# Wellbeing: Successful interventions

While literally tearing down walls to accommodate a surge of Covid patients, the management at the Anaesthesia and Intensive Care Clinic at Södertälje hospital in Sweden adopted a combined approach for resilience, robustness and maintaining staff's physical and mental ability to function at individual and group level. Here, our authors build on the concepts introduced in CRJ 16:4

By employing a methodology for cross-training, the clinic could access a blend of military/field security experience of resilience and science tailored as a toolbox for the health sector.

In the initial stages there was a need for crisis management, but soon enough the challenge and narrative matured. The main issue was performance under pressure over an uncertain and prolonged period of time. This required a different mindset and there was a shift towards pre-emptive interventions to retain staff.

The Covid intensive care unit (ICU) at Södertälje hospital made structured and proactive psychosocial welfare an integral part of its pandemic response. Long-term health and wellbeing of staff were made matters of strategic importance. This translated into tactical preventive measures to identify and reduce stress issues at the earliest stage possible. The strategic goal to preserve the force was allowed to imbue decision-making. As Bengt Cederlund, MD and Chief Medical Officer at Södertälje Hospital, said: "It was used to navigate in the uncharted waters that tested all protocol and stretched all levels in the organisation."

## Transferring methodologies

After two years of monitoring psychosocial wellbeing and mental – as well as physical – health of the clinic's staff and management, the results indicate that approximately around 30 per cent are in the 'risk' zone of mental health issues. In addition, several individuals have developed medical conditions that can be attributed to prolonged stress, such as type 2 diabetes and hypertension.

This article is an in-depth look based on the overview presented in the December 2021 issue of the *CRJ*. We start by looking back on the situation as it emerged.

In March 2020, Managing Director of Anaesthesia and Intensive Care in Södertälje Hospital Stockholm, Sweden Håkan Kalzén MD, PhD, called on Metis Services, experts in human security. It was clear from the start that the Covid-19 pandemic was a novel situation, requiring innovative thinking. At Metis, we believe in the transfer of methodology from one context to another, having successfully used and incorporated insights and tactics from counterterrorism, counterinsurgency and psychological operations in our field security programmes and crime prevention projects on behalf of municipalities in Sweden. A key success factor in the Södertälje model lies in actively looking for similarities rather than differences when developing solutions.

We quickly established a conceptual understanding of Håkan's perception of the problem. His military background meant he not only had the ability to assess a situation from a tactical perspective, but we also had a joint vocabulary. Together, we drilled down through the complexities to find the core challenges and needs – similarities and analogies – from operating in conflict and post-conflict zones. We identified cues together, enabling us to identify patterns and discuss prototype solutions.

Södertälje Hospital provides emergency and hospital care for 233,000 inhabitants in the greater Stockholm region. Initially, the hospital had a total of three to four ICU level two beds and no intermediate care. Covid-19 infected patients are expected to be treated at their local hospital. A socioeconomic structure susceptible to rapid virus spread made the situation in Södertälje more troublesome. Over the course of three weeks, staff numbers were increased from 180 to 320. Half of the recruits had no medical training and needed to be trained rapidly. ICU capacity rose to a total of 17 three to four level ICU beds during the pandemic's first peak.

It was clear that a traditional training set-up was out of the question. Our shared understanding that grew into a mission statement was formulated: "We need to maintain high functional capacity (stridsvärde) among the staff until we can rest. We don't know when that will be. The train has already left the station and we'll have to grease the engine's moving parts while travelling at full speed."

We built our model on three pillars: Capacity building organisational endurance and leadership; stress management and psychosocial environment; and overlapping immediate interventions.

Four main elements set the Södertälje clinic apart. First, it could tap into the experience and transfer knowledge from other sectors, such as military and academic research into decision-making and performance under pressure. Second, it made the move from being reactive to pre-emptive. Third, the interventions integrated

*Staff in transfer following a shift at the Södertälje hospital covid-ICU*
Staffan Löwstedt | Svenska Dagbladet

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organisational endurance with psychosocial environment to be mutually reinforcing. And finally, we can add documentation, monitoring and measuring the impact of stress from the onset of the pandemic and our involvement.

We approached the Södertälje assignment as a team of three. Johan from Metis provided thought leadership, his experience in building resilient organisations with capacity for crisis response and a methodology for cross-training and transfer of skills along the strategic-tactical nexus. Niclas, a military psychologist and PhD candidate on extreme stress, contributed with his knowledge of stress reactions and management. Magdalena brought knowledge in organisational risk mitigation, crisis communication and crisis management. She also played an integral role in forging the overlap, anchoring and building rapport for the model.

Looking at the codified approach, one of the pillars is the scientific subject matter expertise and interventions on mental health, stress and endurance. Here, we combined military experience and field security and strategies with academic research and tools.

Combat and Operational Stress Control (COSC), as developed by the US Marine Corps, comprises policy and methods to identify and address operational stress issues. Combat stress reactions can be either positive and adaptive, or negative; the latter resulting in distress and loss of functioning. Positive or negative, they need to be understood and are a factor in operational risk management.

Stress is understood along a stress continuum and not all stress is harmful. Not tending to negative impact factors is harmful, but even this is not dangerous as long as we ensure recovery. The military perspective also presents a realistic view on casualties; some can be avoided, but some will occur. We need a mindset that prepares us for this. To maintain a cohesive force ready for deployment, a COSC programme aims to prevent, identify and manage impacts of combat and operational stress and promote wellbeing among troops and their families.

In Sweden, the concept of 'stridsvärde' has a long history (*CRJ* 16:4) and indicates capacity to perform a specific task, including both physical and psychological abilities. Stridsvärde is a gradient for functional or combat fitness monitored at individual and group level. It is dynamic, depending on recovery, preparation, experience and expectations. Keeping track of stridsvärde helps to inform a leader if there is the capacity to take on a task and succeed (high stridsvärde), or if we risk failure and are putting too much pressure on personnel (low stridsvärde). In the organisation, there is a vertical line of responsibility running top-down to be informed and assume responsibility, and bottom-up to report status. It also runs horizontally between peers to listen, boost and act in order to maintain the individual and unit's stridsvärde.

Work-related stress should no longer be treated as a matter of simply too much to do and too little time to get the job done. The amount of information we are exposed to, constant availability, along with increased cognitive and emotional load, constitute additive stress (many stressors at the same time) and/or cumulative stress (building up over time).

Different types of stress can appear in combinations. Low-intensity, everyday stressors wear and tear over time and lower the threshold for intense or acute stress. Intense or acute stress can become traumatic if their load supersedes an individual's resources to manage them. The understanding that stress is present all the time informed our model, but such needs are often largely ignored or beyond the realms of assistance provided by an employer. However, the problem arises when low-level stressors accumulate, but the situation can be managed successfully when stress is balanced and recovery administered. Stress is often taught to be closely associated with flight or fight, or play-dead scenarios; so activities to counter stress are focused upon and only triggered *post factum* when the harm is already done.

We knew from the onset of the pandemic that individuals and functions at the hospital were impaired by a negative balance and that the health sector is particularly short-staffed and fraught with sick leave.

In a holistic response, at any given time or in any organisation, there will be a significant number of individuals with unique combinations of stress, vulnerabilities and limitations regarding accessibility of methods and resources to deal with them.

## Communication & camaraderie

Considering the resource-balance model, we acted to stimulate the ability of managers and staff to exercise: Impact; clear communication; mindset about the situation; and camaraderie. These are the types of resources in stress-reducing leadership that have a positive balance vis-á-vis demands that are placed on us. Stimulating daily uplifts can compensate for daily hazards. Monitoring is also important to identify those in need of support and to assume responsibility for psychosocial wellbeing.

Starting in April 2020, we introduced weekly assessments to monitor the load on staff using the psychosocial work environment leadership tool (PWELT) to collect, analyse and provide management with a dashboard to get a temperature check and visualisation of staff conditions and impact on critical functions. It allows for a comparison between units, flagging those whose low scores show a negative balance and internal differences that could potentially cause strain or conflict.

Sensors among staff collect ratings of demand and resource balance and the impact of relevant stressors. The negative impact factors (NIFs) we applied were: Workload; conceptual (regulations, routines, procedures, and systems); moral (mood and psychosocial environment); emotional load; and miscellaneous. Monitoring NIFs helps to avoid the common pitfall of measuring stress but failing to identify psychosocial hazards – ie the stressors and where the threat is coming from. Another use of the tool is to observe changes over time that are too small to stand out, but that indicate trends and opportunities to follow up on interventions. It is also used to respond to hazards as soon they appear. Importantly, management acknowledged stress and sent a very clear signal that: "We care, we're acting, we're in this together and we can all impact our situation." Developments were monitored with weekly follow-ups of impact factors, enabling management to take intelligence-based decisions on how to lead under pressure and informing them as to whether an intervention worked or not. These were phased to avoid – rather than respond – to counselling and sick-leave needs and could be designed with a specific NIF in mind.

Drawing on our findings from the participatory observations and the monitoring, we also sought to address any inhibiting factors.

An immediate effect of introducing the tool was that it gave the organisation the terminology, training and occasion to create awareness and talk about stress.

Stress can be tackled by learning to recognise a stress reaction, what causes it and how to handle it. It made a difference for hospital staff to be able to understand the stress continuum and be able to distinguish between 'fear of fear' and what is actually hazardous, in order to address strong initial fears about the virus. Working closely with strategic support on information sharing and stress management methods, we provided direct support to management and indirect support to staff, to address identified problem areas.

We employed psychoeducation to address specific themes such as interpersonal conflict and to ease the transfer of information, access to treatment, support in self-help and self-care, and to offer a time and safe place to express frustrations constructively.

Building on the experience from military and overseas humanitarian missions, we introduced a package to prepare staff and their families for the reactions and stressors that may surface when on leave or at the end of an assignment. After the first wave in the summer when society was bursting to go back to normal, we recognised a pattern of pressure building up, so we invited all staff to discuss their expectations and any apprehensions.

In addition to moral stress and worries over patient care owing to understaffing, stress about summer leave was high, which caused tension within units, between different professional groups in the hospital and agitation

| A structured methodology of: |
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| Actively building rapport |
| Sizing up/sense-making of the situation – creating an immediate action plan |
| Participatory observation – holistic perspective and deeper understanding |
| Applying the Pareto Principle and a sense of urgency – systematic, calming and avoiding being a digression |
| Going tactical – applying a tactical approach for strategic effect |
| Presence mid-action |
| Maintenance of stridsvärde being mandatory and a standing order |

*Table 1: Principles of the concept developed for the clinic*

towards management. With the finishing line now being moved and much needed and deserved breaks in jeopardy, questions from families about holiday bookings were mounting. So too were anticipations about coming home; some created by staff themselves and others by their families. Many had been working 12-hour shifts for weeks on end. For some, going on holiday felt like the last push over the cliff, with comments such as: "All I want to do is crash in bed," "I'm drained, don't touch me and don't ask anything of me," and, "No-one understands we've been in a warzone; they've been out in the sun playing."

To create awareness of discrepancies in expectations, to make staff aware that they might encounter stress reactions rather than relief going on holiday and to help with feelings of guilt about not enjoying themselves or being able to rest, we produced a leaflet from hospital management aimed at family members.

The inclination to relativise and downplay symptoms of stress was strong. At the same time, compassion fatigue was setting in. We addressed this with a mixture of reading the culture and climate of the particular profession or unit and by making use of parallels to other fields where the expectation of being 'fit-for-fight' is explicit. A stark contrast was made by comparing staff's awareness and levels of self-care with those of truck drivers, pilots and soldiers who view it as a matter of professionalism and are not only obliged, but are also provided with the means, to ensure they are fully operational and to monitor suboptimal conditions.

Management struggled to tend to tasks related to strategic leadership (tasks that were invisible to the staff) and go home for the night; a single person often tried to be available for three shifts. There was a strong element of solidarity among the nurses that made them neglect stress-related issues or stopped them from alerting their peers and management. Out of solidarity, some nurses and, in some cases, a tight unit of doctors, would step in for others in a way that violated all mandatory rest regulations. Other groups nurtured a macho climate of no rest and mystical elitism that was assumed to protect them from fatigue and burnout.

When we implemented a routine, a method or made other adjustments, we soon found that hospital staff, like most people, let go of the remedy as soon as the problem was no longer acute. This is not uncommon. The physiotherapist's dilemma occurs when a patient stops doing rehab exercises or reverts to old habits when the pain is lessened, but before the injury has healed, leading the patient to think that the rehab has not worked and is therefore not worth pursuing. The health profession is well aware of the challenge with patients who stop taking their medicine prematurely. However, it was imperative to explain and repeatedly create awareness around the needs and methods to manage stress and recovery. We needed to address organisational culture and introduce supporting practices like tactical after-action reviews and checking stridsvärde to remind people of the responsibilities to themselves and their peers.

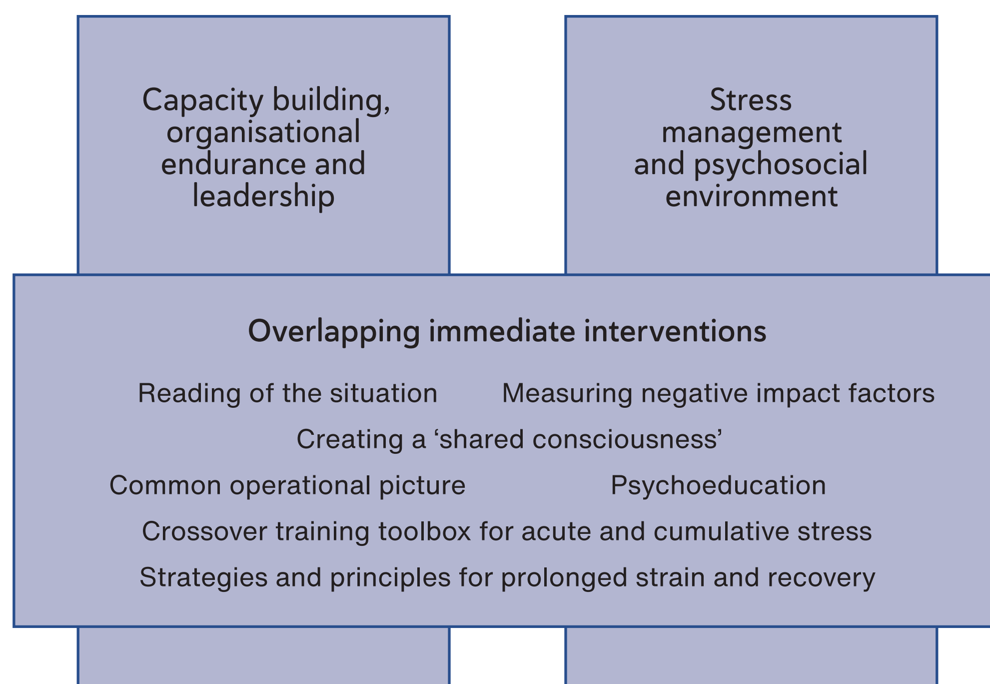
It was crucial – using principles, transferable evidence-based methods and science – to anchor strategy and methods with the entire staff; a group that is highly skilled and professionally trained to review treatments critically and whose members were under intense pressure to respond to various divergent demands. To make it work, Håkan asked us to maintain a presence to remind and mentor staff. This is even more necessary in a civilian organisation that works within a less command-based structure, to emphasise that recovery has to be requisitioned and followed up intimately.

What was, and still is, needed is recovery on a strategic level, addressing not only the imminent need for rest and recuperation, but also the rebuilding of individual and organisational capacity. At the levels of exhaustion most ICU-staff were experiencing, merely removing the stressors or decreasing the workload are not enough. Simply going back to the pre-pandemic workload will not suffice. A more active approach to recuperation to create a positive balance at individual and organisational levels is needed.

Strategic recovery is not the sole responsibility of the individual. The employer needs to ensure that it can – and will – be done. Resources are finite, yet the insight and input regarding recovery must be reflected in the hospital's strategic resource management. To keep staff safe and sound is a moral obligation as well as an investment that pays off and avoids the costs of rental nurses and doctors, sick leave and resources spent on introducing new staff instead of on 'production'. At Södertälje, this eventually fed into a policy and agreements with other larger hospitals, for example, to transfer patients to another ICU.

In anticipation of a new wave, mental health screening was arranged in mid-September, 2020. The goals were to make individuals aware of their level of risk and reflect upon their individual structures for support, and to make the hospital aware of how affected staff were after more than seven months of pandemic response.

Figure 1




A total of 151 people, including management, were screened using a trio of clinical forms to assess the impact of stress on an individual level. We used: The hospital anxiety and depression (HAD) scale; post traumatic stress disorder (PTSD); and the Shirom-Melemed Burnout Measure (SMBM). The screening used external professional staff and representatives from the human resources department were present and ready to refer staff members directly to professional care.

## Intense stress reactions

Our findings indicate that one-third of the staff needed support in some way, either with stress-mitigation strategies, work-life balance, recovery or clinical support. In this group, 20 per cent were at risk and 10 per cent showed symptoms at a clinical level. Almost all of those who scored high experienced anxiety. Only a few showed signs of depression and none indicated PTSD or burnout.

Although stress reactions may be extremely intense, they can be normal, given the situation and exposure. We cannot fully exclude that a portion of these adequate responses feature in the screening. However, in order to provide adequate support and to avoid diagnosing or scaring the larger group into thinking that they are experiencing something that is harmful or signs of poor mental health, it is important to distinguish between what constitutes an adequate response and what does not.

The screenings were a key component to identify individuals in need, barriers to treatment and understand the relevance of differentiated recovery.

When asked, very few of those at-risk or with clinical-level symptoms had taken part in any of the activities or recourses provided. From this, we can infer that the threshold of recognising the need for support is so high that it prevents staff from seeking help based on how they feel. There was also a tendency for staff to normalise their own reactions. The screenings show that a structured way to assess staff individually was needed to identify and prompt active behaviour with regard to supportive needs.

Medical screening of physical health was arranged 15 months after the first wave, as staff started to feel that their physical health had taken a heavy toll. From the 155 people screened, 25 per cent showed abnormal blood-lab findings that needed addressing. We discovered five cases of hypertension, four thyroid malfunctions and three type 2 diabetes. All members of staff were offered screening. The 25 people who did not participate already had an established contact with a GP, owing to a medical condition.

Figures relating to staff retention have, surprisingly, been on a par with the two years prior to the pandemic. However, Södertälje experienced a peak in resignations among anaesthesia nurses occurring recently, 1.5 years into the pandemic. This correlates to a much lower than expected yearly salary increase, a disappointment after having been conscripted to work at the Covid-ICU.

In particular, we noted that according to the preliminary data, the clinic has not seen an increase in long-term sick leave owing to burnout. This stands out in comparison with other neighbouring hospitals.

When asked to reflect on the preliminary results and the dedicated effort to maintain functional fitness, Håkan offered four take-aways:

- It is possible to implement tools used in a different context. It is most likely that doing so saved this ICU from collapse during the challenge of the first pandemic wave in 2020;
- Data showed that stridvärde was kept to a higher degree than in neighbouring hospitals;
- Documentation of methods used makes it possible to learn and implement the codified approach elsewhere in the future; and
- Even though data on our stridsvärde was presented to authorities, new demands were forced upon the organisation, despite awareness that recovery was badly needed.

The data collected seems to indicate that the damage caused to mental health is on a par with that of natural hazards; on average 30 per cent experience symptoms after the event. This was to be expected and it may be that the outcome was inevitable. Given Södertälje's catchment area, its size and staff numbers, at a time when all hospitals were left to fend for themselves, the expectation was that this ICU would be hit particularly hard. It was not.

> The inclination to downplay stress symptoms was strong. At the same time, compassion fatigue was setting in

There is no way of knowing what damage was prevented. The difference we can point to however, is that in the case of Södertälje, the effect on staff was identified and individuals could be referred to adequate support early on. We also see a correlation in staff retention figures being at an all-time high relative to the clinic's pre-pandemic figures and those of other clinics. Perceptions that the organisation is looking out for the individual and unit, as compared to experiencing it as neutral or even hostile, have a positive and immediate effect on alleviating stress.

Our system of monitoring and following up personnel sent an unequivocal message to the entire organisation that staff wellbeing is a priority. And this makes a significant difference.

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