What the COVID-19 pandemic tells us about the need to develop resilience in the nursing workforce

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Abstract
Most research on resilience in healthcare systems such as the NHS is based on organisational crises, such as nurse shortages, an ageing workforce and financial restrictions. However, nursing can learn lessons from the past to consider how to become more resilient, particularly considering the 2020 COVID-19 pandemic. This article briefly looks at previous pandemics and disasters that have affected healthcare systems, as well as the 2020 COVID-19 pandemic, and considers how nurse leaders can support staff and show organisational resilience during such emergencies. The article also discusses how nurse leaders can develop their own resilience.

Introduction
In December 2019 a novel coronavirus, now termed COVID-19, was reported in Wuhan, China. In early March 2020 it was declared a pandemic by the World Health Organization (WHO) (Huang et al 2020, WHO 2020a, Wu et al 2020) and since then healthcare workers in the UK and across the world have been working in unprecedented circumstances. Managing workforce stress during a crisis is challenging for leaders as they try to support staff in terms of their mental well-being and resilience (Health Education England (HEE) 2019). Most research on coping with crises in the NHS and other healthcare systems, however, centres on topics such as nurse shortages, an ageing workforce and financial restrictions (Hart et al 2014, Hudgins 2016). Nevertheless, although there is little research on staff resilience during a pandemic, nurse leaders can consider how to support their workforce by looking at other experiences of disasters (Turner 2015).

Background
COVID-19 can be a mild illness, but it can also be deadly, causing massive alveolar damage and progressive respiratory failure (Chan et al 2020, Huang et al 2020, Wu et al 2020). At the time of writing there is no consensus on the case fatality rate in the UK due to difficulty in accessing detailed data from hospitals, care homes and the community. There may be factors, such as patient demographics or co-morbidities (Oke and Heneghan 2020), that account for high death rates in different areas and tracking data helps NHS trusts prepare for potential demand on services. There is also as yet no definitive treatment or vaccine (Cascella et al 2020) and treatment of patients with COVID-19 consists of supportive measures, while prevention and control are based on social distancing and strict personal hygiene (Public Health England 2020, Rothan and Byrareddy 2020).

Although this is a recent and at the time of writing ongoing public health crisis, early data on various aspects of the COVID-19 pandemic reveal organisational issues such as concerns about the adequacy of pandemic planning, the effect of redeployment and training new staff to support staffing capacity, and staff concerns such as fear of transmission (Emanuel et al 2020, Wu and McGoogan 2020).

The NHS has used data from Asia and Europe to support planning decisions (Lai et al 2020).
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McKinley et al (2019) suggest that resilience 

can be difficult to conceptualise, and found 

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resilience levels in medical doctors that 

important points include demographics, 

personality factors, organisational or 
environmental factors, social support, leisure 

activities, overcoming previous adversity and 

interventions to improve resilience. 

The importance of workforce and 

organisational resilience has been highlighted 

by Kotze and Lamb (2012), who assert 

that measures that increase these will help 

nurse leaders to make sound decisions in 

critical moments. 

Resilience in healthcare workers 

Research into previous pandemics and other 

disasters discusses what resilience means in 

healthcare workers. For example, Ling et al 

(2017) identified resilience in staff as a critical 

attribute of a strong healthcare system 

following the 2014-15 West Africa Ebola 

epidemic, but concluded that it requires long-

term investment and sustained attention once 

a crisis abates. Kruk et al (2015), who also 

wrote about lessons from the Ebola epidemic, 

suggested that a resilient healthcare system 

is one that can prepare for and respond 

effectively to crises, learn from such events 

and improve services. Admasu (2016) has 

proposed that such a system is also forward-

thinking, problem-solving, innovative and 

focused on implementing solutions, all of 

which rely on strong leadership. 

An examination of resilience in nurses in 

the context of the 2011 US tornado disaster in 

Tuscaloosa, Alabama (Turner 2015) concluded 

that more research is required on the reasons 

for increased resilience in nurses. This is 

important because research shows that nurses 

can develop post-traumatic stress disorder 

(PTSD) following events such as the epidemics 

of severe acute respiratory syndrome (SARS) 

and the Middle East respiratory syndrome 

(MERS) (Tam et al 2007, Shih et al 2009, 

Kim and Park 2017). 

Before the COVID-19 pandemic there was 

already concern about nurses’ mental health 

and well-being in relation to depression, 

anxiety, anger, irritability and burnout 


Critical care nurses, for example, are at risk 

of burnout if they have reduced resilience 

(Jackson et al 2018) and are at a high risk of 

developing PTSD (Mealer et al 2012), 

which is a particular concern for nurse leaders 

during the COVID-19 pandemic. This shows 

the need for clear and definitive leadership 

to determine staffing levels, organise staff 

rotas that include extra time for rest and 

recuperation, and ensure adequate provision 

of equipment (Ross et al 2020, WHO 2020c). 

Key points 

- Resilience involves ‘rebounding’ and 

  'carrying on’, self-determination, 

  maintaining positive relationships, 

  self-esteem, self-efficacy 

  and hopefulness, and 

  can support clinicians 

  during stressful events 

  and periods 

- Nurse leaders can 

  support resilience in 

  themselves and their 

  staff by using healthy 

  coping strategies, 

  positive language 

  and managing their 

  own efficacy 

- Nurse leaders should 

  focus on skilled 

  communication, 

  collaboration, effective 

  decision-making, 

  appropriate staffing, 

  meaningful recognition 

  of staff, and authentic 

  and transparent 

  leadership to support 

  and improve staff, and 

  organisational resilience 

2020, Phua et al 2020); healthcare providers 

in England, for example, have been advised 

to develop strategies to manage space, 

staff and supplies of personal protective 

equipment (PPE) to provide optimum care 

to patients (Wong et al 2020). However, this 

has caused additional stress because it has 

resulted in shortages and rationing of scarce 

resources (Emanuel et al 2020, The Lancet 


Lack of PPE is of particular concern. 

Lai et al (2020), for example, highlight the 

traumatising effect on clinical staff in Asia and 

Italy of the high workload and intermittent 
lack of protective equipment, while Newman 

(2020) suggests that staff could leave their 

jobs, or die, because of the lack of such 
equipment. In the UK at least 100 healthcare 

workers had died of complications of 

COVID-19 as of 20 April 2020 (Marsh 2020). 

The continual flow of new information to 

NHS decision-making bodies from countries 

that are further along the pandemic trajectory 
is obviously helpful, but it means that soon 

decisions may have to be made and 
disseminated rapidly to staff (WHO 2020c), 

which can further increase their anxieties. 

Nurse leaders must therefore support 

critical staff who are experiencing high levels 

of anxiety and stress during the pandemic 

(WHO 2020d, Xiao et al 2020), as well as 

non-clinical front-line staff who can be affected 

by what is known as vicarious traumatisation 

(Lai et al 2020). To achieve this, they must 

attempt to strengthen organisational and 

workforce resilience. 

Resilience 

Resilience can be defined as an individual’s 

ability to ‘bounce back’ despite adverse 
circumstances (Rutter 2008) and as a process 
in which someone recovers quickly from 

a specific event (Zautra et al 2010). Some 

authors consider it a personality trait 
(Fredrickson et al 2003, Campbell-Sills et al 
2006) while others regard it as a process 
(Egeland et al 1993, Luthar 2006). Hudgins 
(2016) has suggested that resilience is an 

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Organisational resilience
Building resilience in the nursing workforce has long been considered important (Gray 2012), but recently there has been a shift to supporting organisational resilience (HEE 2019). In the current context, organisational resilience is important as the NHS has had little time to prepare for the COVID-19 pandemic (Qian et al 2020). Organisational resilience is defined by McManus et al (2008) as ‘a function of an organisation’s overall situation awareness, management of keystone vulnerabilities, and adaptive capacity in a complex, dynamic, and interconnected environment’. Its components include contextual integrity, strategic capacity and strategic action, and lead to organisational evolvability (Kantur and Işeri-Say 2012). Resilience is considered a positive organisational factor that results in improved productivity, improved well-being and reduced absenteeism and staff turnover (Andolo 2013), while Di Sipio et al (2012) suggests that positive personal resources or characteristics and organisational well-being are distinct entities that interact, leading to positive outcomes.

Importance of personal resilience for nurses
The WHO (2020d) recommends that all healthcare staff be protected from developing chronic stress and poor mental health during the COVID-19 pandemic and suggests that leaders focus on long-term occupational capacity rather than short-term crisis responses. Resilience is one of the foundations of good mental health (Lai et al 2020) so building personal resilience in all healthcare professionals across primary and secondary care should be a priority (McAllister and McKinnon 2009, Foureur et al 2013, Matheson et al 2016).

Research into resilience in clinical practice has highlighted the fact that ‘rebonding’ and carrying on, self-determination, positive relationships, self-esteem, self-efficacy and hopefulness can support clinicians during stressful times (Earvolino-Ramirez 2007, Gillespie et al 2007). This is supported by Hart et al (2014), who found that personal characteristics including hope, self-efficacy, coping, control, competence, flexibility, adaptability, hardness, sense of coherence, skill recognition and not focusing on deficiencies supported increased levels of resilience in nurses.

A high level of emotional intelligence enables individuals to adapt to various adverse conditions while maintaining a sense of purpose, balance and positive mental and physical well-being (Sergeant and Laws-Chapman 2012).

Hudgins (2016) suggested that nurse leaders can support resilience in themselves and their staff by practising healthy coping strategies, using positive language or supporting their self-efficacy. Work-based education programmes that teach resilience techniques and support personal development have also been shown to improve resilience (McAllister and McKinnon 2009, Foureur et al 2013, McDonald et al 2013). Even if these programmes do not focus on resilience specifically during a pandemic, they will still be beneficial for the workforce.

Positive emotions
Bonanno (2004), writing about loss, trauma and human resilience, suggested that people develop personal resilience in a number of ways, such as by finding ‘meaningful purpose in life, the belief that one can influence one’s surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences’.

In essence, understanding what you are doing, or having a meaningful purpose or a strong belief system, helps people become more resilient during stressful situations (Bonanno 2004). This is important for all healthcare staff, including nurse leaders.

In earlier work, Bonanno et al (2002) suggested that positive emotions and laughter promote resilience, and camaraderie in healthcare teams has been evident on social media during this pandemic. The ability to find positive meaning in adverse situations helps curb negative emotions (Tugade and Fredrickson 2004), and Bright (1997) has noted that emotional awareness and self-care are important in developing resilience in nurse managers, in addition to optimism, autonomy and empowerment. Shimoinaba et al (2015) has further shown that nurses working in palliative care developed resilience through self-nurturing, which included being self-aware, coping adaptively and accepting limitations.

Nurses spend most of their time caring for others, but they must develop self-care as well to improve their personal resilience (Bright 1997). McGee (2006) suggested that nurses can support their own mental and spiritual well-being by sharing their experiences of vulnerability and resilience through reflective journals and debriefing. This can also enhance emotional insight, according to Giordano.
Implications for nurse leaders
Nurses and nurse leaders must practise self-care but they must also remember that they are part of a community in which there are social support networks (Uddin et al 2020) that are a significant component of resilience (Tugade and Fredrickson 2004). Building positive and nurturing professional relationships is therefore crucial for nurse leaders as they navigate this crisis. During this pandemic nurses and nurse leaders will undoubtedly struggle to achieve a work-life balance, which supports resilience (Kim and Windsor 2015), so it is important to develop other methods of ‘connectedness’ to maintain some kind of ‘anchoring force’ (Giordano 1997).

Nurse leaders should focus on skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership (Hart et al 2014, WHO 2020d) and encourage and support debriefing sessions to address the ethical and moral distress, for example about who is and who is not eligible for treatment, that nurses are facing (Rushton et al 2015).

In an article on supporting the healthcare workforce during COVID-19, Adams and Walls (2020) suggest that honest and transparent conversations with front-line caregivers can help to relieve the stress and anxiety they feel. Topics for discussion can include planning for home separation, childcare, protocols for arrival home after duty, and decontamination of surfaces.

There are also significant challenges for leaders as they support newly deployed staff, those returning to work and newly registered nurses. The WHO (2020d) suggests that nurses should regularly rotate from areas of high stress to those with less stress, and that inexperienced staff should be partnered with more experienced colleagues.

Nurses caring for patients with COVID-19 are at risk of developing psychological problems including PTSD, but resilient individuals will cope better (Tam et al 2007, Adriaenssens et al 2012, Mealer et al 2012). Once the number of cases of COVID-19 falls, there needs to be further research on trauma-informed resilience, post-traumatic growth and PTSD in the nursing workforce. Business magnate Bill Gates (2020) has said: ‘In any crisis, leaders have two equally important responsibilities: solve the immediate problem and keep it from happening again.’

All staff, including nurse leaders, need to be aware of where and how they can access mental health and psychosocial support services (WHO 2020d).

A summary from various sources of how nurse leaders can support organisational and staff resilience is shown in Box 1.

Conclusion
Nurse leaders must attempt to support resilience in the nursing workforce and in their organisations during crises such as the COVID-19 pandemic and consider the long-term effects of such crises.

Although there is a wealth of research on resilience in the context of stressors such as staff shortages, the ageing workforce and financial restrictions, there is a need to consider how events such as the COVID-19 pandemic affect the nursing workforce.

Building resilience in healthcare professionals across primary and secondary care should be a priority, while increasing workforce and organisational resilience will help nurse leaders to make sound decisions in critical moments.

Box 1. Recommendations for nurse leaders

<table>
<thead>
<tr>
<th>Support organisational resilience during a crisis</th>
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<tbody>
<tr>
<td>» Good communication</td>
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<tr>
<td>» Meaningful recognition and authentic leadership (Hart et al 2014)</td>
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<td>» True collaboration with no fragmentation of services (Stange 2009, Hart et al 2014, Giovannetti 2016)</td>
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<tr>
<td>» Supporting and providing opportunities for analytical thinking and problem-solving (Bumard and Bhama 2011)</td>
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<td>» Support for joint goals and vision (Jee et al 2015)</td>
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<tr>
<td>» Effective decision-making throughout the organisation (Hart et al 2014)</td>
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<td>» Supporting staffing, deployment of staff into crisis areas (Hart et al 2014)</td>
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<td>» Providing workplace buffers (Matheson et al 2016)</td>
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<td>» Supportive well-being strategies (Sull et al 2015)</td>
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<th>Develop personal resilience</th>
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<tr>
<td>» Practice of healthy coping strategies (Hudgins 2016)</td>
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<tr>
<td>» Encouraging hopefulness (Hart et al 2014)</td>
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<tr>
<td>» Using positive language and supporting self-efficacy (Hudgins 2016)</td>
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<tr>
<td>» Supporting positive emotions (Bonanno 2004)</td>
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<tr>
<td>» Development of a mentoring relationship (Jackson et al 2007)</td>
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<tr>
<td>» Developing strong social support (Tsai et al 2012, Kalahar-Levering 2019)</td>
</tr>
<tr>
<td>» Journal writing and self-reflection to enhance emotional insight (Giordano 1997)</td>
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References


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