Wellbeing interventions for Emergency Department staff: 'necessary' but 'inadequate' – a phenomenographic study.

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Abstract [291 words]

Introduction

Stress and burnout are prevalent among emergency department (ED) staff in the UK. The concept of wellbeing interventions for ED staff is a growing area of interest and research worldwide. Various interventions are described in the literature, yet little is known about the experience of ED staff in the UK of interventions designed to support their wellbeing. This study therefore aimed to understand their experiences of these interventions.

Methods

Semi-structured interviews were carried out with nine members of staff from different professional backgrounds at a tertiary trauma centre in the UK between June and July 2023. The inclusion criteria were staff who had worked in an NHS ED setting in the UK for more than 12 months. Participants were asked about their experience and perceptions of wellbeing interventions delivered in the workplace. A phenomenographic approach was applied to analyse the narrative data.

Results

The findings resulted in seven qualitatively different, but related categories. Participants experienced interventions to be: 1) necessary due to their stressful working environment; 2) beneficial in supporting their wellbeing; 3) feasible in an ED setting; 4) inadequate due to lack of quality and accessibility; 5) improving, with increased acceptability and support; 6) restricted by clinical and organisational factors; and 7) ambiguous in definition, measurement, and individual interpretation. Space for facilitated reflection and role modelling by leaders were felt to be important.

Conclusions

Job demands simultaneously necessitate and restrict the provision of adequate interventions to support wellbeing in the ED. These demands need to be addressed as part of wider organisational change, including the provision of self-care facilities and opportunities, protected time for facilitated reflection, high quality and accessible learning opportunities for personal and professional development, training for staff delivering wellbeing interventions, and positive role modelling by leaders.

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Key messages

What is already known on this topic

The concept of wellbeing interventions for ED staff is a growing area of interest and research. Studies have demonstrated the need for wellbeing support amongst ED staff to prevent burnout. Numerous potential interventions have been described in the literature, but few UK studies have addressed the perceptions of staff experiencing these interventions.

What this study adds

In this qualitative study of staff working at a tertiary trauma centre in the UK, ED staff experienced wellbeing interventions to be necessary, but inadequate. Space for facilitated refection was identified as a common and beneficial wellbeing intervention, whether provided in supervision sessions, support meetings, group settings (e.g. debriefs) or informally by colleagues; however, training for those delivering these interventions was considered important.

Implications for practice, policy, and research

Recommended wider organisational change that can benefit wellbeing includes the provision of self-care facilities and opportunities, protected time for facilitated reflection, high quality and accessible learning opportunities for personal and professional development, training for staff delivering wellbeing interventions, and positive role modelling by leaders.

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Introduction

Working in the Emergency Department (ED) includes exposure to death, serious illness, trauma, and suffering (1). The dynamic volatility of the work environment demands that staff move quickly between patients, even from significantly impactful experiences, to care for others (2). A stress response takes place in which staff experience a state characterised by high levels of arousal and distress, often accompanied by feelings of not coping which can lead to ill health (3,4,5). Working long and unsocial hours may limit recovery capacity and impede peer support for external processing. This is important, as the opportunity to talk to others is known to be a key coping mechanism for emergency care workers (2,6).

The concept of wellbeing interventions for ED staff is a growing area of interest and research worldwide. The current literature suggests that a common intervention is debriefing (7,8,9), defined as a session that involves sharing and examining information after a critical event to improve communication and review team performance, as well as provide emotional support (7). Other interventions include wellness training (9,10), with the common themes of knowledge-based education around wellbeing, and training in techniques for self-regulation or self-care; mindfulness training (11); reflective supervision (12); and team training (13). Role modelling by leaders, who exemplify a supportive culture of inclusion and kindness, has also been found to be a key means of facilitating wellbeing among ED staff (13). However, few studies have been conducted in the UK. Therefore, the aim of this study was to explore the experience of ED staff working in the UK's National Health Service (NHS) of interventions designed to support their wellbeing.

Methods

Participants were recruited from a tertiary trauma centre in the UK between June and July 2023 via e-mails, posters, and social media posts advertising the study. Wellbeing interventions had been introduced in this centre in the previous 5 years. The inclusion criteria were staff who had worked in an NHS ED setting in the UK for more than 12 months. An information sheet was given to prospective participants to facilitate informed consent. Semi-structured interviews were conducted by the first author, AB, via Microsoft Teams to permit video recording with auto-transcription. Participants were asked about their experience and perceptions of wellbeing interventions delivered in the workplace (see supplementary file 1). Data analysis was carried out manually following the seven steps taken from Dahlgren and Fallsberg (14) as recommended for phenomenographic research (15). Meaning units, in the form of narrative quotes, were organised into categories in an iterative approach using an Excel spreadsheet and agreed by both authors. Categories were compared and related to one another in a hierarchical relationship and represented in graphical form (the outcome space). The results were then shared with participants so they could comment on the accuracy of the categories.

Phenomenography is a qualitative methodology which explores the different ways in which a certain phenomenon is experienced and understood by a particular group, but also how

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these ways of understanding are structurally related to one another (16). In a phenomenographical approach, narrative data are systematically read and interpreted and organised into categories. Each category reveals something distinctive about a way of understanding the phenomenon (15). The results are presented as an 'outcome space' – an illustration representing the findings and their relationships, with each category described and accompanied by illustrative narrative quotes (17). As the aim of phenomenography is to capture the range of possible ways in which a certain phenomenon is understood within a group, the sample size needs to be large enough to allow a range of perspectives and reach data saturation (15,18), but for studies with a high level of homogeneity among participants, a small sample may be sufficient to identify meaningful categories and useful interpretations (19).

The first author, AB, is a Specialty Doctor in Emergency Medicine. As an insider-researcher, reflexivity – the continual internal dialogue and critical self-evaluation of the researcher's positionality (20) – was key. This was facilitated by regular perspective taking with the second author, NC, as well as participant validation of the results.

Patient and public involvement

None.

Results

Twelve participants volunteered to be interviewed but three withdrew before interviews could be arranged, citing work pressures, sickness, and leave. Nine staff members were therefore interviewed: 4 doctors (1 consultant, 2 registrars, 1 teaching fellow); 3 nurses (a charge nurse, advanced clinical practitioner, and emergency nurse practitioner); 1 physician associate and 1 flow co-ordinator. Participants had worked in ED for between 2 and 11 years. Interviews lasted for 44–114 minutes. Data analysis resulted in the 7 categories described below and in Fig 1.

Figure 1: Outcome space here

Participants articulated that they perceived wellbeing interventions to be:

1. Necessary: needed to prevent burnout due to their unpleasant and stressful working environment
2. Beneficial: supportive of their wellbeing through direct training and indirect demonstration of organisational care
3. Feasible: possible in an ED setting, with examples of facilitating factors
4. Inadequate: poor quality and requiring training of those who deliver interventions; poor accessibility due to lack of availability and siloed training
5. Improving: becoming more accepted and supported as part of a societal and organisational change
6. Restricted: constrained by wider clinical, organisational, and cultural factors

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7. Ambiguous: lacking clarity of definition and measurement, and diversely interpreted by individuals.

The seven articulated categories, with constituent themes, are described below with illustrative quotes from the transcribed interview narratives.

Category 1: Necessary

Participants perceived the nature of the ED environment to be a frequently unpleasant workplace:

- 'It's a very scary place… it's very hectic and mental and then you have something very traumatic.' P5
- 'What we're expecting you to do, in the environment we're expecting you to do it, is kind of horrible.' P3
- 'It's hellish out there.' P6

In the ED, extraordinary circumstances of grief, trauma, aggression, and incivility were experienced by participants on a regular basis:

- 'I had six cardiac arrests in resus on my last day. I was fuming because I didn't even want to be in there. One of them was very traumatic and I cried my eyes out. Me and one of the nurses cried and cried our eyes out when we went on break, we just broke down.' P5

Participants perceived that these regular stressors impacted upon their wellbeing, with resultant burnout, negativity, and staff attrition:

- 'The work in ED is just constantly hard … every day I see someone that I think is struggling and wanting to leave … people just leave because they're so stressed and they're so burnt out … and then that's more pressure onto everybody else.' P1

Participants identified that the lack of wellbeing training and investment left some staff feeling devalued. They felt that wellbeing training and debriefing were necessary to provide support to workers:

- 'It's not normal the stuff that we see and the stuff that we deal with and so I think debriefs … would contribute to a better environment, better staff wellbeing.' P1

Category 2: Beneficial

A variety of different interventions were identified to have been helpful to the wellbeing of participants and their colleagues. These included facilitated reflection, wellness training, role modelling, and training in non-technical skills.

Facilitated reflection

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Multiple forms of facilitated reflection were identified, both from mentors and supervisors, and non-supervising individuals trained in psychological support:

- ‘Having a mentor… knowing that you've got somebody that's looking out for you and somebody who… gives you the skills and the space to self-reflect.’ P1
- ‘She literally sat there, listened to me cry. Just tell her about anything and she was very helpful with advice. It's hard to explain, she was very impartial …’ P5

Group reflection was also felt to be helpful:

- ‘The whole room will start a conversation… so not only do you vent, get off your chest and recognise everyone else feels like that. You also come up with solutions on how to try and stop it... and it makes you feel better knowing everyone else is in that same position.’ P2

Some participants felt that feedback from colleagues that prompted them to reflect, seek help, or self-care was also useful.

The value of debriefing after a critical event to support wellbeing was raised by participants:

- It's really good and I'd never seen it until about two months ago and we had an arrest in Resus, and it was a really traumatic one, but they were like, “Let's have a debrief. Let's all get together and talk about it” … the thought of it, made me think that's amazing because a lot of people would go and leave very upset.’ P4

Wellness training

Training delivered in the ED to educate staff regarding wellbeing, and strategies to support coping and self-care were also identified as being beneficial:

- ‘It is helpful to know about these things. It’s a little bit empowering to know that this is burnout. This is where it comes from. This is what you can do about it.’ P3

Role modelling

Participants identified the presence and example of role models who promoted a personal and professional culture of wellbeing as being beneficial:

- ‘Seeing somebody who you respect talking about their own experience or being visibly emotional or really caring on the shop floor I think can be a really helpful thing’ P7

Role modelling by leaders was felt to be especially important:

- ‘Having a leader who is approachable, but also willing to listen to your ideas and willing to acknowledge if you need a moment off the shop floor, if you need to go to

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a meeting or an appointment, they're very open to that. That massively supports wellbeing.' P9

Non-technical Skills

Another intervention designed to support wellbeing that participants perceived to be beneficial was training in non-technical skills, including leadership, team working, communication skills, civility, and learning about self.

- 'I've had a lot of training recently about self, in leadership and in terms of kind of Myers-Briggs personality types or Belbin team roles or where you fit in different places, and I think the more that I've understood and known about myself has massively improved my wellbeing.' P7

Participants also noted that the provision of wellbeing training had the indirect impact of allowing staff to feel valued.

Category 3: Feasible

Participants perceived wellbeing interventions to be feasible as well as beneficial. This perspective was expressed with regards to numerous different forms of wellbeing interventions they had seen employed or believed to be achievable in the ED environment, such as mentoring, supervision, accessible counsellors, debriefing, drop-in wellness training sessions, and team training:

- 'Little sessions, you know like drop-in sessions throughout the day.' P5

Some also commented on the team being a key factor in releasing staff from service provision to access reflective spaces or to address self-care, further contributing to the feasibility of wellbeing training interventions:

- 'ED are absolutely amazing with things like that … even if they're busy there's still people around to cover here.' P5

Category 4: Inadequate

Participants expressed the view that while wellbeing interventions are necessary, beneficial, and feasible, the current provision was inadequate. This inadequacy was expressed in the twin themes of poor quality and poor accessibility in relation to supervision, debriefing, wellness training, role modelling, and non-technical skills training:

Poor quality

- 'You're supposed to have regular check-ins with your line manager. But I've never. I mean, we have a general chat but then it's not away from anyone. It's not away from anywhere. It's in the department.' P2

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- ‘It was a clinical debrief where we sort of spoke about the running of the arrest. There was no addressing of staff psychological needs, psychological safety. I just remember saying I was going to go to the toilet, and I went up the stairs and cried.’ P1

The lack of development provided to those expected to train and support others in their wellbeing was highlighted and was felt to contribute to poor quality, particularly for those in supervision roles, but also in other domains like role modelling and leading debriefs:

- ‘The main negative experiences that I’ve had from a wellbeing side that may be detrimental is sometimes that supervision relationship … if the supervision sessions are completely imposed and guided by what they want to get out of the session.’ P9

Poor accessibility

Participants perceived that lack of provision was one reason for the poor accessibility of wellbeing interventions:

- ‘I had an induction. No, it didn't include anything around wellbeing, it didn't say anything about signposting to any services that were available, just no mention at all. The induction was very much focused on this is how you do your job.’ P1

Participants also perceived wellbeing interventions to be siloed so that different professional groups were given different opportunities and had different levels of access to support and education.

<u>Category 5: Improving</u>

While participants perceived wellbeing interventions to be necessary, beneficial, and feasible, as well as inadequate because of poor quality and accessibility, they also remarked that the culture towards wellbeing interventions is shifting towards being more supportive:

- ‘Things are changing … I think the impact of how staff members are and how if we have our good own wellbeing then that contributes much more to the team and much more to doing a good job.’ P7

<u>Category 6: Restricted</u>

Participants felt that interventions designed to support their wellbeing was restricted. Numerous clinical, organisational, and cultural issues were reported to constrain the provision of wellbeing interventions:

- ‘It's so busy that even going to the toilet or going for your break is an impossible task. So I'm not sure how that would fit.’ P2

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- ‘In order to have really good wellbeing training and team training, that's multidisciplinary, again, you'd have to have a place to do it.’ P7

Category 7: Ambiguous

Participants perceived wellbeing to be ambiguous; that is unclear, open to interpretation and not having a single obvious meaning. This ambiguity was acknowledged in the lack of clarity surrounding the definition of wellbeing and its proper measurement. Ambiguity was also felt to arise due to the diverse interpretation between individuals of what interventions supported wellbeing:

- ‘The trouble with wellbeing a little bit is that it's so personal. My experience of it will be different from your experience, will be different from the next person. Equally my needs, will be different to your needs, will be different to the needs of the next person. And I wonder if that's also just part of what makes it such a hard problem to tackle, is that what works for me might not work for you.’ P3

Discussion

The experience of ED staff is that interventions to support their wellbeing are necessary, beneficial, and feasible, yet inadequate due to poor quality and poor accessibility. The situation is thought to be improving but remains housed in systemic restrictions and the ambiguity of what wellbeing means and approaches that support it.

The perspectives presented by participants are in accord with other research in this field (21). Space for facilitated refection was identified as a common and beneficial wellbeing intervention, whether provided in supervision sessions, support meetings, group settings (e.g. debriefs) or informally by colleagues. This recognition of the power of facilitated reflection corresponds with the medical education literature which asserts that the potential of reflection for individuals may not be fully realised without the help and support of another (22). The UK’s General Medical Council also highlights the benefit of reflective spaces in supervision, coaching and mentoring, citing that there is considerable evidence of the importance of good supervision for care quality, productivity, and wellbeing (23).
The perspective that positive role modelling by, and development for, leaders is important for staff wellbeing in the ED is in agreement with a recent study by Daniels et al (24) who found that leadership emerged more prominently than in prior studies as both a barrier and opportunity for wellbeing and retention in the ED.

Some of the ideas expressed by the participants regarding feasibility are borne out in the wider literature. El-Shafei (10) utilised an accessible staff room for the delivery of wellness education and Braganza (25) harnessed the convenience of drop-in sessions. Sugarman (8) found that despite high reported levels of staff satisfaction and perceived benefit from hot debriefing, utilisation was not sustained following a period of implementation. Staff turnover, attrition of awareness, workplace logistics and siloed professional involvement were potential barriers to feasible and sustainable delivery and must be considered for any initiatives implemented in the ED.

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Examples from around the world highlight the traditional failings of Emergency Medicine in appreciating the psychological impact of the emergency environment upon its staff and tailoring training accordingly (6). However, this is changing, with national bodies such as the General Medical Council (26) and Royal College of Nursing (27) increasingly promoting the agenda of staff support and wellbeing.

A system-wide solution is required to meet this challenge, with changes necessary at managerial and organisational levels (28). Many now recognise that strategies that focus on individuals alone are ineffective (29) and rightly state that if burnout is the canary in the coalmine, the solution is not stronger canaries (30). Deutsch (12) identified that having basic needs met, meeting work goals, receiving individual feedback, being valued, experiencing clinical community, and having ownership of time outside work were factors identified as improving wellbeing among Emergency Physicians in the USA. This does not, however, negate the value of individually targeted interventions as one piece in a multifaceted approach. A recent literature review of burnout among ED nurses concluded that organisations should use their resources and influence to promote interventions at multiple levels, from organisation-wide change initiatives down to individual-level training (31).

Limitations

This research was carried out in a single ED in the UK and may not be representative of all EDs. However, the findings resonate with the wider literature on this topic. Another potential limitation (but also a strength) is the chosen methodology which focuses on developing an understanding of the qualitatively different ways in which a small homogenous group of individuals experience a phenomenon.

Conclusion

This study has found that job demands simultaneously necessitate and restrict the provision of adequate interventions to support wellbeing in the ED. These demands need to be addressed as part of wider organisational change, including the provision of self-care facilities and opportunities, protected time for facilitated reflection, high quality and accessible learning opportunities for personal and professional development, training for staff delivering wellbeing interventions, and positive role modelling by leaders. Further research is needed to clarify what is meant by wellbeing among ED staff to allow reliable and valid measures to evaluate the efficacy of different interventions.

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Data availability: full interview data are available upon reasonable request.

Contributors: AB planned the study, conducted the interviews, co-analysed the data and co-authored the article. AB is the guarantor. NC co-analysed the data and co-authored the article. Both authors approved the final version of the submitted manuscript and agree to be accountable for all aspects of the work.

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Ethical approval: Faculty of Medicine and Health Sciences Research Ethics Committee, University of Nottingham UK, 25/11/2022. Reference Number FMHS 79-0922. This study was conducted as part of a MMedSci in Medical Education dissertation.

Patient and public involvement: none.

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Supplementary file 1

Interview schedule.

Supplementary file 2

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Completed guideline checklist from: O'Brien BC et al. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. Academic Medicine 89(9): 1245-1251.

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