**NICC Editorial**

**Remember why you became a nurse in the first place**

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There are articles on staff stress everywhere at the moment. Burnout has been a hot topic at critical care conferences internationally over the last few years, prompting the joint societies for intensive care in the United States to put out a call for more research in this field.1 Health professionals working in intensive care settings are reporting alarming rates of burnout, post-traumatic stress and moral distress,with nurses in particular reporting higher rates of distress than their colleagues.2

Some cite staffing pressures as the primary cause of strain in the health service at the moment and prefer the term ‘moral injury’ to ‘burnout’.3 Others draw attention to the ever-increasing clerical burden on health professionals, which has been found to be associated with general stress4 and moral distress5 in recent studies. But there are also new pressures which specifically apply to critical care staff. The pace at which technology has raced ahead of medical ethics has allowed insufficient time to think through the implications of ‘doing everything’ for our patients.6 Patient survival rates are up, but so too are rates of morbidity - and having to make complex treatment decisions in the full glare of social media is a new, particularly 21st century, form of work-related stress in this field.7,8 Furthermore, the welcome move to ward more family-centred care in ICU9 has been associated with a number of unforeseen consequences for nursing staff, such as reduced opportunities for on-the-job peer support and training, as well as increased exposure to the family’s distress.10

But this literature is bewildering. The term ‘burnout’ is a particularly contentious one, in that it is not a formal diagnosis and has no agreed definition. Even when the best known scales are used in studies, scores are interpreted differently in different papers.10 The terms ‘stress’ and ‘burnout’ are used loosely sometimes to mean any type of work-related stress, when the causes of and remedies for *moral distress* are likely to be different to those for *post-traumatic stress*, for example.

In relation to interventions, there is some evidence in favour of cognitive-behavioural approaches and mindfulness12 and the impact of approaches to address burnout appears to be enhanced when they are applied at an organisational level, rather than at the level of the individual.13 In general, however, most reviews conclude that there are very few studies of a good enough quality in this field for anything definitive to be recommended for the prevention of work-related stress in critical care. Indeed some researchers have questioned whether we should be measuring burnout at all, if we do not actually know how best to help someone who reports consistently high scores.14

What is an individual intensive care nurse to make of all this? How can a conscientious professional starting out in critical care best protect themselves against the development of these potential adverse outcomes, while we await the results of the definitive RCTs?

In terms of what can usefully be applied from the current literature on work-related distress in ICU settings and, more widely, from the discipline of occupational psychology, there are three strategies which may be helpful in the meantime: a) monitoring symptoms of stress and satisfaction at regular intervals; b) finding time and space in which to reflect and c) remembering the meaning of your work.

**Monitoring wellbeing**: We are increasingly well informed about our state of physical health and can now access a wealth of information via smartphone as to whether our body mass index is within normal limits or how the quality of our sleep varies from one day to the next. There are also a number of simple scales, readily available online, which measure symptoms of burnout, post-traumatic stress, compassion fatigue,15,16 enabling us to monitor our psychological wellbeing, generally and in relation to our work. In doing so we may be in a better position to identify when we might potentially benefit from taking some time off or seeking extra support, before things get on top of us. In an interesting study by Shanafelt et al17 a group of 1150 surgeons, who were given feedback on their wellbeing scores, were spontaneously prompted by this information to make adjustments to their work-life balance and their lifestyle, which in turn led to improvements in their functioning. This evidence suggests that, whilst acknowledging concerns about the ethics of measuring burnout, it may be necessary to measure a problem in order to appreciate it and do something about it.

Another kind of self-monitoring – of when you last had a break, ate your lunch on time or went home on time – also has a place in relation to self-care and has been recently encouraged, at a organisational level, at a large teaching hospital in the form of the HALT programme, in which staff were reminded to encourage each other to take more regular breaks and provided with information on how to manage their sleep better, particularly when working nightshifts.18

**Making time and space to reflect:** The importance of making time and space to reflect on the demands of this challenging, but vital, role has been eloquently outlined in a recent NICC Editorial.19 At the level of the individual it is not always be possible in a busy workplace, to find someone available to talk a problem over with, but it can prove invaluable to spend even only a few minutes to write down your feelings about a difficult encounter, whether this has been with another member of staff or with a patient or family member. There is evidence that the simple act of labelling an emotion serves to reduce its intensity20 and, in the process of writing about a difficult experience, people often find they naturally begin to come up with their own solutions to the underlying problem that gave rise to the stressful emotions they are examining.21

There are also ways that units can support reflective practice by providing protected time and space for regular discussion of work-related issues, whether in the form of a one-to-one with a supervisor (associated with reduced burnout in one cross-sectional study22) or in groups, at regular staff meetings (associated with lower moral distress in another study23).

Where the predominant symptoms being experienced relate to a particular traumatic event, it may be that a facilitated team debrief is warranted. But if symptoms persist, input from to a mental health professional to facilitate full emotional processing of what has happened, may be required for emotional equilibrium to be restored. Other organisationally mediated forms of support, such as Ethics or Moral Distress Consultation services, or more recently ‘Nursing Ethics Huddles’,24 are also reported in the literature as being helpful in critical care settings.

**Finding the meaning in your work:** Finally, one of the aspects of a person’s approach to their job which is most consistently found to be associated with job satisfaction, and is protective against burnout, is the ability to find meaning in their work role.25

One way to re-connect with your own sense of purpose in relation to your work could be to try writing your own mission statement. In considering how your current role reflects your values and makes use of your strengths, you may realise that some adjustments are necessary. This ‘job crafting’, which has been found to protect against burnout,26 may serve to improve the way you feel about your work and help you derive more direct satisfaction from it.

Put simply, it may well be worth taking the time to remember why you became a nurse in the first place. In this vein it seems fitting to give the final word to a nurse with over 40y experience, who still treasures (almost!) every day, and who did just this, recently:

I wanted to become a nurse from about the age of 5y, as I wanted to help people to get better and live the best lives they could. I wanted to have an impact the lives of others; as I see it, once you are a nurse, you are a nurse for life.

As a nurse you need a broad range of skills, respect, sensitivity and empathy and most importantly be a good communicator. As a child in hospital in the 1960s, I realised how lonely this was and how isolating it is when your parents go home. I have therefore striven, during my career, to encourage families to stay as much as possible, to stop the feeling of loneliness and abandonment that a patient can feel.

Nurses can be trained but they need to have compassion and kindness which comes from their heart, not a book (or a nursing journal!). Great nurses need to be a loyal advocate for their patients – they need to be able to manage the stress of a bad situation, but also to be able to draw strength from a wonderful unexpected outcome. People get better more quickly when they are cared for by nurses who are compassionate and who work with their families to get the best care and most appropriate treatment for them.

Patience and non-judgemental thoughts are useful assets and team working and networking vital, but empathy and kindness are the most valuable tools and help achieve the best outcomes for patients. It is great to be the nurse with the hard skills - adjusting ventilator settings, drawing up IV therapies - but the nurse the patient remembers is the nurse with *soft* skills; the kindness, the empathy and the desire to get them better, so they can get home and back to their lives.

1277 words (inc text in box)

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