The coronavirus disease 2019 (COVID-19) pandemic has exacerbated an ongoing epidemic of burnout among health care workers (HCWs). Most literature on pandemic-related stress has rightly focused on clinicians. Studies describing the impact on burnout among health care workers (HCWs). Most literature on pandemic-related stress has largely been limited to comparisons between undifferentiated non-clinical staff and frontline clinicians.

This study investigates burnout and sources of COVID-19-related stress among health care risk managers and patient safety practitioners – specifically, members of the Southern California Association of Healthcare Risk Management (SCAHRM). This workforce plays an important role in facilitating the delivery of safe and effective care in both routine and disaster response operations. During the current COVID-19 pandemic, for instance, these workers staff incident command centers respond to emerging threats to patient and staff safety, and even engage in contact tracing/exposure notification.

To the author’s knowledge, this is the first study to address the psychological impact of the COVID-19 pandemic in health care risk management and patient safety professionals.

Methods

An online survey was used, including the Oldenburg Burnout Inventory (OLBI), a validated burnout measure,1,2 and 1 open-ended question: Since the start of the COVID-19 pandemic, what work or non-work-related issues have been causing you the most stress?

The OLBI is a 16-item Likert-type scale made up of two 8-item subscales: exhaustion and disengagement. The instrument is evenly divided between positively and negatively coded items. Negatively coded items relate to the opposite of the subscale constructs (ie, energy and engagement, as opposed to exhaustion and disengagement). Survey items are constructed on a 4-point scale, ranging from strongly agree to strongly disagree, with scoring reversed for negatively coded items. While proprietary, the OLBI is free to use and has been widely applied in studies of the health care workforce. OLBI outcomes were defined by subscale scores, calculated as the mean of the item scores for each subscale (range: 1–4):
Results

A total of 31 participants completed the OLBI, and 27 responded to the open-ended question for an overall response rate of 17% of SCAHRM’s 187 members.

Burnout

Twenty-one (71%) participants had burnout. Twenty-one (71%) were disengaged, all of whom also had burnout. Twenty-four (77%) were exhausted (emotionally), 3 (10%) of whom did not qualify as burned out. Six (19%) had no burnout.

Sources of Stress

Impacts of social distancing (especially the lack of personal interaction) tied for the most common theme, appearing in 48% of responses. Subthemes included work-related and non-work-related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home). Outside of work, the inability to relieve related concerns, as well as the interface between the 2 (eg, effects of working from home).

Regarding the effects of social distancing on work, participants described impaired communication when working from home, as well as degrading work relationships with peers and managers (eg, “...not getting to go out and do the things I enjoy – shopping, church, the gym, travel, seeing family and friends”) and concerns about the social isolation of family members were prominent themes. Difficulties managing family obligations while working from home were also an important issue – especially for the parents of school-aged children (eg, “I think the greatest challenge has been learning to work from home with my kids home! March and April were VERY difficult.”).

Many respondents also described the need to cover for staffing cuts and absenteeism.

Some participants reported new duties (eg, exposure notification, as noted above) and changes to work hours (“We are pretty much on-call 7 days a week and frequently work 12-hour days when we have a list of patients to call”). Less common subthemes included an increased number of adverse events, reduced organizational capacity for handling ordinary safety and compliance work, and the need to develop policies for ethically challenging situations.

Real and potential impacts of the virus, itself, were another important theme, accounting for 19% of responses. The most common subtheme related to fear of family members contracting COVID-19 (eg, “Constantly trying to choke back our own personal fears of contracting COVID at work and bringing it home to my family and my elderly mom who lives with me”). Other subthemes included fear of becoming ill, the emotional toll of patient deaths, and the struggle to keep patients and staff safe from the virus. Failure to follow guidelines on the part of both the general population and staff members was an important part of this last challenge (eg, “One major stress is hearing that some HCWs have continued to work while symptomatic by basically lying at our checkpoints, thereby exposing others unnecessarily. This unethical behavior is by far the biggest stress I have.”).

Financial concerns (both personal and organizational) were an important theme identified by 26% of participants (eg, “impact of unemployment of family members on me and fear if I lose my job” and “Severe cuts in leadership due to financial shortfalls are my most stressful work-related issue.”). One respondent had already been laid off. Another feared losing her/his job, and many described covering for staffing cuts.

The 3 remaining themes were less common. One was untrustworthy and constantly changing guidance, which was identified by 11% of respondents (eg, “Dealing with the constant changes in directives from the CDC [The Centers for Disease Control and Prevention] and Government agencies when it comes to guidance that can literally change overnight,” and “The lack of consistency of rules for business and schools throughout the state. Many high risk activities seem to be permitted while others are not.”). Another theme, reported by 4% of participants, was feeling abused by persons in power. Finally, 11% of participants responded with positive comments about their work during the pandemic, especially regarding management support.

Discussion

Burnout was extremely common, affecting >70% of participants. The sample size (n = 31) was fairly small. Additional research is needed to more robustly estimate the burnout rate among health care risk management and patient safety personnel. However, the findings of this pilot study are sufficient to suggest that burnout is an important issue in this population and that further research is warranted.

Recent attention to burnout among clinicians reflects an overdue acknowledgment that the goals of health care safety apply to everyone in the health care ecosystem. This article expands that logic to non-clinical HCWs, focusing on members of the health care quality and safety workforce, a population that has been mostly (but not entirely) neglected.

Among clinicians and other workers, burnout is associated with impaired work performance. If this holds true among members of the health care risk management and patient safety workforce, burnout among these professionals represents a threat to the
delivery of safe and effective care, both during the pandemic and in the recovery phase, when posttraumatic stress disorder may impose a continuing burden. Turnover related to occupational stress may also lead to poorer outcomes, given the dearth of experienced risk and safety professionals prepared to step into these roles.6

The pandemic-related stressors identified by the participants of this study present important targets for both prevention and mitigation. They broadly align with the “psychological triggers” identified by Meredith et al.9 as important drivers of mental health during large-scale disasters. These include restricted movement, limited resources, trauma exposure, limited information, and perceived personal or family risk.

In designing interventions to address burnout, it is important to differentiate between sources of avoidable suffering (issues with work design, which should be addressed through systems improvement) and unavoidable suffering (which should be addressed by promoting individual resilience).5,10 Expecting workers to shoulder the burdens of unsafe or unnecessarily stressful working conditions through “grit” or resilience is “... an unethical abdication of duty on the part of health care managers.” Many sources of pandemic-related stress, however, are beyond the organization’s scope of control. In these cases, interventions aimed at individual resilience may be warranted.

While additional research is clearly warranted, the findings presented here have led the professional association that hosted the survey to begin designing a peer support program for its members. Health care organizations and other stakeholders should follow suit by taking immediate action to reduce burnout among health care risk management and patient safety personnel. In the longer term, researchers should investigate the causes and consequences of burnout in this population (and among non-clinical HCWs, more generally).

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