Guidance

quick guidelines are not approved by some

theory of ethical issues vs everyday practice auick decisions

Tasks

New roles: mediation, communication btw family and patient, different relationship with patients Support for dying people Deep conviction that nothing better can be done for patients New responsibilities

> Situation: Health Care Workers in the early phase ("first wave") of the COVID-19 Pandemic

We created a model based on the coding paradigm by Strauss and Corbin (1996) using grounded theory methodology.

For more detailed data or insights into earlier steps in the data reduction process, please contact: alexander.kreh@uibk.ac.at

The research article can be found here: https://doi.org/10.1371/journal.pone.0249609

Work Environment

No space for social support (share experiences, eat, smoke)

PPE: Thermal discomfort, long time (shortage, lack of relaxing room)

Shifts: Volunteer work overcoming normal shifts

Stressors

Resources

Shortage of staff (Working alone on tasks)

Shortage in supplies

Shortage in PPE

Shortage in medications

Shortage in replacement parts of

instruments

Delay in treatments of non-covid patients

Scared staff hoarded PPE material

Triage

Shortage of resources not major issue

Stress Experience of Health
Care Workers

Stressreducing factors

Organisational

Central team in the background for strategic planning and support of regional teams

Guidance

Regularly updated guidelines for protection of health care workers Accurate information and training Clear guidelines have led to more stable routines

Leadership

Head physician entering patient's room together with staff leads to less conflict

"Leadership from ahead"

Abandonment/recognition

fear

Nurses: rage

Doctors: silence, "paralysis of thought"

Guilt: Being "plague-spreaders"

Exhaustion & fatigue

Insomnia

Confusion and unrest

Unsafety, loss of control, not feeling sufficiently

protected Dissociation

Frustration

Frustration

powerlessness

Lack of trust in external or newly hired workers

Smoking: Used to have a moment without

PPE outside the ward

Sleeping with masks a home (nurses)

HCW not returning home to not put families at risk

Strategies

Psychological Interventions

focus groups (Staff too overworked to attend)

Intervention by phone, videocalls

Small groups

Other Challenges

Stigma

Colleagues

Rapidity of evolution of COVID-patients

Evolving situation: perplexity for testing

No time to elaborate/process feelings

Cannot balance risks: no tests for staff

Living with older population at home

Impact on families (infection risk)

Lack of trust in external workers

Lack of trust in newly hired workers

Strong expected Impact of dying colleagues

Intervention in wards

Individual when requested

Calling psychologists to mediate between pts and fam. +

helping patients

Free and anonymous service for staff

EMDR focus groups for hospital staff and EMS

staff help patients in talking on the phone with relatives

Management

HCWs possibility to report if they work in unsafe conditions

Protection of health care workers

Staff that have kids protected from contact to covid patients

recruiting young doctors/nurses or recent graduate doctors/nurses

Peer Support

Sharing of experiences: moments, clinical cases, decision making, directions on how to relate to patients/relatives Reassurance: Operating in couples