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Sustaining frontline ICU healthcare workers during the COVID-19 pandemic and beyond

Healthcare workers (HCWs) on the frontlines of the COVID-19 pandemic in the intensive care unit (ICU) are under immense pressure as they provide essential care with challenges few have previously encountered. Fear, anxiety, and uncertainty have been reported by even the most experienced ICU HCWs as they care for escalating numbers of critically ill patients, each of whom pose a risk to the HCWs' own health. Inconsistent messaging from government health agencies on appropriate precautions, often framed around availability of personal protective equipment (PPE) instead of best practices, has shaken the foundation of what has been considered usual ICU care. Competing demands regarding self-care and care for their own families in the context of professional duties have placed seemingly insurmountable strains on ICU HCWs. Confidence has been shaken as HCWs contemplate the scope of their professional obligation to save lives.

Support for HCWs in the ICU and other care settings is critical to facilitate ongoing patient care and to avoid burnout.[1,2] Burnout includes elements of emotional exhaustion and depersonalization and impairs HCWs from connecting with the significance of their work, leading to workforce strains.[3] ICU HCWs were at high risk for burnout and mental health issues in pre-COVID practice environments.[4] Sustaining them through a pandemic requires helping them to find meaning in their work personally, clinically, and structurally, with opportunities for engagement with healthcare systems to enact needed changes in real time. Based on clinical and administrative experience from two hotspots of the COVID-19 pandemic (New York, NY, and the metropolitan region of New Haven, CT), we offer approaches to sustaining frontline ICU HCWs.

Deploy staff strategically

Distributing the burden of the pandemic response while employing innovative and responsive staffing models is essential to sustain ICU HCWs. For specialties that see increased utilization, such as ICU and palliative care, embedded staffing models (i.e., a palliative care provider assigned to a COVID-19 ICU) can provide increased access to experts, reduce consult volume, and provide continuity for complex cases. Scheduling respite time requires expanding the pool of potential frontline providers. With elective procedure schedules curtailed, anesthesiologists and surgeons have contributed to clinical needs in emergency departments and ICUs. If needs are not immediate, these HCWs can serve in back-up or remote positions. Ideally, these assignments are made on a voluntary basis.

Redeployment may be a source of stress for HCWs working outside their specialty. Providing targeted training and resources to those redeployed to ICU settings is helpful, with many professional organizations, like the Society for Critical Care Medicine, having developed curricula.[5] Interdisciplinary support and novel staffing models can likewise alleviate redeployment stress. For example, pairing redeployed medical-surgical nurses with a seasoned ICU nurse "coach" can ease the transition. HCWs' multiple life roles should also be considered, especially those who are primary or sole caregivers or who have personal health issues. For example, assigning these staff to remote support roles (i.e., providing telephone support and medical updates for ICU patients' families) can balance HCWs' needs.

Collaborate beyond the local hospital community

Cross-discipline and cross-institutional collaboration offer opportunities to share information, resources, and support. Larger scale collaboration, such as through social networking resources, can rapidly disseminate observations and best practices while offering virtual support to frontline HCWs in real time. For example, ICU HCWs in South Korea, China, Iran, and Italy shared frontline observations and adaptations to clinical care during the pandemic as cases spread globally. HCWs across institutions are now collaborating in weekly video meetings and chats to discuss clinical insights and experiences.

Proactively offer opportunities for self-care

HCWs may be distraught as they respond to calls of COVID-19 patients suffering from pain, dyspnea, delirium, fear, and loneliness. This distress can be exacerbated in the ICU where mortality rates are higher, and the human aspect of bedside care is impeded by isolation rooms and layers of PPE. Weathering this pandemic requires resilience that may more readily be developed if ICU HCWs have dedicated time to reflect and to find hope and meaning in their work. Debriefing following critical events can help HCWs process and begin to acknowledge some of the challenges and pain they have experienced.[6]

Mental health and employee health clinicians can offer encouragement and support. These clinicians can "check the pulse" of frontline HCWs to determine additional resources needed to reduce fatigue and burnout. For example, providing virtual support groups for HCWs led by a chaplain or social worker experienced in ICU settings can help support teams in addition to offering one-on-one support. Mindfulness and team-building exercises may also bolster HCWs and promote a focus on self-care after long, heartbreaking shifts.[7] Virtual social gatherings, such as book clubs, journal clubs, or coffee talks are low-key ways for HCWs to connect outside the hospital. Reflecting on life before and during the COVID-19 pandemic

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through shared poetry or creative writing also provides opportunities to de-stress.

It is challenging for ICU HCWs to find the time to engage in self-care under usual circumstances. While often identified as a priority, its implementation remains elusive.[8] The pressures of the pandemic further constrain time and energy for this vital domain. Frontline HCWs may not have the bandwidth to plan or seek out self-care activities; therefore, self-care strategies need to be realistic and readily available, e.g., free lunch in the breakroom. Effective self-care activities may happen organically, e.g., virtual dinners or happy hours. Offering different options for self-care maximizes the chances of HCWs' engagement. Most important now is helping HCWs remember their humanity and retain their agency to continue providing bedside care.

Build future clinical practice

Learning from shared experiences and committing to doing better next time, whether it be the next patient, the next clinical shift, or the next pandemic, helps make meaning out of a crisis. ICU HCWs' reflection on how to improve future practice can be empowering. It is important to enable HCWs' self-selection of their preferred form of engagement, whether it be direct feedback to supervisors, participating in focus groups on institutional response, or serving on institutional or professional society committees to develop position papers and guidelines. More broadly, engagement may take the form of advocating to local, state, and federal representatives for system and policy changes. Future clinical practice depends on insights gained from these extraordinary times, and HCWs may be sustained by knowing they have contributed.

Conclusion

The response of frontline HCWs in the United States has been swift and dutiful. Many have returned to ICUs and settings where they have not practiced for years to serve patients and health systems in need. Others have traveled across the country to stand with colleagues on the frontlines in New York City and other hotspots. These acts of grace and nobility cannot be overstated. Concerns remain over the devastation this period has brought on our ICU healthcare workforce for the next wave of the pandemic. Frontline HCWs will serve as valuable resources to plan for future crises, but they must first be sustained through the present one.

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