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Time out to check in- part 2

South London HFNS Forum

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Ground rules

1. Confidential and safe space
2. Discuss/ share only what you want to
3. We can talk about whatever we like- please shape where our conversation goes today!

Agenda

- 1. Burn out and depression
- 2. PTSD and trauma symptoms
- 3. HF teams 'recovery' plans

Concerns

- Distress
- Burn out
- Depression
- Anxiety
- Behavioral responses – self harm, alcohol, drugs, self neglect, relationships, risk taking
- Moral Injury
- PTSD

Burn out

- What do you understand by this term?
- Note evolving evidence base and some areas of debate/ contention

3 dimensions

- **Burnout** is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job.

1. overwhelming exhaustion
2. feelings of cynicism and detachment from the job
3. sense of ineffectiveness and lack of accomplishment.

Stress occurs within a specific **context**

3 dimensions

- **Exhaustion** - wearing out, loss of energy, depletion, debilitation, and fatigue.
- **Cynicism** – 'depersonalization', negative or inappropriate attitudes towards clients, irritability, loss of idealism, and withdrawal.
- **Inefficacy** – 'reduced personal accomplishment', reduced productivity or capability, low morale, and an inability to cope.

Why such high rates in healthcare?

- “the prevailing norms are to be selfless and put others' needs first; to work long hours and do whatever it takes to help a client or patient or student; to go the extra mile and to give one's all”
- Moreover, the organizational environments for these jobs are shaped by various social, political, and economic factors (such as funding cutbacks or policy restrictions) that result in work settings that are **high in demands and low in resources”.**

Evolving evidence base and suggested models

- a) job stressors (an imbalance between work demands and individual resources)
- b) individual strain (an emotional response of exhaustion and anxiety),
- c) defensive coping (changes in attitudes and behavior, such as greater cynicism).

Models

1. The Job Demands-Resource model

- Focuses on the notion that burnout arises when individuals experience **incessant job demands** and have **inadequate resources available** to address and to reduce those demands

2. **Areas of Worklife (AW) model-** frames job stressors in terms of person-job imbalances, or mismatches.

- 6 key areas in which these imbalances take place: **workload, control, reward, community, fairness, and values.**
- Mismatches in these areas → experience of burnout → outcomes, such as job performance, social behaviors, and personal wellbeing.

Organizational risk factors

- **Workload**
- **Control**
- **Reward**
- **Community**
- **Fairness**
- **Values**

Control

- When employees have the perceived capacity to influence decisions that affect their work, to exercise professional autonomy, and to gain access to the resources necessary to do an effective job, they are more likely to experience job engagement.

Vicious cycles

- Physical health e.g. exhaustion - stress symptoms - headaches, chronic fatigue, gastrointestinal disorders, muscle tension, hypertension, cold/flu episodes, and sleep disturbances.
- Diminishes opportunities for positive experiences at work, decreased job satisfaction and a reduced commitment to the job or the organization.
- Contagious – e.g. impact on colleagues
- Person vrs group? - characteristic of workgroups rather than simply an individual syndrome?

Prevention or treatment?

- Individual versus workgroup vrs entire organization?

Interventions

- a) changing work patterns (e.g., working less, taking more breaks, avoiding overtime work, balancing work with the rest of one's life);
- b) developing coping skills (e.g., cognitive restructuring, conflict resolution, time management);
- c) obtaining social support (both from colleagues and family);
- d) utilizing relaxation strategies;
- e) promoting good health and fitness;
- f) developing a better self-understanding (via various self-analytic techniques, counseling, or therapy)

Interventions

- Reduce workplace demands
- Response to exhaustion- sleep, exercise, and nutrition
- Workplace civility (reducing cynicism)
- What else?

Burn out versus depression

- Burnout is job-related and situation-specific
- Depression- more general and context-free.

- But- ? If things are ever that straightforward!
- What do you think?

Reflect on what you have heard

- What can:
- You
- Your team
- Your department
- The organisation
- Do differently to try and prevent burnout?

- Discussion- what strategies are you using/ can you use to build the resilience, cohesion and support in **your team**?

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Checklist for leaders and managers working under uncertainty and change

All teams are under enormous stress. How and where we work is changing.

This checklist will remind busy leaders and managers how to make their team feel safe.

1. We ask the team how they are feeling and reassure them it is OK to feel this way

2. We remain aware that each staff member has different stuff going on at home that we may not know about

3. We ensure the team knows they can ask for help, support and guidance and that this will be responded to

4. With increasing levels of illness in the community and fewer resource to help them, teams know their leaders have full trust in them and that they are doing the best they can

5. The team knows the best resource we have is each other and we need to prioritise supporting each other

6. The team knows who is in charge each day even when consultants and managers are absent

7. The team knows how to communicate with patients including key messages about services, medication, symptoms, and where to get help

8. The team knows every day, who to ask for clinical advice and support

9. We have replaced 'corridor conversations' with regular, pre-arranged virtual huddles

10. The team keep in touch and stay connected through virtual MDMs/WhatsApp. This includes those who have been redeployed to other teams

11. Leaders and managers of this team know the importance of looking after themselves, and how to let others lead so they can get some rest

12. The team know there is a Staff Wellbeing Hub on site – open daily for food, breaks and to decompress

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A word on debriefs…

It is good to talk!

Team based reviews and debriefs

An end-of-shift operational review

- What went well.
- What didn't go well.
- What can be done next time.
- How is everyone.
- Who needs a bit more support.
- Additional 1:1 support should not focus on re-processing the incident but supporting the individual to access their coping resources and support systems.
- People should never be **required** to talk about their feelings.
- This method is incorporated in the **end-of-shift** checklist.

A leader-led operational/team review

Focus should be on:

- Identifying the reasons for specific outcomes
- Identifying ways of improving practice.
- This is a semi-structured regular facilitated meeting giving an opportunity for the team to come together, reflect on the experience of working together, build a shared understanding or narrative of what happened, support and foster connection as a team and think about both operational processes and self care needs.
- Attendance should not be mandated but encouraged.
- These sessions should not involve anyone being mandated to talk about their thoughts or feelings.
- Ad hoc arrangement rather than regular is acceptable.
- Ideally these should be co-lead with regular clinician and experienced MH professional.

Discussion – 'Staff support'

- How would you like to have been and be supported?
- What do you need currently?
- What strategies have you found to look after yourself/ your team?
- What would you like to 'keep'?
- What would you like to change?
- What would you like to be different following this?

PTSD

PTSD

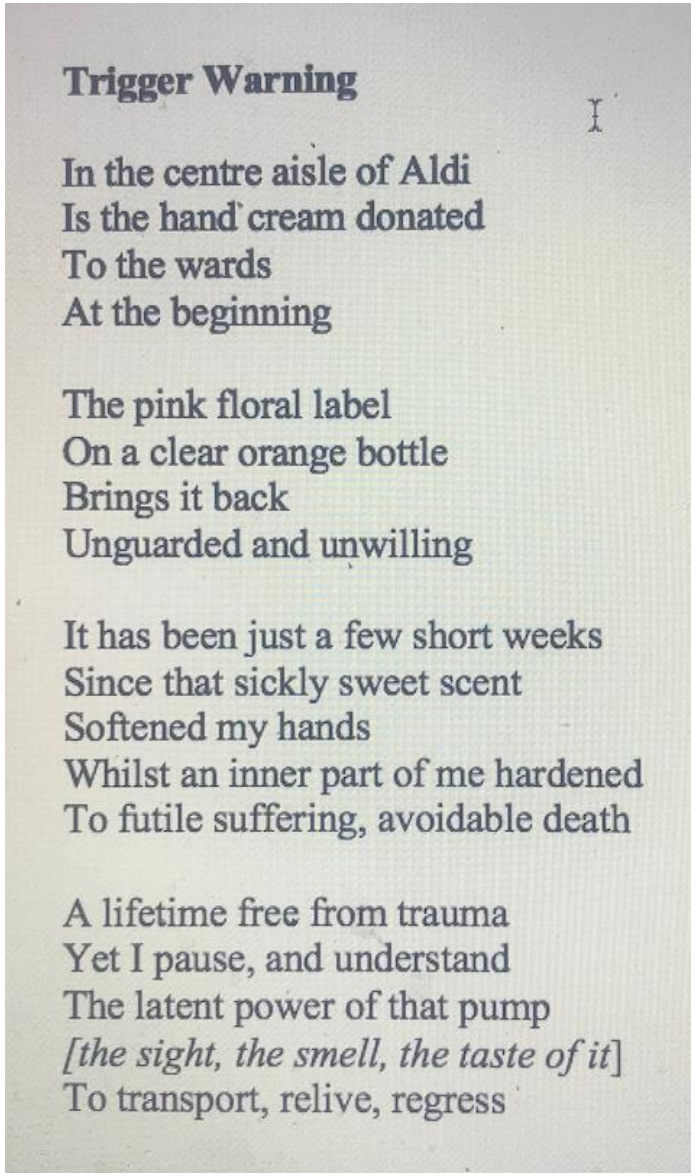
- What do you know about PTSD? Would you know the signs in yourselves or others?

What's normal, what's not

- Following a traumatic event it is not unusual to experience feelings of fear, distressing unwanted memories of the event, sleep difficulties, feeling low or numb, increased irritability, less interest in socialising or hobbies.
- Perhaps even depersonalisation/ derealisation.

What's normal, what's not

- **Acute Stress Disorder** – symptoms usually begin to subside a few days after the trauma / when the danger is over
- **Adjustment disorder** – preoccupation with stressor and its consequences, rumination, failure to adapt, typically resolves within 6 months of stressor ending
- But, if symptoms persist for more than 4/52, or worsen, and include **re-experiencing** the event as if it is happening now, consider **PTSD**



Trigger Warning

In the centre aisle of Aldi
Is the hand cream donated
To the wards
At the beginning

The pink floral label
On a clear orange bottle
Brings it back
Unguarded and unwilling

It has been just a few short weeks
Since that sickly sweet scent
Softened my hands
Whilst an inner part of me hardened
To futile suffering, avoidable death

A lifetime free from trauma
Yet I pause, and understand
The latent power of that pump
[the sight, the smell, the taste of it]
To transport, relive, regress

Dr Caroline Barry

Post-Traumatic Stress Disorder

- Exposure to an extremely **threatening / horrific event(s).**

Characterized by all of the following:

1. **Re-experiencing** the traumatic event(s) -vivid intrusive memories, flashbacks, or nightmares. Typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations.

2. Avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s)

Post-Traumatic Stress Disorder

3. Persistent perceptions of heightened current threat, indicated by hyper-vigilance or an enhanced startle reaction to stimuli such as unexpected noises.

Mood changes, numbing, sleep disturbance, withdrawal.

4. Onset at least 1 month after the trauma, symptoms persist at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Managing Psychological Symptoms

- Information giving – normalize symptoms and explain causes
- Support emotional distress
- Plug into social support
- Active monitoring - at least 4 weeks to see if symptoms persist
- Are there re-experiencing symptoms or just rumination and preoccupation?
- If so, and symptoms have persisted for more than 4 weeks, client can self – or- refer to IAPT
- IAPT can refer onto CADAT as required.

Treatments

- CBT- trauma focused
- EMDR - Eye movement desensitization and reprocessing
- Medication- venlafaxine or SSRI

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How to respond to someone in distress
(If you don't have the reserves to do this - get help)

1. Don't panic	Do not think that you need to fix it.
2. Go somewhere quiet	Invite them somewhere quiet and let them sit down – in their own time – don't force or rush them.
3. Let them express their feelings	Let them cry or shout if they need to. Don't hush or stifle the emotions they are expressing.
4. Reassure and validate	**Reassure** them they can take their time. **Validate** their distress – say: '*It's OK to be upset.'*
5. Listen to what they are saying	Try to ignore your own thoughts about 'what you need to do/getting it right'. Just listen. Hear what they are saying.
6. Use your body	Your body can show someone you are listening – make eye contact, focus on what they are saying, notice their facial expression and mirror it, let go of a defensive posture - face them, turn in towards them, uncross your arms.
7. Show them you have you listened and heard	*Open questions, summarise, reflect, clarify, encourage, react*. • **Summarise** what they told you*: 'It sounds like you felt so scared and overwhelmed.'* • **Clarify:** when people are distressed, they talk quickly or unclearly. Get them to expand: *'Tell me more.' or 'Help me make sure I've understood this right: you told me that…'* • Don't pretend you heard or understood when you didn't: *'I'm sorry I didn't fully understand what you said about X, can tell me again – I want to understand.'*
8. Follow up	**If you have more concerns ask them:** *'Are you ok to go home? Who is going to be there? Do you want to stay a it longer here with me/a colleague/the team?'* **Ask if you can call them tomorrow and check they are OK.**

- Discussion: What would you do if you thought a colleague was suffering- how would you know and, what action would you take?

Staff support initiatives

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Responses/ interventions to provide staff support

Individual, team and leader and primary to tertiary prevention

- Self care information and signposting to services
- Education training to leaders and managers
- Morale boosters/ treats
- Food, parking, salary access, childcare
- Rotas, breaks, leave, thoughtful redeployment
- Hubs – connection, information and food
- Ward buddies/ well being partners
- Reflective practice- Groups, Schwartz, team time
- Counselling, brief psychological interventions
- Case finding- ensuring prompt access to evidence based care
- + Increased resources to support your patients (befriending, extra staff, distraction packs)

The problem

- Evidence
- What we thought they wanted
- What they wanted
- What they needed
- What we gave them …..

Discussion

- How would you like to have been and be supported?
- What do you need currently?
- What strategies have you found to look after yourself/ your team?
- What would you like to 'keep'?
- What would you like to change?
- What would you like to be different following this?

Taking responsibility for looking after ourselves

- Not rocket science (but oddly hard to do sometimes!)
- Healthcare workers can be VERY good at looking after other people and pretty bad at looking after ourselves….

- Make a **plan to look after yourself** : This has to be a conscious and active commitment!!
- Identify your **support system** and use it: family, friends, colleague(s), online group, coach, therapist
- Eat, rest, hydrate, exercise, reduce digital media, and say when you need time out

➢Caution alcohol, nicotine, caffeine.. other props we use to manage emotions

➢Caution problematic relationships and influences ….

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Taking responsibility for looking after ourselves

- Acknowledge that you will **make mistakes**. We are learning whilst doing. Mistakes may happen:
  - clinically
  - in communication with patients, their families
  - in communication with your staff and team
  - with your family
- **Mistakes are OK. Forgive yourself. If or where possible: laugh at yourself, say sorry**
- Understand and forgive **others making mistakes**. Being the best version of ourselves at this time is very hard
- Be aware: SARS-COV 2003: >10% of clinicians came to work with symptoms
- If you are struggling to look after yourself: Remember, **this isn't just for you, it's for your patients and your team**
- **Take time out. Take a break. Tell someone when you need help.**

Where we have been today

1. There are real risks to you all at the moment
2. There is a need to ACTIVELY and INTENTIONALLY look after yourselves – make a plan, stick to it
3. There is a need to ACTIVELY and INTENTIONALLY look after each other and the team - make a plan for your team and stick to it
4. If you are experiencing problems- PLEASE PLEASE reach out early
5. Be aware of the wide range of defenses we use to protect ourselves against pain- this may give you more awareness of what is happening within us and, around us
6. I would like to send you all GOOD information on where to get support and advice- please let me know anything specific that would be useful

PS- It was just lovely to see you

- And moreover- thankyou. For all you do.