Preventing and responding to staff burnout

Strategies for coping with the COVID-19 challenge

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Tracking the spread

Two months after the first reported death, COVID-19 has circled the globe

Jan 11, 2020

Chinese government reports first death due to new virus that began spreading in late 2019

Jan 13, 2020

The first case outside of China is confirmed in **Thailand**

Jan 30, 2020

WHO declares global emergency

Cases reported in **Japan, South Korea, India, the Philippines**

Jan 31, 2020

Russia, Spain, Sweden, UK confirm first cases

9,800 reported cases, 213 deaths worldwide

Feb 1, 2020

Cases reported in **Australia, Canada, Germany, Singapore, the UAE, the US, Vietnam**

Feb 14-21, 2020

First cases reported in **Egypt, Iran, Israel** as the virus spreads to the Middle East

Feb 24-27

Kuwait, Bahrain, Iraq, Afghanistan, Oman, Brazil, Norway, Romania, Greece, Georgia, Pakistan, North Macedonia report cases

Feb 28, 2020

Nigeria, Lithuania, Wales report first cases

The US reports its first death, near Seattle

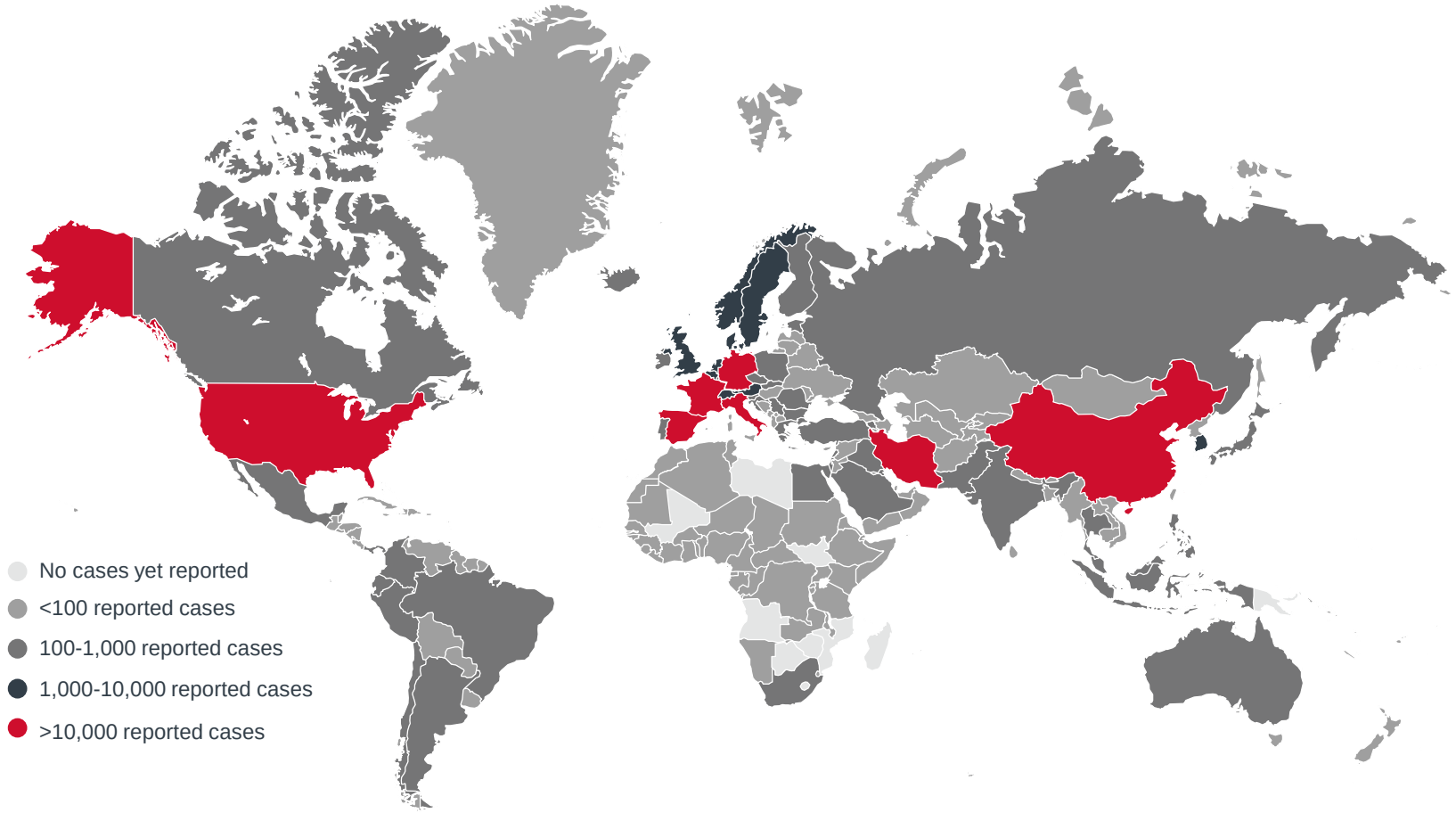
Mar 10, 2020

114,000 reported cases, 4,000 deaths worldwide

Source: "A Timeline of the Coronavirus," The New York Times, March 4th, 2020.

Knowing no borders

Current as of 20th March, 2020



Current COVID-19 cases

244,602 cases

160 countries reporting cases

10,031 deaths

Time it takes for deaths to double

World in 8 days

Italy in 5 days

UK in 2 days

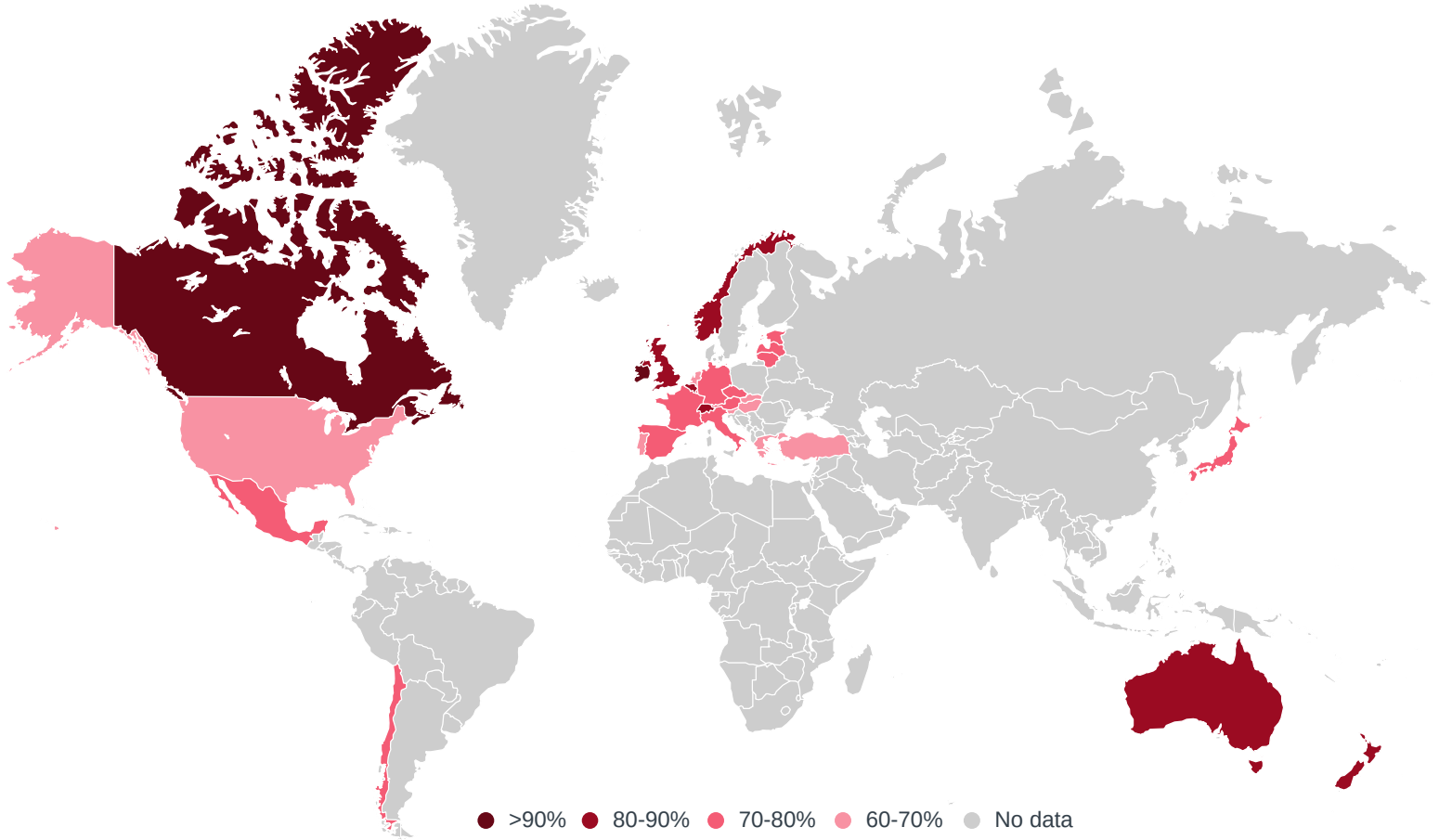
Canada in 3 days

Australia in 5 days

Source: Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU); https://ourworldindata.org/coronavirus

Ready to absorb the shock?

Average hospital occupancy by country



DATA SPOTLIGHT

80%

Common heuristic for full occupancy

75.2%

OECD28 average hospital occupancy

61.6%-94.9%

Variation in occupancy from Greece to most Ireland heavily occupied country

Source: 'Hospital beds and discharge rates 2018', OECD, available at: https://www.oecd-ilibrary.org/sites/0d67e02a-en/index.html?itemId=/content/component/0d67e02a-en

Advisory Board interviews and analysis.

Study concludes longer-term suppression strategy needed

Mitigation strategy may not be sufficient to prevent more than 1M U.S. deaths

March 16, 2020

Impact of non-pharmaceutical interventions to reduce COVID-19 mortality and healthcare demand

Introduced by: Imperial College COVID-19 Response Team

2.2M Predicted number of deaths in the U.S. in the absence of control measures (no action by the government and individuals to curb spread of COVID-19)

Mitigation strategy

Slow the spread (R^1>1) in order to reduce peak healthcare demand and protect high-risk groups

- Case isolation at home
- Voluntary household quarantine
- Social distancing of individuals over 70

8X Minimum additional capacity[2] needed to prevent **1.1-1.2M deaths**

Suppression strategy

Reduce overall number of cases to low levels (R<1) in order to eliminate human transmission

- Case isolation at home
- Voluntary household quarantine
- Social distancing of entire population
- Closure of schools and universities

18+ Estimated number of months before a vaccine will be available

1. Reproduction number (average number of secondary cases each generates).
2. Med/surg and ICU capacity.

Source: Ferguson N, Laydon D, et al, "Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand," Imperial College COVID-19 Response Team, March 16, 2020.

Countries expect influx of patients to strain available capacity

Millions expected to be hospitalized for coronavirus infection

80%

of Britons are expected to be infected with Covid-19 in the next 12 months in worst case scenario estimates

15%

Of infected patients could require hospitalisation

7.9M

Estimated number of people who would be hospitalized, **47 times current bed capacity**

531,100

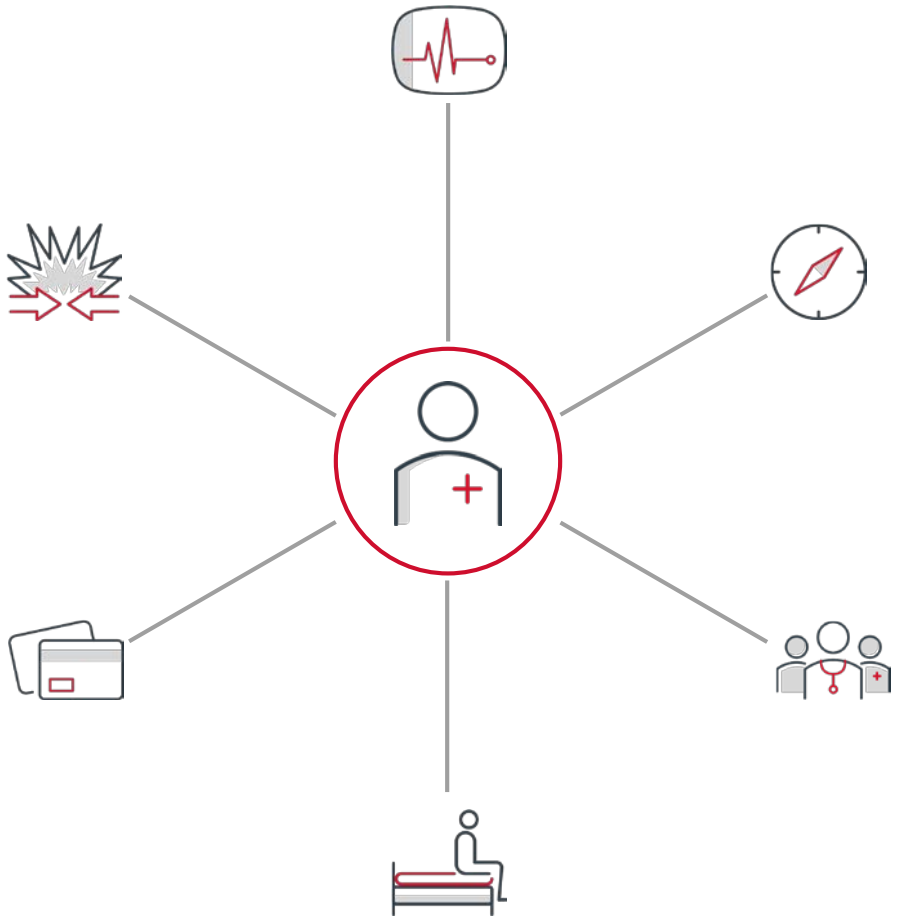
Potential number of deaths assuming a 1% fatality rate

Source: "UK coronavirus crisis 'to last until spring 2021 and could see 7.9m hospitalised'," Guardian, 15th March, 2020.

Pandemic piles on to existing stressors for the workforce

Regular sources of stress haven't gone away…

- Documentation
- Staffing ratios
- Policies and protocols
- Challenging patient and family dynamics



…and emergent needs have the potential to push staff over the edge.

- Equipment shortages
- Media and public scrutiny
- Worries about personal safety
- Daily spikes in COVID-19 cases and new hot spots
- Bed capacity limits

Advisory Board interviews and analysis.

Three things to do NOW to preempt clinician burnout

Build your organisation's "stop doing" list

- **Press pause** on as many initiatives as possible. Ask:
  - Can we push this [project, meeting, report, training] out 8 weeks?
  - If not: what's the bare minimum we must do? Who absolutely has to be involved – and who can we release?
- **Tell staff** what is okay to de-prioritise

Double-down on supporting the emotional health of managers

- Remember: frontline managers have a **disproportionate impact** on both daily operations and the emotional health of their staff
- Make sure you have:
  - A **dedicated forum** for managers to share concerns
  - The list of things managers can **stop doing** so they can better support their teams

Be ready to capture and share moments of greatness

- Ensure leaders know **where to send stories** about how staff are rising to the challenge
- **Share these stories** every chance you have

Advisory Board interviews and analysis.

Typical communication pitfalls make a crisis worse

Legacy communication missteps

Overwhelming amount

Staff already inundated with information; overly abundant change communication just compounds sense of “noise”

Excessive urgency

Difficult for staff to distinguish the truly important if too many messages marked as urgent

Unclear action steps

Messages focusing on big picture give requisite context, but lack critical details staff need about next steps

Communication challenges during acute crisis

- Increased stress and emotional pressure on staff responding to outbreak
- Potential for misinformation from external communication channels
- Difficult to convene frontline staff to deliver messages

Advisory Board interviews and analysis.

Five communication best practices for executives

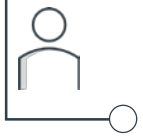
1. **Give staff a consistent source of COVID-19 truth**
2. **Minimise non-essential emails**
3. **Field and respond to rumours**
4. **Make yourself accessible virtually**
5. **Share your gratitude personally and often**

#1: Give staff a consistent source of COVID-19 truth

Tactics to reduce the noise re: COVID-19

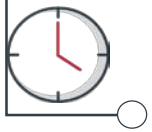
Single, trusted sender

- Send COVID-19 messages via a single sender/ email address
- Use a consistent structure for email subject lines



Consistent cadence

- Update staff regularly even if there is no new information to share
- Send at a consistent time (e.g., 7 AM daily)



Scannable information

- Write messages at primary school reading level
- Use colour coding or text formatting to separate action items from useful information

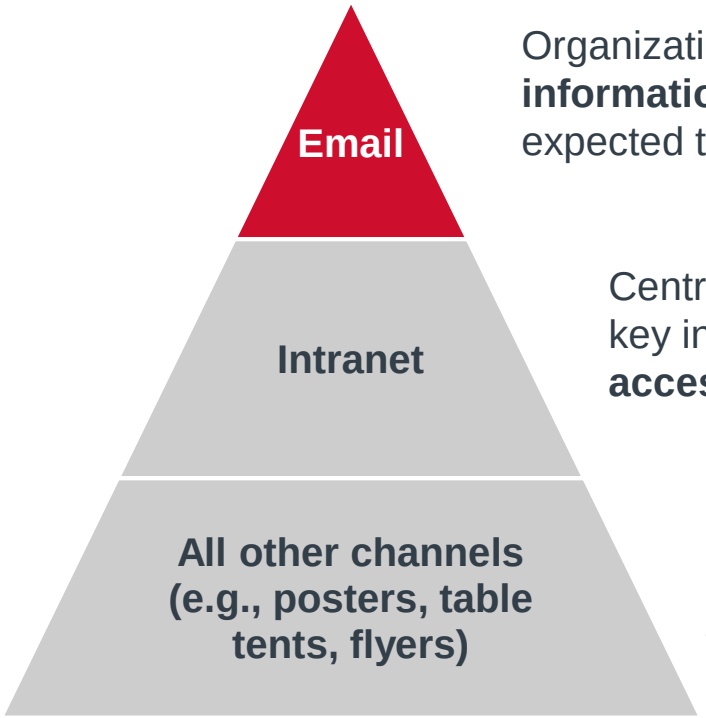
Archive communications

- Archive all communications in a single place for easy access (e.g., intranet, employee website)

Advisory Board interviews and analysis.

#2: Minimise non-essential emails

Tiered communication hierarchy



Organization sends **only most important information** via mass email; in turn, staff expected to check email as regular part of job

Centralised intranet hub captures and stores key information for **quick, on-demand staff access**; many emails link back to intranet

Other channels used to **reinforce key messages**, ensure widespread staff awareness

NEXT STEPS

Block use of organisation-wide email

- Appoint “gatekeeper” to centrally manage non-urgent messages to staff
- Standardise request protocol -- staff and executives must send any planned communications to gatekeeper
- Gatekeeper approves sending via email or another channel

Source: Nursing Executive Center, *National Prescription for Nurse Engagement,* Advisory Board, 2014.

Advisory Board interviews and analysis.

#3: Field and respond to rumours

Two approaches to stay abreast of staff questions and rumours

Open an anonymous feedback channel

- Give staff a number to call where they can leave an anonymous **voice message** with questions, comments or concerns regarding COVID-19
- Alternatively, open an anonymous **survey** with an open-ended text box to capture feedback

Set up a "what's the buzz?" committee

- Pull in **staff who are likely to hear the questions or rumours** circulating because they interact with a wide number of staff – consider roles like: float pool nurses, social workers, environmental services staff.
- Host a **regular quick virtual meeting** to understand current rumours and questions

NEXT STEPS

Questions to ask your "what's the buzz?" committee

- What are the questions your peers are too afraid to ask?
- What communication has sparked a lot of questions or confusion? Why?
- What news are people hearing from outside sources that needs clarification?
- What support do your peers/staff need?

Respond to surfaced questions/rumours in your regular COVID-19 update

Source: Nursing Executive Center, *National Prescription for Nurse Engagement,* Advisory Board, 2014.

#4: Make yourself accessible virtually

1

Virtual town hall

- Keep it short – 30 minutes (5 to 10 minutes context, remainder Q&A)
- Repeat session across shifts
- Consider segmenting invitees by level (staff roles, leadership)

2

Virtual office hours

- Schedule recurring block of time when staff can dial-in as they choose
- Have discussion questions ready to prompt conversation among attendees:
  - What's effective about our COVID-19 response? What's not effective?
  - What are you most worried about?
  - What questions do you have?

NEXT STEPS

Make virtual conversations more effective

- ☑ Turn on your webcam
- ☑ Ask open-ended questions to spark conversation
- ☑ Use a platform with capability for participants to "raise hand," use video, and chime in on the phone

Respond to surfaced questions/rumours in your regular COVID-19 update.

Source: Nursing Executive Center, *National Prescription for Nurse Engagement,* Advisory Board, 2014; Physician Executive Council, *Data-Driven Road Map for Physician Engagement,* Advisory Board, 2018.

Advisory Board interviews and analysis.

#5: Share your gratitude personally and often

In your communications with staff:

- **Acknowledge** the challenges and uncertainty staff are navigating
- **Recognise** the sacrifices team members are making
- Emphasise **staff health and safety** as much as patient/family health and safety
- Highlight **the wide variety of teams/ departments contributing** to the response

NEXT STEPS

Capture stories to share

- Ensure leaders know where to send stories about how staff are rising to the challenge:
  - Directly to the CEO?
  - To a dedicated email inbox?
- Review other good sources of stories: patient feedback, existing recognition platform
- Share these stories every chance you have (e.g., tell a 90-second story in every team meeting)

Source: Nursing Executive Center, *National Prescription for Nurse Engagement,* Advisory Board, 2014; Nursing Executive Center, *Rebuild the Foundation for a Resilient Workforce,* 2018.

“During a time of crisis, leadership is a matter of having people look at you and gain confidence; seeing what you do and how you react. If you are in control; they are in control.”

Tom Landry

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