical symptoms of Post-Traumatic Stress Disorder, they should have access to evidence-based psychological therapy.

For example

- Some units have regular shift leader-led check-ins at the start of the shift and at the end, particularly in more testing shifts; principles of psychological first aid⁴⁰ are a possible framework to consider.
- Systematic “debriefs” are not recommended for the prevention of PTSD⁴¹ however following difficult clinical situations may be useful along with reflective practice approaches such as Schwartz Rounds and Compassion Circles and team supervision can improve team relationships⁴². GPICS V2⁴³ recommends Reflective Rounds, which is a model of bringing teams together to reflect upon the impact of our work. New models such as group EMDR⁴⁴ have been used in some units.
- Smaller units have told us they find a regular time per week to come together to reflect on the work is helpful for staff and providing food at these sessions is a positive gesture of care.
- For many larger units, it can be hard to create regular spaces to reflect on the work given the 24 nature of intensive care, and one unit described a small group of Wellbeing Champions to flag the need for a reflective space to the Practitioner Psychologist.

10. Staff need access to evidence-based Psychological Therapies

The nature of the work is such that some will find they need a professionally trained confidential space to reflect and recover from work-related stress. For others, the pressures outside of work can make work feel untenable. Embedded professional Practitioner Psychologists within the multi-professional team to work with staff, patients and families is a gold standard model recommended by GPICS V2. Practitioner Psychologists can provide in-house support for staff wellbeing, and signpost staff to psychological intervention if required.

Depending on the local model, such access could be provided within the unit or the hospital. It is important to offer staff choice. Information about local services should be promoted within the unit.

It is important to note that psychological therapy is considered a tertiary intervention, where in the majority of cases staff access help following a deterioration in their mental health or general wellbeing. Although access to such services is paramount, it should not be considered without points 1-9 listed above.

Conclusion

Maintaining workforce wellbeing in intensive care is an ongoing need, and the ten points above should be considered in combination, and as a dynamic rather than static process. We recognise that it takes time to embed any initiatives and that it takes a whole team approach to create and maintain a wellbeing culture. This document should be considered as a guiding framework for intensive care units.

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