I'M FINE PROJECT

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paintings in hospitals

Acknowledgement

This resource is the result of the combined efforts, experiences, and expertise of nurses and colleagues who stepped forward during the COVID-19 pandemic.

It has been made possible through a grant from the Burdett Trust for Nursing and has been designed and developed by the team at Paintings in Hospitals.

For whatever nursing role you took during COVID-19, for every masked moment of care, thank you.

You are seen.

Drum sound rises on the air,

Its throb, my heart.

A voice inside the beat says,

"I know you are tired,

But come. This is the way."

Rumi

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Preface

How will we understand the impact of COVID-19 on nurses? What are the metrics we will use to measure the nursing care innovations, moral injuries, and systematic impacts? Can we collect more than the statistics? How can we count what counted to us and use this to heal ourselves and our health systems?

This *I'm Fine* resource contains information and images to help us heal and make art a part of our healing. It brings together the statistics, policies, and educational practices to help us recover as a profession, as organisations, and as individuals. It brings and builds upon the stories and images of nurses during the COVID-19 pandemic 2020-2022. It allows us to cherish and challenge these images, and potentially change how nurses are seen. This gallery of nurses and nursing images can help us to remember, reflect and recover from our COVID-19 experiences.

The statistics of morbidity and mortality, of workforce trends and resilience 'mends' give a static view devoid of the detail needed to truly notice what nurses did. We know that in the first 17 months of the pandemic COVID-19 killed 115,000 health and care workers, that is 200 a day globally. Nurses make up the majority of healthcare workers but their deaths were not counted separately: we however know many colleagues who have died. For those who survived we continue to deal with ongoing illness, including mental health challenges. However, the problem with statistics is that they do not tell the whole story, the story of what happened behind the masks, behind the curtains, behind the eyes of the nurses who stepped in front of this pandemic. One solution is perhaps to look through another lens, to explore the images and stories behind the *I'm Fine* responses, to see and hear what really happened.

The *I'm Fine* idea grew from collective COVID-19 nursing experiences. Like many experienced nurses, I answered the call to clinical care. Along with thousands of colleagues, I doffed and donned protective clothing (Physical Protective Equipment) and practised mental health survival techniques (Psychological PPE).

From behind a steamy visor, I remember seeing the images of nurses splashed across the media. We got used to seeing nurses enshrined in blue, only their compassionate and exhausted eyes showing, yet somehow able to reflect what those eyes had seen. Such photographs captured critical moments in ITU, showing nurses in full life-saving flow, others caught moments of joy, collective celebration at care well done. Others captured private moments, hands held and tears shed, sharing iPads with families, last words, everyone, unable to let go. Such images shared flashes of life and death moments, making previously invisible nursing skills, visible to all. However, media visibility of the nursing care given is fleeting. The impact of COVID-19 is not.

Our *I'm Fine* images are real, taken from the media showing nursing moments, pathos, professionalism, and joy. They show the expertise and experiences of nurses during COVID-

19. They show nurses in many lights, from the collective noise of public protests for adequate PPE to the (previously) private, singular, silent moments of a lost life.

Our *I'm Fine* resource may be a way to remember, reflect, recover, and even rejoice. Our twenty-first century Florence Nightingale 'lamp' showing others what we did, showing us all what we do. However, such pictures and stories need to be seen and spoken to be shared. They need to be built into education, into supervision, and into our own reflective practice. As with all art, it is what we enable others to see through our images that matters. Maybe *I'm Fine* showing and sharing our COVID-19 legacy.

We, therefore, invite you to pause, look and listen, to take the delicate slowness needed to notice. Notice what is in the images, and what is not. Notice what is in your own reflections, then also what is not.

Please take a moment, give yourself permission to stop and stare at where we have been. Recovery comes from such recognition, from sharing experiences and showing ourselves, honestly, supportively, and compassionately. This *I'm Fine* collection of images connects us and through this connection, as with all moments in nursing, we may heal.

In 2020, 2021, and 2022, for brief moments the media shared nurses' faces. The faces of those who suffered and died doing their job, who shouted and tried to get more PPE, who silently cried, leaning on hospital walls. And then they were gone. With this resource, we remain visible, as does the work we did, we do and will continue to do beyond COVID-19.

Dr Marion Lynch RN RMN

I'm Fine Project

Chapter 1

Introduction: Aim, Approach, and Importance

1.1 Introduction to the I'm Fine Project

June 2021. As I sit here in the dark, in silence, in scrubs, my mask is making my glasses mist up as usual, and my mind is wandering. My colleagues all look the same too and, when asked how we are, we all respond the same. "I'm fine. How are you?" We are not fine.

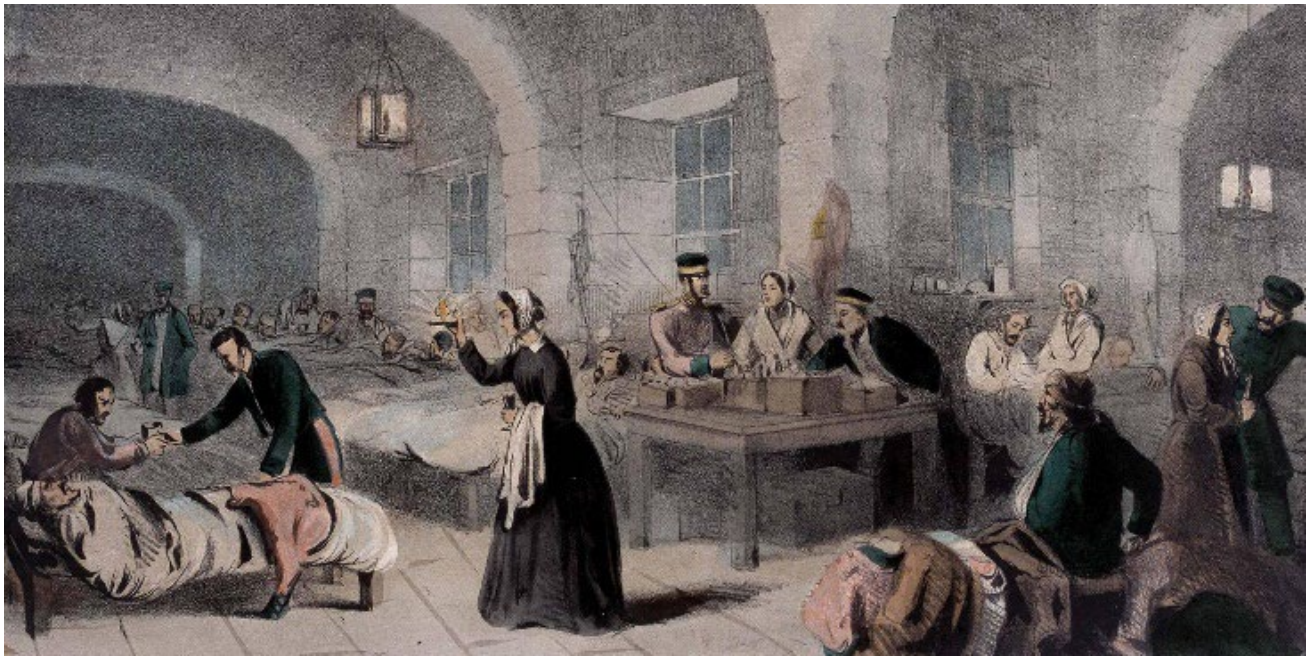
I am however also wondering what this COVID-19 pandemic will look like through the lens of the future.

Images from past pandemics show nurses on the wards, or in the wars, mostly portrayed in the background of paintings but sometimes featuring the foreground of poetry, for example, Longfellow's poem about Florence Nightingale in which he coined the phrase "Lady with the Lamp".

Santa Filomena

A Lady with a lamp shall stand
In the great history of the land.
A noble type of good.
Heroic Womanhood...

Henry Wadsworth Longfellow (1857)



Such words reflect some of the media messages of the COVID-19 pandemic but do not resonate with most nurses' experiences. Nurses do not feel like 'heroic womanhood'.

For 200 years ideas of nursing have been framed by the words and an accompanying image of Nightingale. We could have some new ones for the next 200 years. Our image needs reframing.

Reflecting on the current images of, and impact of, the COVID-19 pandemic on nurses, and the future of our profession, I am left pondering questions about how we will remember this pandemic and recollect the impact it has had?

Questions

- What images will prevail?
- Are they real and do they reflect the reality of nurses' experiences?
- What methods and measures are we using to recollect what happened during the COVID-19 pandemic of 2020/2021 and to reflect on what we did?
- Could we use images of nurses to help us recognise what nurses did?
- Could such images represent innovation, adaptation and compassion?
- Could such images show what we as nurses felt? The community support, the moral injury and the exhaustion?
- Could such representative images help us recover? Recover ourselves and the systems we work in?

1.2 What is the aim of the I'm Fine Project and where did the idea come from?

The aim of the *I'm Fine Project* is to help nurses reflect and reframe our experiences of nursing during COVID-19 to aid our, and our health systems' recovery. We know personal images and experiences help personal reflection and discussion about what happened.

Mary Beard has summarised the idea of arts and health and COVID-19:

> *"The real reason we needed the arts was because we needed to understand what we were going through. I'm not going to sit here and say, what do we need more: a vaccine or the arts? That's a false equivalence. But crises are recovered from by people learning about them. What did we feel and why?"*
>
> Mary Beard 2021

A year before her words the idea for the *I'm Fine Project* formed from seeing the images of nurses splashed across the media. The public got used to seeing nurses enshrined in blue paper, only their compassionate eyes visible. We saw nurses in places most people have never been. We saw nurses involved in personal care, private moments that are not usually seen.

We heard of nurses holding phones to patients' faces, helping families say goodbye. Such images made what had previously been invisible, visible to all. Whilst the media visibility of the care was fleeting. The impact of COVID-19 is not.

Our idea for a gallery of images builds upon artist Tom Croft's Healthcare Heroes work with the Charity Paintings in Hospital (Paintings in Hospitals 2020).

1.3 What is the I'm Fine Project and what approach does it take?

The *I'm Fine Project* brings together the statistics on the workforce alongside the stories from the workforce, told through images and accounts of our own experience. The resource can help us remember, reflect, and recover from our COVID-19 experiences and record these events respectfully and artfully.

The content outlines the context of the current nursing crisis and the opportunities arts offer to address the crisis. The information on workforce issues frames the project in the world of nursing and reflects the challenges being faced. The selected images of nursing reflect the current COVID-19 pandemic experiences and expertise as well as our past.

The images have been chosen in consultation with nursing colleagues and in consideration of the global role nurses play in social justice, equity, health, and wellbeing.

We hope that when looking at the images and reading the blogs you consider how they could be used in your learning and teaching. We hope that you take an educational approach that builds on strengths and abilities that in turn support nurses' psychological wellbeing.

1.4 What approaches are taken?

The *I'm Fine Project* encourages a positive stance to discussion informed by three approaches familiar in nursing; 1) an appreciative inquiry approach to the concept of images and improvement and to the experiences being discussed, 2) a strengths-based approach to the images chosen, 3) a resilience-based clinical supervision (RBCS) approach to the facilitated discussions held to support nurses' health and wellbeing.

1.4.1 Appreciative Inquiry

Appreciative inquiry approaches to supervision. Appreciative inquiry (AI) is an approach to support transformational change and instead of a 'gap analysis' negative situational event analysis' it moves any discussion from a problem-based focus to a strength-based approach.

Such an approach focuses on affirmation, appreciation, and positive dialogue and identifies what went well and why.

The steps taken in an AI approach are:

- Identify and value the best of 'what is' – what is working here and now?
- Envision what else might be. How could we do even better?
- Discuss what should be. What is important that must not be missed?
- Innovation and plan – what will our plan and future be?

1.4.2 Strengths Based Nursing

Strengths-based nursing supports our goals of promoting health, facilitating health, and alleviating suffering by creating environments that work with and support patients (and our own) capacities for health and innate mechanisms of healing (Gottlieb 2014)

1.4.3 Resilience-Based Clinical Supervision (or Restorative)

Resilience-based Clinical Supervision (RBCS) focuses on the 'emotional systems motivating the response to a situation.' RBCS helps people to become aware of how important self-care is, to notice and then question organisational practices which have a negative impact on their own, their colleagues', and their patients' wellbeing.

Such supervision opportunities include elements of mindfulness-based exercises which could include these images to enhance wellbeing, resilience and improve patient care.'

Such reflective discussions require; a safe space, the integration of mindfulness approaches, noticing our emotional systems that create our responses, listening to our internal critical voices, and keeping a compassionate 'flow' to ourselves and so to others. (FONS)

Such positive and solution-based approaches provide a language that communicates nurses' contribution to health and empowers us and our patients to have greater control over our health and healing.

1.5 Why is it important?

We wish to help counter the harm COVID-19 has caused to the population, and to nurses, to do this we need new approaches. The statistics of populations' morbidity and mortality and the workforce trends provide one view of the state of nursing. However, as we mourn the more than 3,000 nurses' lives lost to COVID-19 we also worry about our own and our professions' future.

We know that simply counting nurses will not cure the resilience and recruitment problems. We have all heard that we have a nursing crisis and there are not enough nurses, not for now

and not for the future. The International Council of Nurses estimates we need 13 million nurses to fill the nursing workforce gap caused by past problems, current retention challenges, and an exodus of nurses.

The problem with such statistics is that they are devoid of the detail needed to see what nurses do. They do not tell the stories of what happened behind the masks, behind the curtains, behind the eyes of the nurses who stepped in front of this pandemic. Solutions to retain and sustain the workforce could include hearing and seeing their stories. This is what the *I'm Fine Project* will do.

1.6 How can the I'm Fine Project help nurses?

These images may form a personal moment for reflection or be used within supervision or teaching as a means for group discussion. Stories are also a way to remember, reflect, recover, and even rejoice. They can be our 'lamp' to see what happened. Such stories need not be spoken, they can also be seen. As with all art, it is what we enable others to see matters most. Our stories are the pictures, we share them as symbols of our experiences.

By examining the images and our responses we can take a moment for ourselves. Some of the images come from moments of pain and joy and shows the expertise and experiences of nurses during COVID-19. These images give us the chance to take the delicate slowness needed to notice. Notice what is in the images, and what is not. Notice what is in our reflections, and what is not. To then speak of both and care for ourselves.

They give us permission to stop and stare at where we have been, and to start to recover ourselves. Recovery comes through sharing experiences and showing ourselves, to us and to others. Through this connection, as with all moments in nursing, we may help and heal ourselves. This work is presented online and free to use to aid individual and collective access.

In 2021, for brief moments the media shared nurses' faces. The faces of those who suffered and died doing their job, who shouted and tried to get more PPE, who silently cried, leaning on hospital walls. And then they were gone. With this resource, they remain visible, as does the work nurses did, do, and will continue to do beyond COVID-19. Through the *I'm Fine Project* we remember, reflect, recover, and rejoice.

Chapter 2

Context, COVID-19, Commons Themes and Collaboration

2.1 The COVID-19 Context

The COVID-19 pandemic has harmed health workers (Pappa et al 2020) and shone a light on the impact of inequality on our health, our access to healthcare, and our opportunities to improve both.

It has also shown us how health systems across the world continue

> *"to grapple with the COVID-19 pandemic in addition to the existing challenges of climate change, growing inequality, and increasing complexity in management of chronic disease"*
>
> Javadi, 2021; 1

It has shown us that the harm health workers experience becomes the issues and bottlenecks blocking quality of care. Before the COVID-19 pandemic studies showed the link between staff mental health, burnout, and quality of care and the negative impact on quality of care as well as staff retention and system performance (Morse et al 2012)

During the COVID-19 pandemic, a rapid qualitative appraisal of experiences with personal protective equipment (PPE) (Hoernke et al 2020) highlighted the issues. Health care workers have had to deliver care without adequate PPE, (Garber et al 2020, Rannay et al 2020) or without appropriate fitting PPE (Tabah et al 2020). In a UK study a third of nurses felt pressured to work without adequate protection (Hoernke et al 2020) and in another study half of doctors said the same (Cooper et al 2020).

It has shown us that the experiences of those receiving and delivering care impact on issues and bottlenecks in the system and has also set unprecedented demand on the healthcare workforce around the world and the UK has been one of the most affected countries in Europe. (Andrews et al, 2020).

Whilst the evidence on the practical approaches to addressing these issues is limited, understanding the contextual factors contributing to burnout can provide insights and levers for interventions to improve working conditions and mental health (Javadi 2021). Using the images within this *I'm Fine Project* may help shine a light on the contextual factors.

It is therefore evident that addressing the harm to health workers, physical and psychological (Morse et al 2012) as well as climate change, inequality, and poor-quality systems is crucial if we are to recover from the pandemic and improve health outcomes. How we do this is also crucial.

2.2 Our Theory of Change, Common Themes, and Collaboration

Our approach to the *I'm Fine Project* was to work in partnership with nurses and the arts sector to co-create a resource built upon evidence-based educational approaches, effective approaches to promoting wellbeing, and representative images to assure equity.

Our theory of change process includes:

- Broad engagement with professional associations, education institutions, support organisations, and arts sector plus the people and nurses providing care during COVID-19.
- Analysis of the data and the literature on nursing workforce challenges and policies, identity, quality, and imagery.
- Key questions asked of nurses representing sectors and stages of their career.
- Dialogue with 'critical friends' to expose key power and equity issues in relation to the images available.
- Searches for representative images and selection for test session with nurses.
- Development of educational resource with images for supporting psychological wellbeing.

By mapping the evidence and the context through situational analysis and synthesising the evidence we were able to identify stakeholders, map out the content of the project, and create key chapters.

2.3 Table One: Our findings can be summarised into key themes

Themes	**Strategic/ policy support**
Nursing workforce crisis	WHO State of Nursing report and 2021 recommendations
Impact of COVID-19 on nursing crisis	Evidence search for key papers
Psychological health of nurses post COVID-19	Mental health papers and NHS people plan
Use of arts to support health	WHO evidence brief 2018 APPG UK paper
Combination of both	International Self Care Forum (2021) linked to WHO mental health team.
Equity and justice issues arising	Ethnic disparities in mortality and representation in media
Appropriate conceptual frameworks for approach	Positive affirmation approaches.

2.4 Ongoing dialogue and review of issues

For the *I'm Fine Project* the psychological health needs of nurses are paramount. As the project was developing there were key international and UK commentaries on this crisis that informed our thinking even further.

International

- ICN: Howard Catton. April 2020 flagged risk of burnout. Update Jan 2021 exodus of nurses Impact of COVID-19 on MH is across nursing specialities. Investment in staff and support needed.
- WHO: MH and psychological considerations during the COVID-19 outbreak. Message to healthcare workers. Look after yourself.
- ICN: Dr Michelle Acorn, Chief Nurse ICN. Nurses' mental health will be helped if they are valued and supported and enabled to work to the top of their ability.

National

- RCN: 8/10 nurses say their mental health has been affected by COVID-19 (Nursing Standard survey)
- Donna Kinnair: *"Managing your stress and psychological wellbeing during this time is as important as managing your physical health."*

There were also developments in the use of arts to address mental health issues and support health.

International

- WHO: Christopher Bailey Arts and Health lead WHO spoke of the impact of the Turner exhibition on his health and insights and how the images showed him that what he saw was real.
- WHO: Dr Fahmy Hanna Technical Officer Dept Mental health and substances. *"Many avenues where arts help health, including my own."*

National

- Lord Howarth, UK Parliament All-Party Parliamentary Group (APPG): The impact of arts to support health is self-evident.
- NHS England: James Sanderson, Head of Social Prescribing. Examples of arts are being incorporated into commissioned services shows just how much they are wanted and needed.

The combination of the evidence on the need for action with the interest and energy in the stakeholder groups including We Global Nurses and Nurse Lifeline, plus via partnership with Google Arts & Culture meant the project was supported.

Ongoing Social Media Work

Twitter chats in April, May, and June 2021, conference presentations, and personal conversations have developed a keen interest group and contributions of images.

A set of questions were sent to key stakeholders and the responses raised the issue of appropriate nurse experiences and demographic representation in the media.

By exploring the 'lens' used to see the images we were able to initiate conversations on gender, identity, equity, and ethnicity and how these relate to the nurses' wellbeing.

By shining a light on these key issues, we expanded the conversations to enable people to talk about the invisible aspects of their experience that only an art image could show. This expansion of conversations about wellbeing ensured that equity of justice and power were part of the dialogue. Such key aspects of nursing could not be included in the curriculum.

We, therefore, included non-newspaper images too and proactively sought images representative of all nurses.

An invitation to publish an 800-word article in the British Journal of Nursing has provided a perfect vehicle to share the project once it is complete.

Chapter 3

Nurses and Nursing, Pre, During and Post COVID-19

> *"The definition in law, type of education, levels and scope of practice of nurses varies between countries raising questions of factors and evidence underpinning such variation. Most policy solutions proposed by international bodies draws on data and research about the medical workforce and applies that to nurses, despite the different demographic profile, the work, the career options, the remuneration and the status."*
>
> Drennan and Ross 2019;25

An outline of the stresses and strains on the health systems and the nurses within them place this project in context and enable us as readers to appreciate the issues faced by nurses and nursing, pre, during, and post COVID-19.

3.1 Pre COVID-19

There is a health workforce crisis globally and in the UK. The World Health Organisation notes that there will be a gap of 14.5 million healthcare workers by 2030 (WHO 2016). And in the UK in healthcare, this will rise from a gap of 100,000 to 250,000 by 2030 (Kings Fund 2018a).

For nurses, the international and national situation is also 'a challenge'. Before COVID-19, 2020 had been designated as The International Year of the Nurse and the Midwife (WHO 2020a) was an exceptional opportunity to accelerate implementation of prior resolutions and decisions of the World Health Assembly with respect to the nursing and midwifery workforces.

The year catalysed unparalleled advocacy and data reporting, contributing to the first-ever State of the World's Nursing Report (WHO, 2020b). WHO encouraged countries to build on the evidence and energy and use the report to influence policy on investment in nursing, nurse education and nurse leadership and involvement in health policies and priority setting.

In the UK prior to the pandemic Politicians had promised more workforce; 50,000 more nurses and a £5000 maintenance grant, 6000 more GPs, 50 million more appointments, and £1 billion for social care.

However, health care is also part of social care. Recognising that the NHS is not the only organisation supporting health and wellbeing and looking to the future, workforce analysis shows that we will need 650,000 – 950,000 new adult social care jobs by 2035. (Skills for Care 2020). In UK adult social care, the situation is dire with one in ten social worker and one in 11 care worker posts unfilled. (Kings Fund 2018 (b)).

We build on the positive experiences and images of nurses in the media during the COVID-19 pandemic and acknowledge the challenges and changes we faced and the innovations we led.

3.2 Then came COVID-19

3.2.1 Global Challenges

The year 2020 was already a time of global unprecedented health challenges and global socio-economic disruption. The COVID-19 pandemic reinforced the universal need to protect and invest in all occupations engaged in preparedness and response capacity, in public health functions, and in the delivery of essential health services.

The WHO State of the Worlds Nursing highlights that nurses make up 59% of the health workforce professionals, we, therefore, make up the majority of the workforce. (WHO, 2020)

However, at 27.9 million, of which 19.3 million are professional nurses, there are still not enough. Over 80% of the nurses are in countries that account for 50% of the world population. The global shortage of nurses was about 6.6 million in 2016 and decreased slightly to 5.9 million in 2018. An estimated 5.3 million (89%) of that shortage is in LMICs (Low and Low Middle Income Countries) where the numbers barely keep place with population growth.

To address the shortfall globally the total number of graduates needs to rise by 8% per year on average and there needs to be greater capacity to employ and retain nurses. Without action, the 36 million nurses by 2030 will be 5.7 short of what is needed. That shortage will be most felt in Africa, Southeast Africa, and the Eastern Mediterranean. (WHO, 2020)

A WHO Global Strategic Directions for Nursing and Midwifery (SDNM) 2021-2025 has been drafted (WHO 2021) and presents evidence-based practices and an interrelated set of policy priorities to help countries ensure that midwives and nurses optimally contribute to achieving universal health coverage (UHC) and other population health goals.

3.2.2 Nursing Solutions.

The intended impact of the SDNM is that countries fully enable the contributions of midwives and nurses towards common goals: primary health care (PHC) for UHC and managing the COVID-19 pandemic, mitigating the health effects of climate change, managing international migration, and ensuring access in rural and remote areas and small island developing states.

The SDNM comprises four policy focus areas: education, jobs, leadership, and service delivery.

Each focus area has a "strategic direction" articulating a goal for the five-year period. Enactment of the policy priorities can support advancement along the four "strategic directions":

1. Educating enough midwives and nurses with competencies to meet population health needs,

2. Creating jobs, managing migration, and recruiting and retaining midwives and nurses where they are most needed,
3. Strengthening nursing and midwifery leadership throughout health and academic systems, and,
4. Ensuring midwives and nurses are supported, respected, protected, motivated, and equipped to safely and optimally contribute in their practice settings.

Globally the COVID-19 pandemic highlighted system-wide issues for nurses and nursing. The wider health system challenges of Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) highlight the importance of the health workforce in the response to this and future pandemics.

WHO (2021) called for the contributions of midwives and nurses to be optimized strategically and collectively (WHO, 2021).

> *"The COVID-19 response underscored new and pre-existing priorities for nursing and midwifery education. Responding to the global pandemic has exposed the need for innovative, resilient, and effective methods for the education of midwives and nurses. It also re-emphasized the need for midwives and nurses to be educated with cross-cutting competencies in interprofessional team-based and culturally appropriate care and the use of digital technologies* (Avery et al 2020, Homeyer et al 2018).
>
> *While digital education and simulation sessions are being effectively scaled up for students in some settings (Chen et al 2020, Knobel et al 2020) greater investments are needed to ensure effective learning design, digital accessibility, appropriate assessments and tailored learning, and the support for faculty to design and deliver digital learning."*
>
> WHO 2021;7

Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership (2021) have undertaken research to define a way forward for nursing that prepares us to lead transformational change. This study highlights challenges faced (47% mentioning burnout and possible solutions.

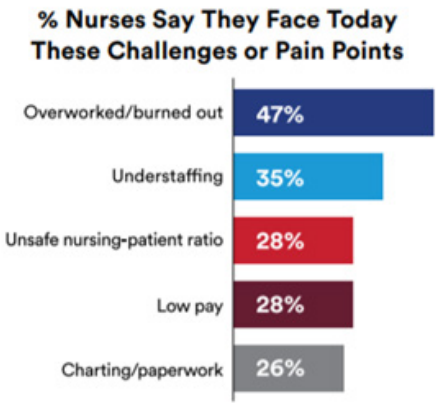


Figure 1. Challenges or pain points facing nurses today. Johnson & Johnson, American Nurses Association, and American Organization for Nursing Leadership (2021)

It recommends that systems prioritise a focus on nurses' wellbeing nurses' mental health and wellbeing.

> *"The pandemic brought enormous strain—mental, physical and emotional—to the nursing workforce, across levels and care types, and will likely affect it for some time. Nurses have experienced feelings of loss of purpose as well as doubt about their own value, judgment, and compassion; they have also experienced high levels of burnout. Nurses may not have had sufficient time to heal or seek help—or they are not being encouraged to do so by employers. Supporting nurses' mental health more openly and comprehensively will not only help them heal from the trauma of the pandemic and reconnect with their purpose, but ultimately it will support patient care, the organization, and the future of the nursing workforce, by reducing the higher risk of attrition that comes with protracted stress, burnout and moral distress."*
>
> Johnson and Johnson 2021; 4

The research, therefore, suggests key steps to enable nurses to lead the transformational change needed to recover from the pandemic one of which is to support our mental health.

3.2.3 Nationally the UK has a major problem.

> *"The current shortfall of nurses represents a major long-term and growing problem for the NHS. And the impact of COVID-19 has brought the urgent need to deal with the identified critical nursing workforce shortages into sharp focus."*
>
> Buchan et al 2020

This challenge sits in the context of a worldwide challenge.

> *"In December 2020 the Health Foundation showed how the UK compares with other high income OECD [Organisation for Economic Co-operation and Development] countries for number of nurses and new nurse graduates. We are below the average. In the UK 15% of registered nurses have trained outside the UK which is double the OECD average, and finally the proposed 50,000 will not be enough to provide the care quality and approaches needed".*
>
> Buchan, 2020

The solutions set by the Kings Fund (2019) to the UK nursing workforce gap and to eliminate nurse staffing shortages by 2028/29 include

- expanding the number of nurses in training,
- expanding routes into training (doubling the number of graduates with other degrees entering training),
- reforming nurse training, expanding range of placements,
- improving support and NHS employment so that more who start training finish training, financial incentives to stay in training.

- Additionally, those already trained need to be retained by ensuring that NHS pay is competitive, becoming a consistently good employer for staff from all backgrounds and across different settings, offering much more support in the early years post-qualification ('preceptorships') when many nurses leave the NHS, offering career pathways and good-quality opportunities for continuous professional development and developing new roles.

However, in the UK during the pandemic 1000s of health workers stepped forward into unfamiliar roles and returned from other roles or retirement to help us cope with COVID-19. The call to action to help was not informed by terms and conditions of employment but by a sense of community and altruism. Such a workforce built on discretionary effort only is not however sustainable, but it is supportable using approaches to support psychological wellbeing. This support is crucial as in 2021, mid or post-pandemic, the workforce challenges are huge and more than the numbers needed to treat a growing number of patients.

3.4 Equality, diversity, and inclusion contributing to the challenges to nursing

The issues faced by nurses and nursing are more than the numbers needed to treat and care for patients. There are systemic issues that create biases, power imbalance, and injustice, all of which are relevant to our psychological wellbeing.

3.4.1 Gender

(Johnson and Johnson (2019) published the report Gender Beliefs, Stereotypes, and Ideologies and noted that some of the ongoing issues facing nursing are those of the structural violence created by the systems we exist in. Some of these pressures come from societal structures and stereotypes including gender bias in nursing.

The gender and power issues in nursing are as old as the profession, however, the thinking behind this is informed by two basic segregation processes in work that are evident in nursing. The first is vertical whereby men tend to dominate the best jobs. The second is horizontal in which cultural or societal notions of gender match people to jobs. This Charles and Grusky framework has been applied to leadership in nursing and suggests why we have more men in leadership positions.

> *"By far the largest category in the Charles and Grusky framework, the cultural mechanisms driving occupational segregation include socio-cultural norms, beliefs, and stereotypes surrounding the role of women and men; for example, the attributes of a good man or woman, what roles are appropriate and what their labour should be.*
>
> *Gender stereotypes that underpin occupational segregation hold, for example, that women are by nature not suited to performing the same jobs or tasks as men and that men are not suited to doing the same jobs or tasks as women.*

Thus, we see the concentration of women in nursing because women are believed to be naturally more suited for care work, and that men are concentrated at the tops of hierarchies because of greater presumed competence.

Research has demonstrated the association between leadership and supposed male-typed traits such as agency, assertiveness, or decisiveness, which challenges women's leadership."

Intrahealth 2019

3.5 Ethnicity

The decolonization challenge of COVID-19 and global health systems is huge and crucial when looking at global health and global health workers. The key aspect for this work is to ensure that there is representation of the workforce and the workforce experiences, and acknowledgement of the issues racism and privilege are causing.

For a UK perspective, demographic evidence for COVID-19 shows that those from a BAME (black, Asian and minority ethnic) background and males have been disproportionately impacted, with age and specific underlying conditions also associated with more severe illness.

- 21% of all staff are BAME – 63% of healthcare workers who died were BAME
- 20% of nursing staff are BAME – 64% of nurses who died were BAME
- 44% of medical staff are BAME – 95% of doctors who died were BAME

Public Health England (GOV UK, 2020) reviewed the disparities in risks and outcomes of COVID-19 and found that:

- The highest age-standardised diagnosis rates of COVID-19 per 100,000 population were in people of black ethnic groups (486 in females and 649 in males) and the lowest were in people of white ethnic groups (220 in females and 224 in males)
- After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of white British ethnicity.
- People of Chinese, Indian, Pakistani, other Asian, Caribbean, and other black ethnicity had between 10-50% higher risk of death when compared to white British.

Research is in place to explore and in time address the issues. The United Kingdom Research study into Ethnicity And COVID-19 outcomes in Healthcare workers (Pareek 2020).

The study represents a unique partnership of leading researchers and clinicians with national organisations including the General Medical Council, Nursing and Midwifery Council, Royal Colleges and ethnic minority healthcare worker associations that will investigate if, how, and why, ethnicity affects COVID-19 clinical outcomes in healthcare workers. Such work will in

time enable us to undo the structural violence that has contributed to the injustice and ill health caused.

3.6 COVID-19 and Racism

The images in the media and the impact of COVID-19 on communities highlight that we are fighting two plagues: COVID-19 and racism. To dismantle racism in nursing we need to notice it in the education we design as well as the work we do. Taking an equity and privilege 'lens' on this project helps us not repeat past failures.

> *"The plague of racism is insidious, entering into our minds as smoothly and quietly and invisibly as floating airborne microbes enter into our bodies to find lifelong purchase in our bloodstreams."*
>
> Waide and Nardi 2019;18

To enable us to act to undo past injustice we reference Brown et al's work building upon Arundhati Roy's vision of the pandemic in India (Roy 2021) as portal for transformation, a chance to start anew, a time to jettison that which no longer serves.

Our work is therefore more than a way to address psychological wellbeing, it is a way to challenge how we think about the impact of COVID-19 on our profession, and in turn examine equity, power, and the plans ahead.

> *"The pandemic has presented nurses with opportunities to shift toward creating a more inclusive and just epistemology. Moving forward, we propose an unfettering of the patterns of knowing, centering emancipatory knowing, ultimately resulting in liberating the patterns from siloization, cocreating justice for praxis."*
>
> Brown et al 2021;1

Additionally, Brown et al remind us that thinking on how we Prescod-Weinstein's ideas are prescient for nursing, an ideology all too often scaffolded around white empiricism and white femininity. He reminds us that Prescod-Weinstein's definition of white empiricism is the:

> *"phenomenon through which only white people (particularly white men) are read has having a fundamental capacity for objectivity and Black people (particularly Black women) are produced as an ontological other"*
>
> Brown et al 2021

The *I'm Fine Project* acknowledges the equity and diversity issues within the work and has applied the Becoming Anti-Racist framework Growth Zone to the analysis of evidence and selection of images.

Figure 2. How to become anti racist. www.surgeryredesign.com

It became evident that the media images of nurses during COVID-19 are not representative of the workforce. Most images in the media were of white female nurses. The project changed its source searches and included the details of the approach.

This means that the images used in this *I'm Fine Project* come from broader sources and are representative. Even more crucially the discussion about privilege, equity, and power is facilitated through the work.

3.7 Looking to the impact of COVID-19 on ways of working and wellbeing

> *"Caring for myself is not self-indulgence, it is self-preservation, & that is an act of political warfare."*
>
> Audre Lorde

3.7.1 International Focus and Nursing

To recover from this pandemic, the need for system and staff support is acknowledged across all health systems and settings internationally, the WHO Global Strategic Directions for Nursing and Midwifery 2021-2025. DRAFT (WHO 2021) outlines that the detrimental effects on mental health have been severe and that the challenges faced will also influence the safety and quality of service delivery.

It also shows how nurses have helped.

> *"While most countries experienced a disruption in health service delivery, many innovated or integrated new service delivery approaches"*
>
> WHO 2021

> *"Responding to the COVID-19 reinforced the need for enabling work environments that support optimized service delivery by midwives and nurses. Health and care workers faced severe challenges in responding to the COVID-19 pandemic, including overburdening, inadequate personal protective equipment and other essential equipment, risk of infection and death, quarantine, social discrimination and attacks, and dual responsibility to care for friends and family members [61, 102-104]."*
>
> WHO, 2021

3.7.2 UK focus and reflection on COVID-19 2020

The 2020 NHS Staff Survey published March [2021] highlights the changes we have faced. Worryingly 44% of staff reported feeling unwell as a result of work-related stress in the last 12 months (q11c)

This measure has seen a marked increase this year (40.3% in 2019) and has increased steadily since 2016 (36.8%)

Increases were sharpest in Acute/Acute & Community Trusts and Acute Specialist Trusts.

The 2020 NHS Staff Survey also found that 44% of staff reported feeling unwell due to work-related stress in the previous year, a steady increase since 2016.

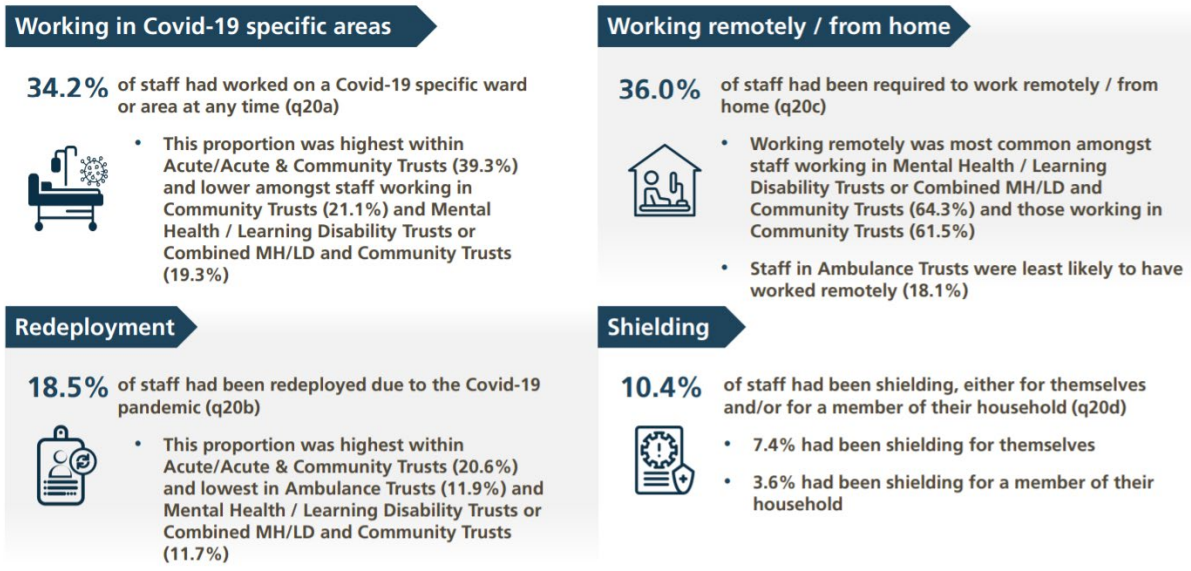


Figure 3. 2020 NHS Staff Survey results (1). https://www.nhsstaffsurveys.com/results/

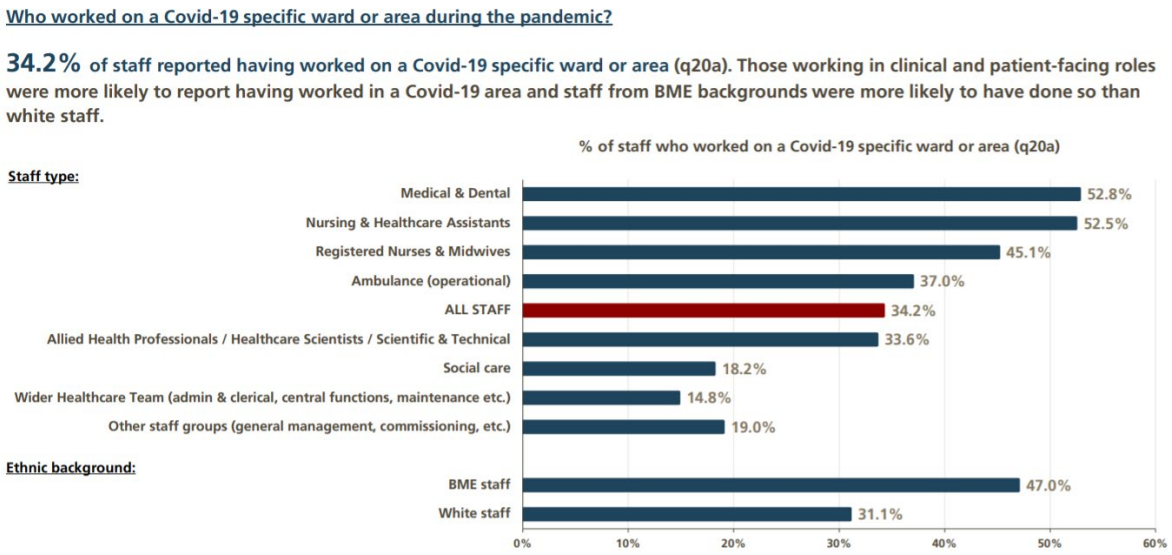


Figure 4. 2020 NHS Staff Survey results (2). https://www.nhsstaffsurveys.com/results/

However, research (Kinman 2020) during the pandemic found that almost six out of ten healthcare staff reported 'good wellbeing'. This sense of wellbeing enabled staff to maybe compensate for the challenges faced.

This feeling of being involved in good work gave a sense of fulfilment and purpose, but it is not enough. Although highly satisfied, engaged, and enthusiastic staff are also at risk of stress and burnout (Kinman 2020)

Additionally, work-related stress, anxiety, and depression are more prevalent among health and social care professionals than most other sectors (Gov 2020).

Investing in the wellbeing of staff is cost effective as well as kind and contributes to patient wellbeing too. (What Works Wellbeing, 2020)

The investment in time and funding in supporting staff through interventions such as the *I'm Fine Project* is not only economically necessary it is also the kind and moral thing to do.

3.8 Why is this important?

Whilst we have the evidence of a gap in staff in the UK as summarised in the House of Commons library report (2020), the health and social care staff are not the only people suffering. Outside of the health service and the health system, we have evidence that:

1. people are anxious about returning to their workplace (CIPD 2021)
2. evidence of mental ill health in other workforces (Health and Safety Executive 2020)
3. pre pandemic evidence and recommendations from the Stevenson and Farmer Review (2017) to inform a way forward to address the mental health needs of the

staff we do have and enable them to thrive and, " prevent mental ill health caused or worsened by work" (Stevenson and Farmer 2017;6) and

4. evidence of what works to improve workforce wellbeing (What Works Wellbeing 2020)

Additionally, the reports of the impact of the COVID-19 pandemic on staff mental health may well be an underestimate. This is because many with serious health problems will have left their roles and there remains a stigma in being open about mental health challenges for nurses (Kinman et al 2020) and doctors (Kinman and Teoh 2020)

These health staff studies have identified the following factors to consider when developing approaches such as the *I'm Fine Project*.

- Psychological distress: higher levels of distress (self-reported mental health problems, sleeping difficulties, and minor cognitive errors) than in the general working population.
- Burnout: the risk of emotional exhaustion is high, with younger staff more vulnerable.
- Post-traumatic stress: with some specialisations (e.g., emergency medicine) more susceptible.
- Suicide: female staff, particularly nurses, are at 24% greater risk than the national average for women.
- Compassion fatigue: a condition characterised by emotional and physical exhaustion leading to difficulties in empathising or feeling compassion for others.

In 2021, mid-pandemic, nurses are recognising their role in supporting healthy and safe working environments, looking after their own health and wellbeing and those of their colleagues. This resource goes some way to help us do this for ourselves and potentially for others. Our approach to the images and the narratives remains conscious of the areas help is needed most and the issues of emotional exhaustion for younger staff and the wider community too.

However, for the purposes of this project, we shall now explore the mental health and mental health support needs of nurses and health care staff.

Chapter 4

Mental Health, Duty, Compassion, and Action

> *"One of the most important things that the Covid-19 pandemic has highlighted over the past year has been that the physical and emotional wellbeing of health and care staff, must be of equal priority to that of patients. This has not always been the case in the past for a number of reasons, including a narrow focus on performance and, sometimes, putting patients' needs ahead of those of staff. Staff who are psychosocially healthy are better able to meet the needs and preferences of patients. So, it is essential to respond to needs of staff now as we emerge from the critical stage of the pandemic and the NHS is in its most fragile state ever."*
>
> Kings Fund 2021 June

4.1 Past approaches and evidence of need

More than 10 years ago the Boorman report (2009) outlined the challenges facing mental health and wellbeing of health workers including recommendations for embedding staff health and wellbeing in NHS systems and infrastructure. This report recommended that

> *"training in health and wellbeing should be an integral part of management training and leadership development at local, regional and national levels and should be built into annual performance assessment and personal development planning processes."*
>
> The Kings Fund, 2009;11

From this report staff wellbeing strategies and services emerged, and staff and wellbeing framework (DoH, 2011) outlined the plans in the Boorman Review (2009) and processes to support the wellbeing of staff.

However, these systems and support processes were not enough to cope with the need COVID-19 created.

4.2 Common issues still having an impact on mental health of health workers

4.2.1 Duty

Duty is always an issue with image and staff wellbeing. The duty to step into the pandemic became a driving force for staff to return to clinical care. Bayerle et al (2021) highlighted this moral issue challenged when health workers carry the community on their shoulders:

> *"The term "duty' has occurred frequently in discussions about the role of healthcare professionals in the current pandemic. Duty can take multiple forms in the professional and private worlds of those working to save the lives of others. At times, different forms of duty create conflicting demands, necessitating some kind of sacrifice."*
>
> Bayerle et al 2021

This sacrifice is not always a healthy action for the health staff.

4.2.2 Compassion

Key research into nurses' mental health was identified by Michael West and colleagues with the Kings Fund. This Kings Fund report noted courage and compassion and identified the impact COVID-19 and provided recommendations to address nurses' mental health (West et al 2020).

> *"The impact of the pandemic on the nursing and midwifery workforce has been unprecedented and will be felt for a long time to come. The crisis has also laid bare and exacerbated longstanding problems faced by nurses and midwives, including inequalities, inadequate working conditions and chronic excessive work pressures."*
>
> West et al 2020

4.2.3 Nurses' Image and Nurses' Words: Lessons from COVID-19

Although a crucial aspect of life and care, as shown in the TED talk (Trzeciak 2018) 8) compassion is not enough.

Nurses are not just about compassion and historical stereotypes and current media images need to be challenges to ensure that the safety-critical, science-based aspects of nursing are as clearly articulated as the kindness and compassion tropes. This is an opportunity to challenge some of the myths through the images we use and maybe some of the stereotypes and harm too.

Rafferty's (2021) lecture from Oxford University on this outlines the issues and opportunities we have to shift the image and help nurses' health.

We now need to listen and learn from the experiences of COVID-19, include both compassion and nurse capabilities in our images used to take care of ourselves as staff.

Kitson et al (2021) provides us with lessons from COVID-19.

4.4 Required action

We need to move beyond conversations about duty, compassion, and image. We need some resources.

> *"Nursing staff are starting to talk about the relentlessness of COVID, the waves of sick patients, the huge death toll unexperienced by many in their career, the physical, mental and emotional exhaustion, individuals coping with their own private grief and trauma and then having to find the strength and resilience to care for others. If the health system is in crisis itself then the systemic manifestations of chronic overwork and stress will come to the fore. Intolerance, frustration, exhaustion, burnout are symptoms of people in a system not having sufficient respite or time out to recover and rebuild their capacity to care.*
>
> *During the first COVID wave, there was a lot of positive attention for doctors and nurses: everyone saw that they did an extraordinary job; they were acknowledged by being provided with extra food, snacks, cards and even public rounds of applause. In the second wave (which was much longer) the work became 'normalized'—it was normal that nurses do 'their job' in the EDs, on the COVID wards and ICUs, and nurses (and the rest of the team) had to cope with many sicker patients.*
>
> *Now as we anticipate the third wave, the workforce is starting to feel apathetic and disconnected from what 'normal' felt like in a pre-COVID world. We will not be able to go back to how it was before COVID, and it might be challenging to think about how we can look into the future—in a positive way—but we must be able to do this, and it requires strong leadership and an ability to learn from our experiences; so we are better prepared for such future scenarios.*
>
> *Nursing staff are starting to talk about the relentlessness of COVID, the waves of sick patients, the huge death toll unexperienced by many in their career, the physical, mental and emotional exhaustion, individuals coping with their own private grief and trauma and then having to find the strength and resilience to care for others. If the health system is in crisis itself then the systemic manifestations of chronic overwork and stress will come to the fore. Intolerance, frustration, exhaustion, burnout are symptoms of people in a system not having sufficient respite or time out to recover and rebuild their capacity to care."*
>
> Kitson et al 2021

> *"Despite the emphasis on the organisation and wider system, individual nurses and midwives should take steps to engage in appropriate self-care and develop a 'tool-box' of stress management and resilience-building skills."*
>
> Kinman et al 2020;8

We need to look at the culture and structures in place to support health, wellbeing, and motivation at work, to minimise workplace stress.

Our *I'm Fine Project* needs to utilise the research evidence within the West et al paper (2021) and design the content to meet staffs' needs. West et al (2021) suggests that people have three core needs:

- autonomy – the need to have control over their work lives, and to be able to act consistently with their values
- belonging – the need to be connected to, cared for, and caring of others around them at work, and to feel valued, respected, and supported
- contribution– the need to experience effectiveness in what they do and deliver valued outcomes.

For people to flourish and thrive at work, all three must be met. West et al (2020) went on to identify eight key areas where action is needed to ensure these core needs are met.

Figure 1: The ABC framework of nurses' and midwives' core work needs

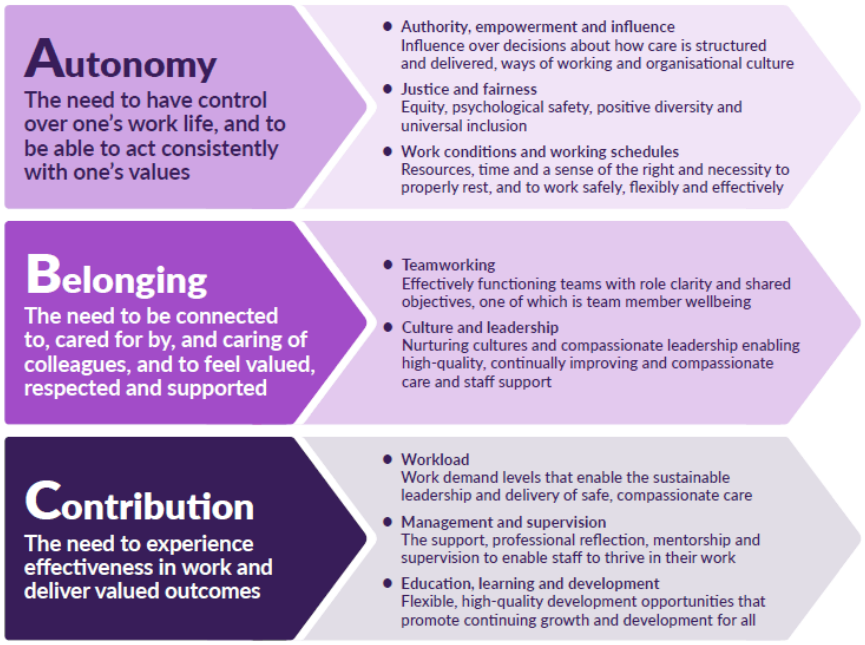


Figure 5. The ABC framework of nurses' and midwives' core work needs. West et al (2020).

LEFT: The courage of compassion, West et al (2020). RIGHT: The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom, Kinman et al (2020)

West et al (2020) in the Kings Fund paper recommendations for action are:

1. Authority, empowerment, and influence. Introduce mechanisms for nursing and midwifery staff to shape the cultures and processes of their organisations and influence decisions about how care is structured and delivered.
2. Justice and fairness. Nurture and sustain just, fair and psychologically safe cultures and ensure equity, proactive and positive approaches to diversity and universal inclusion.
3. Work conditions and working schedules. Introduce minimum standards for facilities and working conditions for nursing and midwifery staff in all health and care organisations.
4. Teamworking. Develop and support effective multidisciplinary teamworking for all nursing and midwifery staff across health and care services.
5. Culture and leadership. Ensure health and care environments have compassionate leadership and nurturing cultures that enable both care and staff support to be high-quality, continually improving and compassionate.
6. Workload. Tackle chronic excessive work demands in nursing and midwifery, which exceed the capacity of nurses and midwives to sustainably lead and deliver safe, high-quality care and which damage their health and wellbeing.
7. Management and supervision. Ensure all nursing and midwifery staff have the effective support, professional reflection, mentorship and supervision needed to thrive in their roles.
8. Learning, education and development. Ensure the right systems, frameworks and processes are in place for nurses' and midwives' learning, education and development throughout their careers. These must also promote fair and equitable outcomes.

Whilst this *I'm Fine Project* cannot deliver all of these it can recognize the principles within them, bring these to the attention of users, and contribute to a fair system and culture of compassion.

4.5 Conclusion

The breadth of literature reviewed in designing this project highlights that there has historically been significant work undertaken to identify nurses' mental health issues, however, in contrast, not enough has been done to address the issue. Before COVID-19 little progress has been made in taking forward the Boorman 2009 recommendations. The 2021 policy paper developed by nursing organisation C3 highlights the evidence and issues around nurses' mental health. Within their policy paper, they summarised the work undertaken to identify the issues and the gaps in work to address the issues. (c3, 2021)

Learning from the evidence and the experiences of nurses and acknowledging the system issues in relation to duty and compassion, gender, privilege, equity, and image our resource

is designed to support positive images and action and provide a psychologically safe, equity focussed learning resource that contributes to a nurturing environment.

Nurses' mental health has therefore hit another crisis point and action is needed. Supporting and transforming the working lives of nursing and midwifery staff supports patients too and improves the quality and sustainability of the care we provide.

Such actions require a strategic approach to ensure that nurse wellbeing is included in national plans. Such an approach needs to be integrated, coherent, and comprehensive. Such approaches may also include the arts.

Such approaches also need to support the development of culture, of compassion, promote fairness, and foster individual, team, and organisational wellbeing.

This *I'm Fine Project* resource needs to help enable people to have autonomy, connect and contribute. It needs to enable them to acknowledge the issues of image and duty and enable them to practice compassion.

We will therefore aim to create an environment that ensures nurses are seen and heard, valued, and respected and provides the psychological safety needed.

Chapter 5

Psychological Safety and Moral Injury

Brooks et al (2019;25) has explored traumatic stress within disaster exposed occupations and states that:

> *"There are many social and occupational factors which affect post disaster mental health. In particular, effective social support, both during and post disaster appears to enhance psychological resilience. The development and evaluation of workplace interventions designed to help managers facilitate psychological resilience in their workforce is a priority."*

Looking at the literature on nurses, nursing and COVID-19 is has become apparent that there are some key social and occupational factors to consider when designing an intervention to support discussion and mental health.

5.1 The language we use

Language does more than describe things, it defines them. It is therefore important when designing an initiative that we are clear about the language we are using, and not using.

In 2021 we are acknowledging that the term resilience may be doing more harm than good and that, "the 'super nurse' culture puts too much responsibility on staff – they are human beings, not machines" (Dall'Ora, 2021).

We are therefore choosing to not use the term resilience or hero in this work, acknowledging that the term hero has been valued by the public and used in previous work with Paintings in Hospitals.

The terms kindness and compassion are valued and such approaches with kindness as a central concept have previously been shown to do good (McSherry 2017). We are therefore using the troupes of kindness and compassion, again acknowledging the need to also speak of nurse capabilities and work culture

5.2 The stories we tell

The evidence of the impact of COVID-19 on nurses is published both in nursing journals and the public press. Three papers summarise the issues that inform this project and ensure that we are meeting a need expressed in the literature and in the lives of nurses.

Lake et al (2021) outlines hospital nurses' moral distress and mental health during COVID-19;

> *"Pandemic patient care situations are the greatest sources of nurses' moral distress. Effective leadership communication, fewer COVID-19 patients, and access to protective equipment decrease moral distress, which influences longer-term mental health."*
>
> Lake et al 2021

Roberts et al (2020) outlines how respiratory nurses did not get the support they needed during COVID-19; and evidence that the mental health of ITU nurses has taken a heavier toll is outlined by Gormes et al 2021.

5.3 Psychological safety and the system we work in

The systems we work within, be that the language, the evidence as already mentioned, and the environment all contribute to our psychological safety.

> *"Psychological safety was originally defined in 1990 as an individual's, "sense of being able to show and employ oneself without fear of negative consequences to self-image, status or career."*
>
> Kahn 1990;692

> *"Psychological safety can also be applied in the context of working in teams as "a shared belief that the team is safe for interpersonal risk taking."*
>
> Edmondson 1999

However, Carmeli et all (2008) have noted that:

> *"Many of the factors that contribute to psychological safety are not malleable or easy to change (especially within the constraints of a resource poor environment). It is also likely to be the case that some factors promoting psychological safety will be unique to the team itself, and the individual personalities and stresses that are found within that particular environment."*
>
> (Carmeli et al, 2008)

However, Cave et al (2016) outline how to create safety in teams. Additionally, the evidence base from Grailey et al 2021 on psychological safety provides a framework for this project to use. Grailey et al (2021) has identified key barriers and enablers at individual team and organisation levels.

By using this evidence and structure the approach is grounded in safe and effective methods and so can be used to address mental health discussions for nurses. This framework as well as the language, image, and stories will tell all combine to help us design the *I'm Fine Project.*

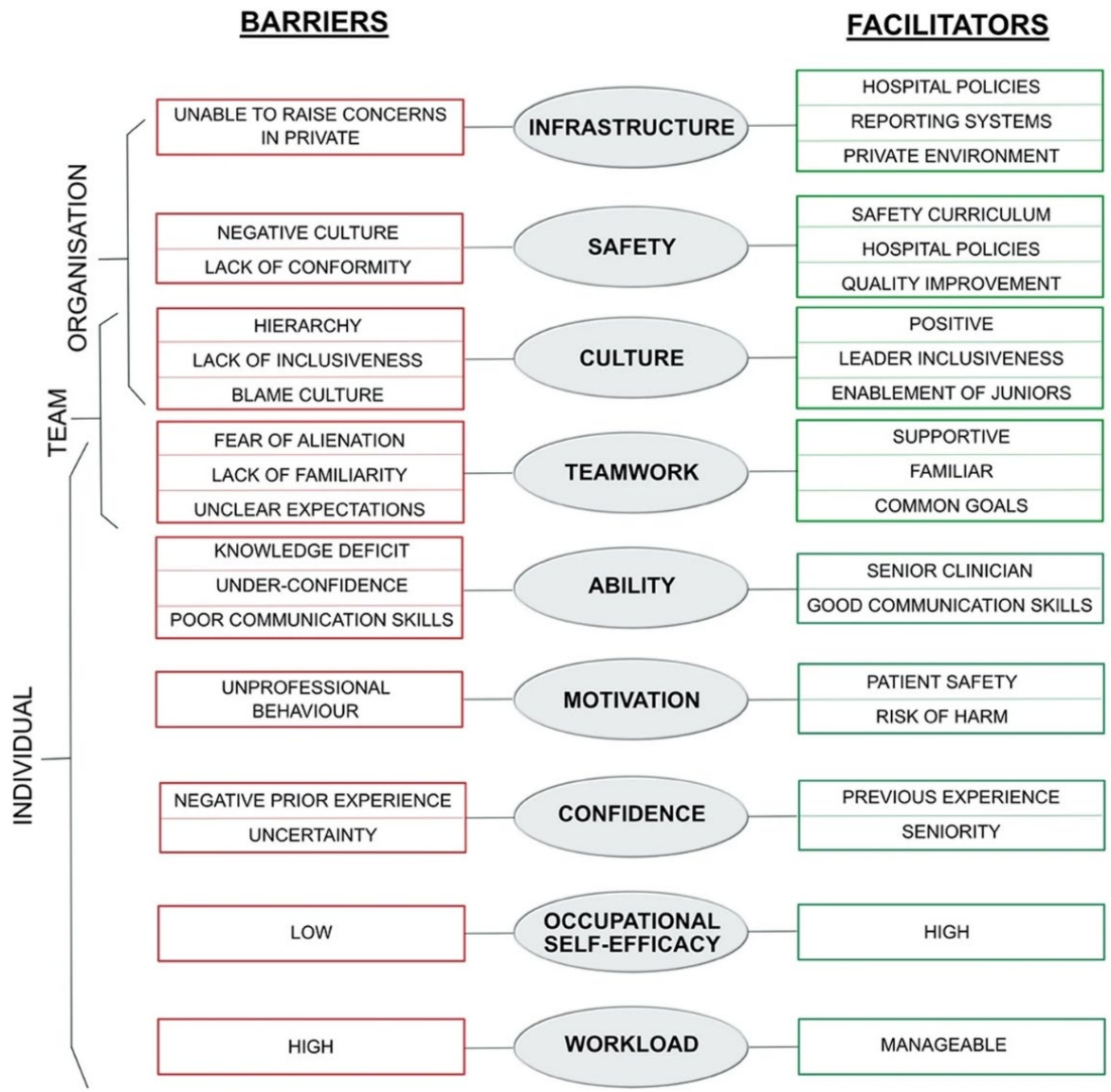
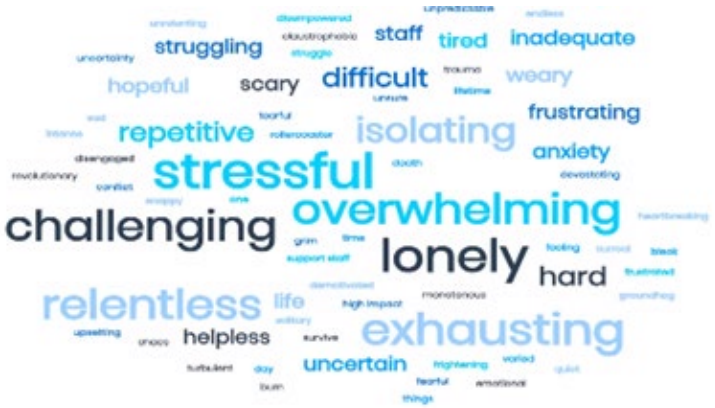


Figure 6. Diagram illustrating the barriers and facilitators to psychological safety. Grailey et al (2021)

5.4 So what does practicing psychological safety look like?

Support comes in many ways. When we ask for words during online conversations to describe peoples' experiences of the COVID-19 pandemic they say:



Such statements also support the evidence that there is a need for action and that whenever people face uncertainty and interdependence psychological safety is essential

Harvard's Amy Edmondson, a lead authority on Psychological Safety, proposes the exemplary behaviours to support effective teams and psychological safety:

- frame the work as a learning problem and not an execution problem
- acknowledge your own fallibility
- model curiosity and ask lots of questions.

She also notes ways to ensure that you are effective (Edmondson and Hugander 2021)

- focus on performance
- train individuals and teams
- use visualisation
- normalise vulnerability related to work.

Compassionate leadership also forms a key component of psychological safety. (West 2018).

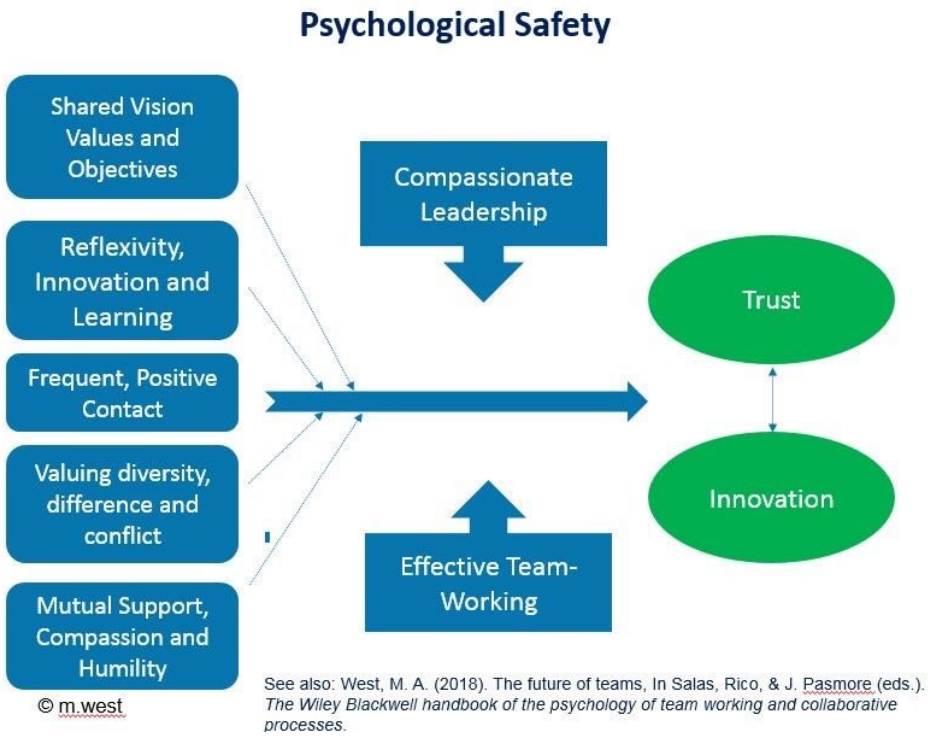


Figure 7. Components of Psychological safety. West (2018)

5.5 Moral Injury

> *"The term refers to psychological, social and spiritual suffering stemming from violation of moral expectations and beliefs by one's own or other people's actions. The concept of*

moral injury has become well-known in research on soldiers and is being increasingly applied to healthcare workers, police officers and humanitarian aid professionals."

Molendjik 2021

Whilst the term moral injury, more familiar in the military, as Molendjik (2021) states has become synonymous with the experiences in health work during COVID-19. Neil Greenberg 2021 describes it best:

"The COVID-19 pandemic has pushed our global healthcare systems and workers to their limits. Clinical infrastructure around the world crumbled as waves of the virus swept across countries. Many doctors and nurses have had to make seemingly impossible decisions, including distributing limited resources, choosing which patients to give oxygen to, and which medicines to try, amongst others. Our healthcare front-liners have been in morally ambiguous situations with no 'correct' answers, but decisions still had to be made. By studying past traumatic events, we know that we can expect substantial mental healthcare repercussions in this community due to moral injury unless we act today. It's worth spending a few minutes understanding the history of moral injury, what it means for healthcare workers in the pandemic, and how we can build resilience.

The concept of moral injury has been around for centuries but was highlighted in military contexts during the Vietnam War. American troops found themselves in morally unclear events and were tired, exhausted, and traumatised but, on many occasions, had to act without sufficient information to enable them to properly assess the situation. When they returned home, they experienced psychological distress symptoms linked to events beyond the death and trauma of war, and we observed 'moral injuries'. Many of them who identified as 'family oriented' and 'good, loving parents' began to feel disappointed in themselves for what they had done and wondered whether they could ever be forgiven. They felt betrayed and let down by people who sent them to war and felt they should never have been in that situation in the first place. "

"There are three ways in which we experience moral injury; (1) acts of commission (things you or other people have done), (2) acts of omission (things you or other people could not or did not do), and (3) betrayal (being let down by people you thought you could trust or who should have been looking out for your welfare). During the first wave in the UK, we surveyed 25,000 healthcare workers and unearthed some interesting data. We found that the most significant impact of moral injury was betrayal. The experience of betrayal in nurses usually manifested in feeling let down by their teams and managers, and for doctors, it manifested as disappointment in society and healthcare systems. So many felt let down that they were doing their best in the worst circumstances. Still, society continued to socialise, refused to wear masks, and indulged freely in concerts, weddings, and other events."

"Examining traumas more generally, we find that there are three stages; pre-trauma, trauma, and post-trauma. The risk of developing long term psychological distress can vary from person to person based on who they were (socioeconomic status, history of mental illness, social support, poor education etc.) in the pre-trauma stage and the intensity of the trauma itself. However, we find that the strongest predictor of mental health repercussions comes from the experience during the post-trauma stage. People who have strong social support, lower exposure to stress, and exhibit help-seeking behaviour early, are much more likely to have a positive outcome than those who don't. This period we are in right now and how we handle it will be the strongest predictor in how our healthcare workers recover from the mental shock of the pandemic. If we can

> *build solid mental health support systems, we may reduce the number of people who have long term mental health conditions while maximising the experience of post-traumatic growth, which describes increases in personal and group resilience as a result of being exposed to adversity."*
>
> Greenberg 2021

> *"One of the biggest misconceptions of moral injury is to believe it's an illness that only psychiatrists and psychologists can help solve. However, since healthcare is a very team-based profession, we can find many answers within the healthcare community in which the person works. To begin with, individuals mustn't wait for their distress to deepen and intensify before they seek help. This is dangerous for the individual and creates a complex situation for any therapist, who, perhaps, could have intervened more successfully at a much earlier stage.*

He also outlines what can make a positive difference.

> *We have observed three things that make a big difference in alleviating moral injury in healthcare teams:*
>
> - *Ensuring all supervisors are confident in speaking about mental health and having 'psychologically savvy' conversations to encourage early help-seeking behaviour. We have found that giving a simple one-hour training course on asking the right questions leads to almost a doubling in the proportion of supervisors who feel confident to speak about mental health with their staff.*
> - *Ensuring that some individuals within the team receive evidence-based peer support training, which allows them to formally check on colleagues who have been exposed to trauma or morally challenging situations. This will enable them to identify if they need support or if they do not recover, whether they have mental health symptoms that may require attention.*
> - *Practising 'reflection' where the team gets together to try and make sense of the situation they are in and build meaningful narratives so everyone can benefit."*

Our resource helps with reflection and we hope, by including the evidence base, also helps with how we practice and the policies we develop. However, there is a danger in our approaches and a risk that we romanticise moral injury.

> *"the concept of moral injury not only* refers *to morally significant experiences but has great moral significance* as a concept, *carrying normative claims about the nature and causes of moral conflict-coloured suffering, with both positive and negative consequences."*
>
> Molendjik 2021

Our approach is therefore focused on shining a light on the issue in a realistic way and supporting others to do the same.

Ways of doing this, such as WHO Psychological First Aid, Society of Occupational Medicine Managing and re-work descriptors on effective teams stress and burnout and fatigue in health and social care are informing the design of the *I'm Fine Project.*

Chapter 6

How Can the Arts Help? Evidence and Engagement

The art and science of nursing is more than compassion and competence. The linking to arts is more than aesthetic. The challenges to how we know what we know applies both to knowing and to art.

> *"As a science based organisation, WHO puts a lot of emphasis on evidence and data. A At the same time, we must acknowledge that art has the power to inspire and communicate in ways that guidelines, graphs and charts don't. To achieve our goals, we must use every tool at our disposal to change behaviours and drive impact."*
>
> Tedros Adhanom Ghebreyesus, Director General of the World Health Organisation

> *"Art is a universal language. Art has no borders and promotes diversity in unity. It responds to our need to share, inspire and transform. It transcends our perceptions and senses to reveal our infinite potential."*
>
> Isabelle Wachsmuth, World Health Organisation

6.1 Ways of Knowing in Nursing

Lauden (1996) tells us that theories are the way to solve the problem of science and so we are using theories to explain our approaches to how nurses may use arts to help with psychological wellbeing. To explain where this sits in nursing theories it may help to explain nursing knowledge.

To aid this thinking we need to explain the types of knowledge nurses need. The synthesis of our experiences requires that nurses work with eight types of knowledge.

Eight Types of Knowledge

1. Empirical, the science
2. Aesthetic, the art
3. Ethical, the ethics of what we do
4. Personal knowing, the interpretation of what we do
5. Socio political, the policies and politics of nurses
6. Emancipatory, the policy and politics of change
7. Spiritual, the spirituality
8. Unknowing, the not knowing what is happening but knowing how to be authentically present.

These ways of knowing are experienced as:

> **Explicit and Implicit Knowing.** (Zander 2007;8)
>
> Explicit knowing is the formal information gained from written words, maps or symbols
>
> Implicit / tacit knowing is the knowledge gained from experience, interaction and the acquisition and combination of skills

Art is part of our health and wellbeing in nursing during COVID-19 and is shown so clearly in the studies exploring health professionals' experiences of COVID-19. For example, Badanta et al (2021) work "A Picture is worth a 1000 words" using photovoice and Lynch et al (ICN 2021 in press) exploration of images and stories shared from nurses from across Europe.

6.2 The evidence base: Key papers on the impact of arts in health inform the thinking

Fancourt and Finn (2019) with WHO outline the evidence on the role of the arts in improving health and wellbeing. This is the first-ever WHO report on the evidence base for arts and health interventions. The Health Evidence Network (HEN) synthesis report maps the global academic literature in English and Russian. It references over 900 publications, including 200 reviews covering over 3000 further studies. As such, the report represents the most comprehensive evidence review of arts and health to date. (WHO, 2019).

Sonke et al (2017) white paper talks about arts in health, 2017 and Daykin et al 2020 outline the role of social capital in arts and wellbeing. This evidence from WHO is welcomed and also questioned and there is a request that the health and social impact needs a robust critical lens (Clift et al 2021). WHO is also leading other work on arts in health highlighted by Christopher Bailey who speaks about the psychosocial support. This conversation recognises the cultural differences and how support conversations for individuals or communities vary.

The conversation stresses that arts do this and take away from the individual focus of psychosocial cure. It is therefore arrogant of us to go to communities because it has existed in some countries for millennia. In the UK, the creative arts movement is not new either.

> *"Creative Health demands a systematic response, but that response has been too slow for those who flinch at new thinking. So, the creative health movement have deployed other powers – leadership, passion, persuasion, patience, skills and sustained commitment."*
>
> Lord Howarth of Newport. Twitter

6.3 The Evidence Base in Medical Education

The field of the use of the humanities and the arts in medical and nursing education is well researched and reported, however, there is a challenge that the use of the arts in medical education is not as rigorously researched as other methods of education.

> *"This literature is characterized by brief, episodic instalments, privileging a bio medical orientation and largely lacking a theoretical frame to weave instalments into a larger story that accumulates over time and across subfields.*
>
> *These findings should inform efforts to promote, integrate and study the use of arts and the humanities in medical education."*
>
> Moniz et al 2021

6.4 Social Capital and Engagement in the Arts during the COVID-19 Pandemic

The evidence of the impact of art on health is important during this pandemic, (Amsen 2021) the arts have been missed and they keep us healthy and happy (WHO 2019) and involvement in the arts builds social capital (Daykin 2021). Social capital is linked to wellbeing as so a key aspect of this work. This explicit link to wellbeing links social capital with the *I'm Fine Project.*

> *"In recent years, wellbeing has come to the fore in research and policy, and subjective wellbeing is increasingly measured at population level in many countries. Wellbeing is a broader concept than health, suggesting a positive state shaped by subjective feelings as well as social experiences.*
>
> *Wellbeing is intrinsically valuable and is associated with many desirable social outcomes, such as those relating to health, education and employment (Huppert, 2017). There is no universally agreed measure of wellbeing, but most indicators encompass hedonic dimensions, such as feelings of happiness or anxiety, as well as eudemonic dimensions focused on perceptions of the extent of meaning and purpose in one's life.*
>
> Daykin et al., 2020

The concept of social capital also links into the changes in the health system that support social prescribing and this, in turn, links this project to the wider shift to working with the arts to help health.

> *"Questions about social capital are relevant in the context of recent trends towards social prescribing and asset-based approaches to health and wellbeing* (Chatterjee et al., 2018; Daykin, 2019).
>
> *These draw on social movement theory, viewing health oriented social movements as assets that can be harnessed to develop shared solutions to common challenges* (Burbidge, 2017; Del Castillo et al., 2016; Kapilashrami et al., 2015).
>
> *Social movement theory challenges public health institutions in Western neo-liberal societies, regarded as ill-suited to fostering social relatedness and trust, to become more agile* (Edmondson, 2003).
>
> *Harnessing social capital through participatory arts is not a straightforward process, as bonding and bridging are contingent on many factors, including participants' responses and the extent to which people view local community assets and networks as representative of their needs* (Campbell & McLean, 2002).
>
> *Nevertheless, social movements can potentially utilize social capital processes to successfully make demands on power holders regarding service provision, resources, and support. Social capital, social movements, and global public health: Fighting for health-enabling contexts in marginalised settings."* (Campbell 2019)

From an emotional perspective, the isolation and loneliness experienced by some during the pandemic could be redressed through engagement in the arts as the arts help us cope.

> *"Loneliness is the inability to express what matters to you most."*
>
> Karl Jung quoted by Christopher Bailey WHO

6.5 How the arts helped during COVID?

The *I'm Fine Project* can help develop social capital and psychological safety and is an asset-based resource to reflect on experiences, moral injury, and support wellbeing. The National Organisation of Arts in Health (NOAH 2020) in the US summarised the issues and challenges.

An Arts and Healthcare Provider Burnout group asked

> *How can NOAH best advance this initiative on how the arts contribute to clinician wellbeing through interventions at cultural, organizational, and individual levels?*

The response was,

> *"The first step is to create greater awareness across the healthcare industry of how the creative and expressive arts can improve staff wellbeing, build resilience, and address burnout."*
>
> NOAH 2021;8

There is often a community focus on engagement with the arts with photography being one way to link image and action. Guidance is available in how to engage communities in the arts.

> *Aebischer et al (2021) provide a snapshot of how arts engagement and the arts themselves have helped during the pandemic and beyond work*

Within medical education, the arts and humanities contribute immensely and immeasurably to medical education. As different ways of knowing, sharing, and meaning-making, the arts and humanities strengthen our understanding, inspire compassion and creativity, and stimulate our cognitive capacities. (Roberts 2021) states:

> *"The pandemic represents a watershed moment which is being communicated and memorialised through powerful grassroots narratives and stories. The use of creative media helps convey (and memorialise) this, reaching different audiences, and creating a legacy."*
>
> Roberts, 2021

> *"Enriching our experience, the arts and humanities connect us with the lives and perspectives of others, proffering fundamental insights into illness and suffering, health and healing."*
>
> Roberts 2021

Examples of work that meets this need and that has informed this work include; Paintings in Hospitals' Healthcare Heroes, China Plate Theatre's Humans Not Heroes, Johns Hopkins' summary of Nursing (Johns Hopkins 2020), and (Chatterjee et al 2017) Non-clinical community interventions: a systematised review of social prescribing schemes. The approach taken is evidence-based, asset-based framing that recognises race equity, social cohesion, and the role of this art in nurse community building and addressing isolation.

Chapter 7

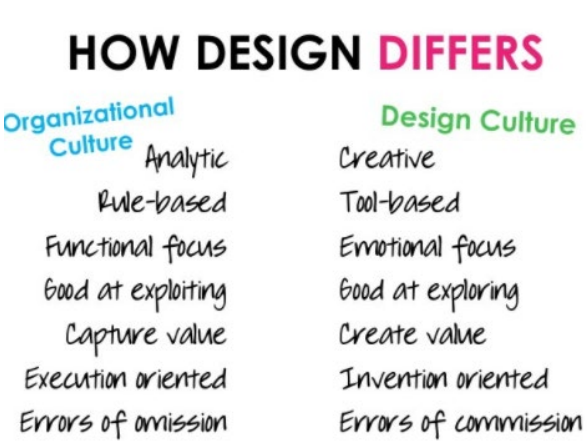
I'm Fine Project: The Design Process

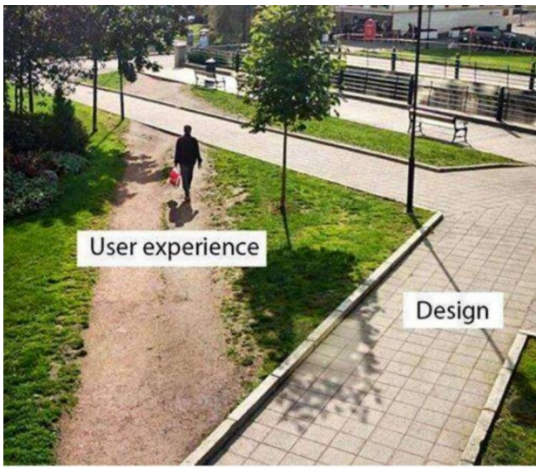
"What we need is a revolution of the heart. Hope is a creative act"

Fancourt WHO 2021

7.1 The design of Paintings in Hospitals' I'm Fine Project

Our approach to design moved us away from the familiar health and social care organisational culture design approach and towards what is more familiar in the arts.





We also know that other forms of art could help improve quality as well as wellbeing and so we focussed on the science and power of storytelling. (Suzuki et al 2018)

> *"Skilful storytelling helps listeners understand the essence of complex concepts and ideas in meaningful and often personal ways. For this reason, storytelling is being embraced by scientists who not only want to connect more authentically with their audiences, but also want to understand how the brain processes this powerful form of communication."*
>
> Suzuki et al 2018;9468

These two approaches of design thinking and storytelling brought the health and arts approaches together and enabled us to think about positive affirmation and positive images rather than the other images seen in the media.

7.2 A six-stage approach to the design aligning with theory of change

Firstly, we sought to understand nurses' needs and the needs of those who would use this resource. The resource needs to be grounded in educational approaches that supported wellbeing, it had to be representative of nurses' demographics, diversity, experiences, and expertise. It must be equitable and accessible.

Secondly, we needed to define the focus. We defined the focus by examining the issues facing nursing and the opportunities such an arts-based resource may hold. We then looked at what the rest of the world was doing in this field and linked with Google Arts & Culture, the key was to ensure that the images met with the nurses' experiences not our ideas or ideals.

Discussions with key stakeholders highlighted the issues of psychological wellbeing and arts as well as the discomfort with the images of nurses in the media. We asked our stakeholders these questions:

1. How nurses have been portrayed in the media during COVID?
2. How does this affect our mental health?
3. What images have stayed in your mind?
4. What could be different and what difference would that make to you?
5. What images or information would like to feature in the educational resource?

Thirdly, we diverged our thinking to explore as many ideas as possible. To aid with our understanding of the need and opportunities we had already explored the evidence, discussed with key leaders the issues, and conducted stakeholder questions. This is when the equity and representation issues came to the fore.

The initial thoughts that the images should come from the media were adapted when it became apparent that these images were not representative or always relished by nurses themselves.

Fourthly, we decided that blogs and images from across the world would be used to highlight the positive experiences and expertise.

Fifthly, the prototype of the resource and images were developed as a webinar for Royal College of Nursing and Nurse Line to test the thinking.

Finally, to validate the ideas the final recourse was developed and presented to Paintings in Hospitals and Google Arts & Culture to see how this could be developed.

7.3 How can you use the images and the learning opportunities?

"Art is not what you see, but what you make others see"

Degas

The images are accompanied by a blog, some questions, a story, a statement, or a reflection piece.

The opportunity here to examine the pictures and notice how they link with you. This is an approach undertaken in nurse education and explained by Nicky Lambert in blog one.

There is an opportunity here to notice what is and is not in the pictures, notice what is happening to you when you see the pictures, and share in the stories.

This type of 'knowing' for nurses is not to sort the problem out, it is to notice what these issues are and / or acknowledge the impact on yourself.

The images can be separated from the narratives as, for example, the image and story from the care homes are from different sources.

The images can be used as reflective moments for personal thoughts and then recorded for revalidation.

The resource and the images can be used as:

- Ways to reflect individually for revalidation.
- Ways to assist one-to-one supervision and to open up discussion in restorative supervision to support wellbeing and self-care.
- Ways to develop group educational workshops to explore mental health and wellbeing, nursing roles, responsibilities and identities, and equity, privilege, and power.
- Ways to create powerful presentations with the statistics and the stories of nurses 2020/2021.

Chapter 8

The I'm Fine Project: Eight Ways of Seeing Nurses

8.1.1 Image One. Nursing Education at The Tate Art Gallery

8.1.2. Blog from Nicky Lambert

We start with a blog from Associate Professor Nicky Lambert from the Department of Mental Health and Social Work Middlesex University. Here Nicky explains the way art has been used in nurse education and sets the scene for our approach and our subject matter. She has given permission for her words and the photograph to be included in this resource and is keen that the arts become part of our ways of learning to be nurses.

Art and nurse education:

This image shows some of the students, their families, and members of the public on a visit to the Tate to look at Fons Americanus before lockdown.

> *"The context for nurse education is increasingly complex - all students are faced with academic stressors however student nurses have had to work in practice throughout Covid whilst studying online and paying for it!*
>
> *To become a nurse students must be self-aware, critical thinkers who can exercise professional judgement; they also need to demonstrate compassion and cultural competence.*
>
> *To meet these needs, we co-created innovative set of modules called Expansive Learning. In addition to working with service users, practitioners, and carers; we also included input from artists, musicians, and staff from museums & galleries to help us to offer choice, volunteering opportunities, and reflective learning.*
>
> *Drawing on art and culture as resources to support student nurses to develop resilience and professional sense of self is a deliberate strategy. Appreciating creativity can be*

nurturing on a personal level and it provides opportunities for student nurses to develop applied skills through active enquiry and reflection and being able to work positively with diversity is a necessary skill and the arts can encourage explorations of the human condition outside of the biomedical model.

One way learning is supported is by art is through encouragement to recognise and regulate emotions using artwork as a trigger for reflection. We emphasise that whilst art is not a panacea, appreciating creativity can be nurturing on a personal level.

It also helps to hone practical skills, for example the technique of 'slow looking' can improve observation and interpretation and it supports students navigate complex meaning and build connections – these are all essential when undertaking a nursing assessment.

For example, when you begin an assessment you need to be able to notice detail and describe it accurately; then you need to be able to interpret what you have seen and draw together your observations to form a coherent opinion.

Being able to work positively with diversity is a necessary skill and art and culture are used to support student nurses to explore the human condition outside of the biomedical model and develop the understanding they need to flourish as active citizens.

Nurses must be able to participate in their local communities and they need to be able to respond to complex information and situations that may be outside of their personal experience.

To that end we have voluntary field trips to a range of exhibitions and galleries, we open these up via Eventbrite to our local community and on one occasion a group ranging from 3 months to 72yrs visited Kara Walker's Fons Americanus where we had a free discussion that covered racism, wellbeing, historical injustice to the Nursing guidance around tackling modern slavery.

It is important that the university takes part in the life of our local community and learning to share discussion on topics that affect us all is key to developing critical thinking. An effective and enjoyable way to do that is to exploring art together – it is an experience that enriches us all."

8.2.1 Image Two. Care Homes. Brazil.

This is a photograph of a nurse and nursing home resident taken by Mads Nissen a Danish photographer. This is the winner of the World Press Photo of the Year Award 2021. It is a Brazilian nursing home resident embracing a health care worker through a plastic protective sheet after months of COVID-19isolation. (Euronews 2021)

Rosa Luzia Lunardi (85) is embraced by nurse Adriana Silva da Costa Souza at Viva Bem care home, São Paulo, Brazil, on 5 August. © Mads Nissen

The photo captures an embrace between a nurse and 85-year-old Rosa Luzia Lunardi after she spent five months isolated in her Sao Paolo nursing home. The women are separated by a protective plastic sheet to reduce the risk of contagion.

8.2.2 Story from Isle of Wight. UK.

With thanks to Island Health Care Isle of Wight 2020 for a memory from a Care Home illustrating the situation faced. Whilst the story and the photo come from different continents the compassion and care shown are the same.

COVID-19 usually comes for the vulnerable and the elderly. It isolates you, it scares you, and for some it kills you. The fear on the faces of families looking through the care home windows fades with the yearned for sight of 'mum,' dressed well, looking well, she is well. The staff are masked but you can see they are smiling; the care home is closed to visitors, but you can hear the singing. Nursing in the community and in care homes is not as visible in the hospital Intensive Care Units and yet intensive care is happening in care homes every day.

So, care homes close their doors, continue to care and residents stay there. Nurses and carers don the protective equipment available and soothe scared residents who no longer see familiar faces. Masks and visors make communication hard, yet people know whose eyes they're looking into, close enough for comfort. The care homes adapt from places designed for social interaction and integration to places of safety and isolation. There is still music, kindness, and care.

A beautiful lady dies. The staff know her, know how she prides herself in her appearance, loves her red nails. In death, as in life, they now hold her hands and paint her nails as she wants them to be seen, bright scarlet nails.

8.3.1 Image Three. Diversity and Racism

Taken from an article in Guardian Newspaper (2021) discussing ethnicity of nurses

© Andrew Redington/Getty Images

8.3.2 Responses from one of the stakeholder groups outlining the issues faced.

With thanks to Mushtaq Kahin

3) What images have stayed in your mind?

> *My image is the elderly ward cleaner who was found at home. He was in the most vulnerable category without proper PPE due to guidelines and low paid job due structural problems affected by race and racism. He is the only person who I knew closest affected by covid-19. He was failed.*

4) What could be different and what difference would that make to you?

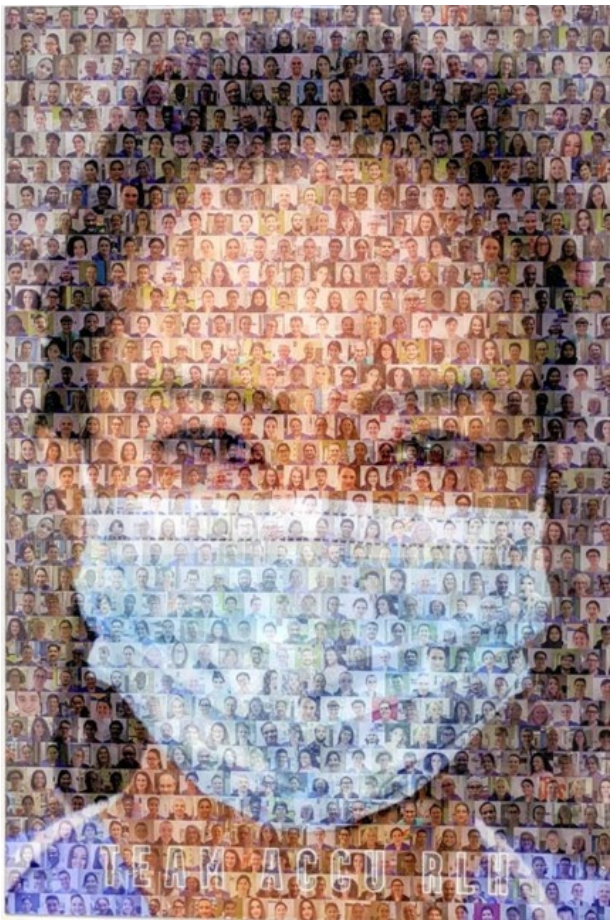
> *Risk assessment and putting health over profit. Exploring why majority of front-line facing nurses are from Black, Asian and other ethnic minority backgrounds. The efforts made through the pandemic to be continued and value staff as they are. I am thinking of the trainee nursing associates and nursing students whose training were paused and put*

on the frontline. The difference is to make sure we take (health) inequalities seriously and become change-agents in our Trusts. Be the vision, voice, and leader you needed at the times of need.

5) What images or information would like to feature in the educational resource?

I want to include the BAME nurses especially those sponsored by NHS Trusts who could not speak out of fear or discrimination. Those who were scared and seeing their colleagues or friends die as they were at risk living in the social economic conditions of UK.

8.4.1 Image Four. *250+ colleagues' portraits*



Lloyd Reynolds (And in recognition of his inspiration for the work Nathan Wyburn), photomosaic featuring Nurse Sarah Soriano

8.4.2 Explanation of the art and its origins

My name is Lloyd Reynolds, Junior Critical Care Technologist from the Adult Critical Care Unit at The Royal London Hospital.

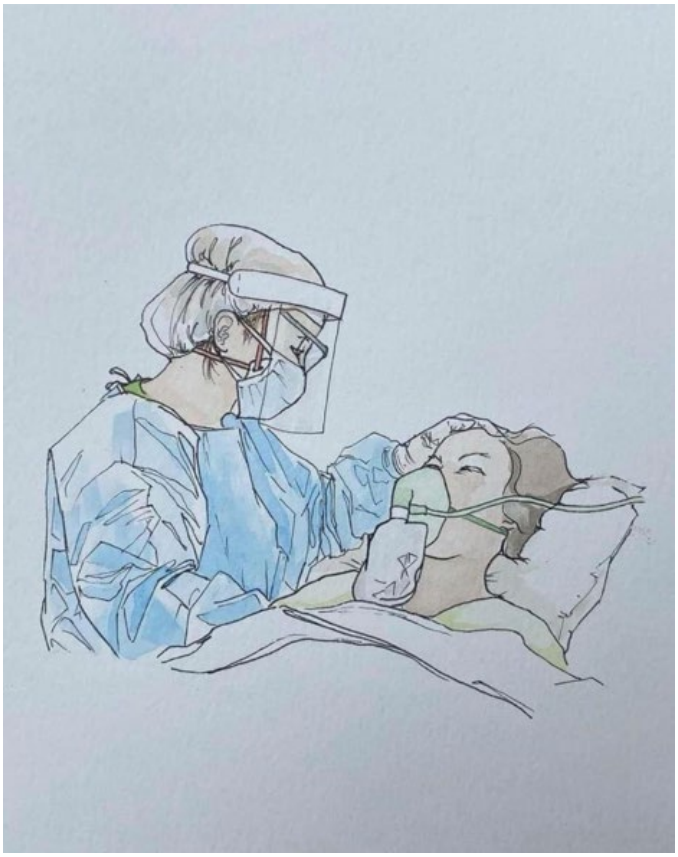
This art piece featured was designed to be printed in large format – the print on display on the 15th floor Covid response critical care extension at the RLH is 100cm x 90cm to clearly see the small individual images that make up the mosaic. The main image features Nurse Sarah Soriano who is honoured to be part of this work

Whilst Lloyd undertook the photography and creation of the mosaic prints himself, he was supported by the management team. They sourced the funding from the Bart's Health Charity for the purchase of the prints.

"I was inspired to make art of the unit when I saw work by the friend of a friend, Welsh artist Nathan Wyburn. He made an almost identical piece of art during the infancy of the pandemic – a mosaic picture of a nurse in a mask, made up of images of healthcare and frontline staff - that were sent to him on appeal. I saw his work as being powerfully unifying and wanted to create something similar to gift to my incredible colleagues - the response to my version has been very positive.

Lloyd Reynolds 2021

8.5.1 Image Five. Image of caring (source unknown)



8.5.2 Your self-reflection

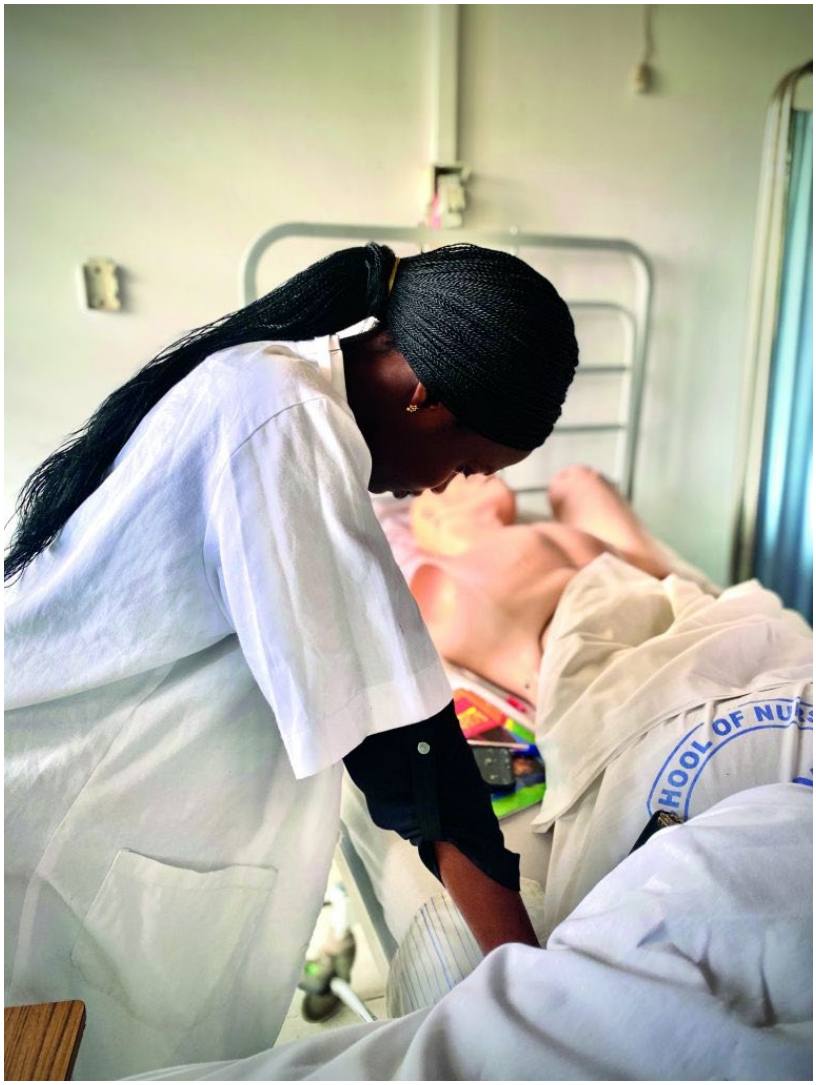
There is no narrative or explanation here. Just a picture found on my Facebook, posted by another nurse with no words.

What do you see?
What do you hear?
What do you feel?
What do you say?

8.6 Image Six. Worldwide workforce of nurses.

In January 2020 Jhpiego, Nursing Now, and the International Council of Nurses hosted the global Nursing in Focus photography contest to highlight the impact, influence, and diversity of nurses across the world (Nursing Times 2021).

8.6.1 Stephan Kofi Osei. Winner of the 'Future Nurse' category. Student nurse training in CPR in Ghana



8.6.2 Klienne Eco from the Philippines. Winner of the 'Why I Nurse' category

8.6.3 Michelle Ajoc from the Philippines. Winner of the 'Where I Nurse' category

8.7.1 News image of nurse in UK waiting outside hospital (source unknown)

8.7.2 Camus. The Plague

> *"There's no question of heroism in all this. It's a matter of common decency. That's an idea which may make some people smile, but the only means of fighting a plague is – common decency."*

How does this relate to your experience of COVID-19?

8.1 Nurses celebrate Nurses Appreciation Week in New York City, 2020, at the height of the COVID-19pandemic

8.2 Question on the image of teams

"Without healthcare workers, there's no chance we will see this pandemic through. Therefore, a greater consideration of self-care for healthcare workers is essential as we learn more about the consequences of the pandemic on healthcare systems," she said in her blog, adding: "Unless we take proactive measures to ensure staff are safe at work and have sustainable working conditions – we're at risk of losing the means that make healthcare possible."

Santos 2021

Questions:

What do you see?
What do you not see?
How does this resonate with your experiences?

Chapter 9

One Nurse's Story of COVID

9.1 Wellbeing and the Pandemic: Embracing our Vulnerability

Joan Pons Laplana (@RoaringNurse)

9.2 Blog from @RoaringNurse from the Frontline.

Monday 29th March 2021 by *@RoaringNurse*

Hello, my name is Joan, I am a senior nurse currently working at the NHS. I am also, according to the nursing times, a well-known activist.

During the pandemic I left my office desk, and I went back to the frontline. During the first and second wave I worked in ITU.

Both emotionally and physically has hit me very hard. Daily I went from joy to grief in a matter of seconds. It has been a rollercoaster. Anxiety, fear, insecurity, guilt, anger, loneliness. These are a few of the emotions that I needed to deal on a daily basis.

You realize your mortality. Inside your head you always have a little voice that constantly tells you that you can be next.

After a year I am very tired physically and emotionally.

Tired of the pain on the phone, of the daily tears, of the only visit for the last goodbye, of the pain in loneliness, of the broken lives, of the eternity of the constant mourning and of seeing people die every day.

Tired of waking up in the middle of the night. Tired of having nightmares. Dreaming of the terror in my patient's eyes. The tear running down his cheek. Tired of patient saying goodbye to their families on facetime before they are put down to sleep knowing that probably that will be the last word the patient will ever say because 50% of them will never wake up again.

Similar scenes are repeated every day, it is very hard.

They are not numbers ... Each death leaves a scar on your heart, imprints an image on your brain that you remember during your dreams.

Psychologically, you are not prepared to withstand the pressure that means that every time you open the doors of the ICU you are risking your life, that any small mistake can mean that death comes knocking on your door. Also, the work is often bleak.

Even I, who am not religious, found myself praying as I closed my eyes and took the hand of my patient as if trying to channel my energy to recharge him and that I could continue to fight COVID. As I passed the sponge through every corner of their skin, I prayed that my patients would get better, even if only a little.

As nurses we take care of the functioning of each patient's body. We monitor heart rate, blood pressure and respiration. The patient's life is in our hands, and it is a huge responsibility. We need to monitor patients constantly because change can happen very quickly. Any fluctuation in blood pressure or breathing may require an adjustment of treatment or may be a sign that the constants are deteriorating. This is why hospitals usually assign a nurse for each intensive care patient. But with COVID this has often not been possible and in some ICUs, especially in London, a single nurse may have to monitor the care of up to four seriously ill people. Normally, the nurse caring for the patient notices the signs that predict an impending crisis, but this perception becomes much more difficult when more than one patient needs to be monitored and cared for. If we cannot maintain the ratio of one nurse per patient, the pressure on caregivers will get worse. Nurses cannot provide the level of care that is expected of us and very often this makes us feel guilty. You often come home with your head spinning: "If I hadn't gone to see that other patient, my first patient could have been better." You feel responsible when things don't turn out the way they should, but what other option do you have?

You need to be constantly on the alert. You can't lower your guard for a moment. A mistake can cost a life. On top of all this emotional pressure we also have to carry a complete PPE protection kit and this makes the job very difficult.

We wore the PPE constantly. All you can see are people's eyes. It is very hot and sweaty throughout the twelve hours that the shift lasts. And you can't lift your visor to dry your face or take a sip of water. Instead, you should plan your breaks so that you can eat and drink regularly. You can't go to the bathroom without carefully removing the entire kit and then putting everything back together.

I am not ashamed to say that I needed help.

I was not prepared or able to cope with the large volume of deaths and the intense pain we experienced every day.

I often worried about the decisions I had made during my shift. Sometimes I was so worried, that I even got to call the unit to talk to the work colleague who was caring for my patient. to check to know how my patient was doing. The broken nights were accumulating and little by little the fatigue was taking over your body. But keep going trying to do the best you can.

At the end of May, I had an anxiety attack. I had not slept well that night. I woke up in the middle of the night and couldn't sleep anymore. The day before, I had lost a patient of a similar age to me who had no serious illness. Statistics said he should have gotten out of it but COVID took him in the blink of an eye. I still remember her daughters saying goodbye to their father through an iPad. Daughters the same age as mine. The death of this patient affected me a lot and I couldn't get the idea out of my head that it could happen to me soon.

The next day, the road to the hospital was exhausted. I parked my car and took the elevator to the floor where the ICU was. I started sweating and palpitating in the elevator. My heart was pounding. I sat in the room where we were given handover before entering. A feeling of panic suddenly engulfed me. My head was filled with thoughts that I would enter the unit that day and that the virus would attack me. I was convinced that if I entered the unit I would be the next to die.

I lost track of time. Next thing I noticed was that the shift manager had put her hand on my shoulder and was asking me if I was okay. For the first time in 45 years I said no.

That day I did not go to work in the ICU. My boss sent me to the hospital psychologist.

However, I felt like a failure, I was ashamed to have had problems with my mental health. I thought this only happened to weak people and at the beginning I didn't tell anyone. For 45 years I had learned to pretend I was fine.

I started my face-to-face therapy with a psychologist and gradually regained my balance. With the help of a psychologist, I realized that having a mental imbalance is nothing to be ashamed of. That my mental state was the result of the situation I had found myself in and many years of neglecting and not taking care of my mental health.

The most important learning I've done is knowing that mental health is as important as physical health. You need to allow yourself to recognize your feelings and learn to share. I'm still learning from it; I still often feel uncomfortable talking about feelings.

Mental health carries a great negative stigma. At first, I thought people would judge me and condemn me. After all, I had always given an image of strength. I realized that my stress and anxiety were illnesses that could affect everyone.

My sense of guilt began to fade. I have learned to detect the first symptoms of anxiety and stress and instead of ignoring them I recognise them and, from what the psychologist has taught me, I apply techniques to control them.

Mental health is very similar to physical health. Every day you have to take care of it as you do with feelings and emotions. As with love, so with stress and anger, if you don't take care, it goes wrong. From a very young age they teach us to have good care of our physical health. We learn to exercise to improve our fitness; going to the doctor when something hurts us. Similarly, we should do mental and emotional exercises to improve our mental health. But this need is never discussed. We need to break the taboo of going to the psychologist. No one had taught me how to take care of my mental health until I first went to a psychologist when I was 45 years old.

Before I used to hide my problems, my anxieties, I did not share my doubts. I did not to accept my limitations. I have learned that I am no less of a man or a worse father or nurse because I had mental health problems. Taking care of mental health is not a weakness, quite the opposite. The bravest thing a person can do is ask for help when they need it. The problem is that for many years society has made us believe that having ups and downs in your mental health is a sign of weakness.

He had the absolute belief that to be a leader he had to have certain qualities: honesty, integrity, trust, being able to inspire others, being passionate and a good communicator. But I also believed I couldn't let my problems show. But I have learned that this is impossible. I am not a hero or an angel, I am human. It was very difficult for me to show this more human face of mine and, when I was not feeling well, to recognize it in front of others.

All I can say is that for 45 years I became very good at pretending I was okay when I wasn't.

We are in the road out of the COVID pandemic but another one is on its way. The impact that COVID has had in our mental health has been tremendous and we will see the full impact in years to come. We need to start talking and supporting each other. It's ok not to be ok.

To finish I want to give you five tips that I learned from a good friend Lisa Rodrigues, that hopefully will help you take care of yourself:

1.- When something goes wrong and you make a mistake, try not to be discouraged. Take time to process what has happened. Apologize wholeheartedly. But don't rush into quick judgments or decisions. Making mistakes is part of life on the road to success. It's important to learn what went wrong to try not to do it again.

2.- When someone criticizes you, try not to take it as a personal thing. You need to take it as it is: just an opinion, which may or may not be helpful. It's important to listen to other people's opinions so that you can improve as a person.

3.- Don't pretend to be someone or something you are not. It's exhausting.

4.- Exercise is important, as is eating well. But sleep is healing. We all need it otherwise we can't function. If you have trouble sleeping, seek help. It is the first sign that your mental health is unbalanced. It's a good starting point.

5.- Remember that being kind to yourself is not being selfish. In fact, it is extremely selfless. Because only when you are kind to yourself can you really be kind to others. To be able to take care of others you must start taking care of yourself, if not totally impossible.

Chapter 10

Looking Back to Florence Nightingale: Image and Imagination

10.1 Most well-known picture of Florence Nightingale (200 years ago) accompanying Longfellow poem

10.2 Reflections on this image and current images of nursing

Are our collective assumptions about the image or identity of 'nurse' are wrong? What picture do you see? Is there a mismatch between the 21st century imagined nurse and real nurse and is this contributing to the global shortage of 5.9 million nurses?

Clinical education includes the humanities, and we know that looking at art as part of health humanities improves nurses' ability. We do not know if nurse images could be used to explore nurse identity and this project is a first step.

Traditional recruitment and retention approaches are failing to keep or care for the profession. A new epistemological lens lets us see 'nurse' and sort the nurse numbers differently. This alternative gaze helps health system designers address the assumptions, beliefs, and values that have caused the nurse workforce and nurse wellbeing problem in the

first place. Audre Lorde puts this succinctly. *The master's tools will never dismantle the master's house.*

The political, professional, and person-centred context of nursing can be explored through art and should be to show up the historical and societal tropes upon which current policy and practice are built. This in turn will build new insights, policy, and practice for the profession. Such explorations with nurses will help with personal insights and behaviour change. This is important not only to address nurse workforce retention but also to pay attention to the tension in the profession. This tension is global, political, economic, societal, psychological, and systematic and is harming nurses' health. Such tension is starting to show in the workforce statistics.

The global workforce statistics tell us a sobering story. An analysis of the state of the world's nursing (WHO 2020) highlighted a current global shortage of 5,9 million nurses. Whilst the 2021 COVID-19pandemic has made nursing more visible and increased the numbers seeking training, this is not even enough to stand still. Care 'from womb to tomb,' from assessment through to discharge, from prevention to palliation means that nurses are never 'done'. The science, skills, and sensitivity of the profession are not reflected in the nurse status and salary globally and organisationally.

Politically nurses are always lauded for their hero or angel-like worthiness. In 2020 the platitudes grew with handclaps, with NHS charities handing out gifts such as hand cream. The pay did not grow and the pay rise did little to reward or recognise nurses' true fiscal worth. Positional power continues to elude nurses. This may be due to the feminisation of the profession or the lack of politicalising action to address organisational and professional politics. The political and economic are always linked and this lack of value of nurses was exacerbated in the UK in 2012.

The economic argument arose again in 2012. Strategically the UK nursing workforce was seen as a productivity opportunity of £421 million (28.9%) rather than an autonomous profession. The NHS introduced skills mix and aligning staffing with clinical need (NHS London 2012). This view of doctors as an asset, nurses as a cost continues to colour any conversations about multi-professional relationships. An organisational design that sees nurses as a cost pressure rather than a profession contributes to the social view of nursing and so contributed to the situation during the 2021 COVID-19 pandemic.

The social view of nurses was sustained and shattered during the COVID-19 pandemic. In 2021 UK senior nurses were unseen and unheard in the media and at COVID-19 political addresses. Nurses did daily, constantly, and privately what others talked about theoretically and publicly. An example is infection control advice. Nurses hold most hospital infection control roles and yet were rarely called on by the media. Medical experts were sought out to speak out about what the public should do.

The social view of nurses was shattered when the usual invisible roles were made visible through media stories, final conversations with families via tablets, and arts projects such as Healthcare Heroes. The images and the art are what is different. This is the disruption in method and message we seek to sustain.

Chapter 11

Looking Forward to the Future of Nursing: Arts, Wellbeing and Next Steps

> *"Nursing and medicine are increasingly about storytelling. The arts play a great role in understanding people's stories, and in representing, and alleviating, people's suffering."*
>
> (Christine Watson in Hurley 2021)

Culture can also be seen as social glue (Manchester Institute for Arts health and Social Change 2019).

11.1 COVID-19 and Culture and the Arts

COVID-19 has shown where the glue in our society is not working. The COVID-19 pandemic has shone a light on inequalities and structural violence and the need to build in a focus on social injustice.

Nursing is part of the issue and the solution. We need to look beyond mental health services for communities with personal-centred and rights-based approaches, (WHO 2021), beyond compassion (Maxwell 2017) and nurse competence or capability and towards equality, quality and wider global health.

The arts, in particular Camus' The Plague can be used to highlight what is happening and the images in this resource perhaps reflect on these too.

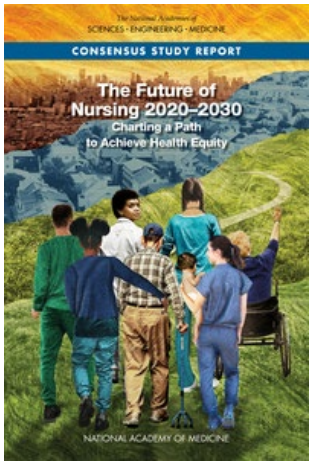
> *"Both Camus' book and Covid-19 intersect with structural violence and suffering which are mediated differentially. Covid-19 intensifies other social catastrophes feeding on the ruins of structural inequality and the racism that condemns the marginalised to loss of agency, social apartheid and disposability."*
>
> (Kabel and Phillipson 2020;4)

The arts, and in particular these images may help us to recover from the pandemic and the accompanying harms we need to develop knowledge of how to increase planetary health, equity and reduce or eliminate planetary health disparities.

This may be done by inviting people to tell their stories of their health experiences (Chinn 2021). Then analyse the stories through the lens of the culture and context.

Such situation-specific theories are grounded in real human experience and the social and political context. This open discussion may also undercovers the social injustice and in turn, the white privilege, therefore, decolonising the knowledge.

11.2 COVID-19 and the Future of Nursing



National Academy of Medicine, The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity

The future of nursing is raising alarms with the number of, and the health of, and motivation of nurses needing action.

> *"Nurses play a key role in the health system. With a unique combination of skills, knowledge, and dedication, nurses can help address health inequities and improve the health and wellbeing for all."*
>
> National Academies (2021)

The COVID-19 pandemic has also raised new alarm bells about the mental health of our population and our professionals. Resources have been developed to help (Danaher 2021).

The arts have helped shine a light on the health workforce and health needs and also health experiences. Theatre has helped highlight the harm done but also the help offered by the arts. Richard Hurley's review of Christine Watsons play The Language of Kindness recounts author and nurse Professor Watson's words:

> *"When I started out, I knew nursing was about anatomy, physiology, chemistry, and maths. But it's also about art, literature, dance, and politics–and nursing is theatre too."*

And highlights the issues we face:

> *"Nurses have long been stigmatised as handmaidens or angels. Wartime language, like the term 'hero,' can be seen as politically convenient, legitimising low pay and inadequate PPE." The show juxtaposes "clap for carers" with "cannon fodder."*
>
> Hurley 2021

11.3 From Heartbreak to Hope

Whilst there is much despair there is also recognition of what has gone well. WHO Chief Nursing Officer states that nurses have risen to the challenges they have faced.

> *"Despite the cancellation of virtually all the activities planned to mark 2020 as the International Year of the Nurse and Midwife, she believes that nurses' leadership, courage, compassion, commitment and expertise have been revealed to the world like never before. However, it is critical to nurture and support the next generation of nurses so that they can help to bring about the necessary reforms for health systems around the world."*
>
> Parish 2021

Additionally, there is a recognition of what nurses do and an internationally supported push for the changing role to be acknowledged (Hardtman 2021) with a call to action to nurses to be heard and government to invest in nurses.

Internationally the safety of our patients and ourselves as staff is crucial and the WHO (2021) has outlined a strategy for protecting, safeguarding, and investing in the health and care workforce (WHO 2021)

Nationally for the UK the issues faced by health workers go beyond the impact of the COVID-19 pandemic. Mackey outlines the range of support that was made available to NHS staff to support staff wellbeing from grab bags of vegetables and popup shops to mental health support (Mackey 2021).

Magner et al (2021) describe the psychological impact of COVID-19 on frontline healthcare workers 'From Heartbreak to Hope' and from the virtual session held they were reassured that:

> *"many staff will not experience moral injury, or any prolonged mental health impacts, related to their front line work during the COVID-19 pandemic. A minority will struggle, and early identification and access to occupationally focussed professional help will be essential. It is important to remember that most healthcare workers thrive in a fast-paced critical environment and may have been attracted to working on the frontline due to the dynamic nature of the work. A certain level of stress is, therefore, anticipated and staff often cope very well with this and indeed develop a level of natural resilience."*
>
> Magner et al 2021

11.4 Moving Forward

Moving forward, the plans to recover, reward and renew the healthcare workforce in the UK are emerging and are containing practical policies (Patel and Thomas 2021) to:

- Recover: Addressing fatigue, burnout, and mental health problems in healthcare workers

- Reward, Realigning contribution and reward in health and care.
- Renew: Creating the conditions and opportunities to make the NHS one of the best places to work.

One of the ways to help this happen is to use resources from the arts such as these images to reflect and learn and enable nurse work to be seen and nurse voices to be heard.

We've learned that quiet isn't always peace
And the norms and notions of what just is
Isn't always justice.

The Hill We Climb, inaugural poem by Amanda Gorman in Browne et al 2021

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Resources

HIOW Staff Support Hub, Resources

Laura Hyde Foundation, Your Suicide Prevention Resource

NHS, NHS talking therapies

NHS England, Support available for our NHS people

NHS England, Wellbeing apps

NHS England, Health and wellbeing programmes

NHS Horizons, A practical guide to the art of psychological safety in the real world of health and care

THIS Institute (The Healthcare Improvement Studies Institute), Arts-based engagement with research

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