

Effects of the COVID-19 Pandemic on Healthcare Providers: Policy Implications for Pandemic Recovery

Effets de la pandémie de la COVID-19 sur les fournisseurs de soins de santé : répercussions politiques pour la reprise



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Abstract

Background: Notably higher rates of mental health issues have been reported among health-care providers (HCPs) during the COVID-19 pandemic. Concerns over the impact of policy decisions on the well-being of HCPs is growing, yet it remains underexplored in the literature.

Method: HCPs from a 301-bed mental health hospital and a 408-bed acute care community hospital, both located in central Ontario, participated in interviews ($N = 30$) and answered open-ended questionnaires ($N = 88$) to provide their experiences with the COVID-19 pandemic.

Results: Using interpretive description methods, we found that public health policies and other strategies intended to mitigate COVID-19 transmission variably impacted HCP well-being and professional practice.

Discussion: Pandemic-related policies contributed to HCP stress by changing the healthcare environment and clinical practice. Understanding HCP experiences is key for leaders, policy makers and health system planners to deal with the current state, recovery and preparation for future pandemics. Direct input into policy development, implementation and evaluation from HCPs may support their well-being.

Résumé

Contexte : Des taux nettement plus élevés de problèmes de santé mentale ont été signalés chez les fournisseurs de soins de santé pendant la pandémie de la COVID-19. Les inquiétudes concernant l'impact des décisions politiques sur le bien-être des professionnels de la santé augmentent, mais elles restent sous-étudiées dans la littérature.

Méthode : Les fournisseurs de soins de santé d'un hôpital de santé mentale de 301 lits et d'un hôpital communautaire de soins de courte durée de 408 lits, tous deux situés dans le centre de l'Ontario, ont participé à des entrevues ($N = 30$) et ont répondu à des questionnaires ouverts ($N = 88$) pour faire part de leur expérience dans le contexte de la pandémie de la COVID-19.

Résultats : À l'aide de méthodes de description interprétative, nous avons observé que les politiques de santé publique et d'autres stratégies visant à atténuer la transmission de la COVID-19 avaient un impact variable sur le bien-être et la pratique professionnelle des fournisseurs de soins de santé.

Discussion : Les politiques liées à la pandémie ont contribué au stress des fournisseurs de services de santé en modifiant l'environnement des soins et la pratique clinique. Comprendre l'expérience des fournisseurs de soins est essentiel aux dirigeants, aux décideurs et aux planificateurs du système de santé pour faire face à l'état actuel, au rétablissement et à la préparation à d'éventuelles pandémies. La contribution directe des fournisseurs de soins à l'élaboration, à la mise en œuvre et à l'évaluation des politiques peut contribuer à leur bien-être.

Introduction

During the very early period of the COVID-19 pandemic, health leaders and governments were alerted to the dramatic impact that the pandemic would have on health system capacity and mental health of healthcare providers (HCPs). As the pandemic monopolized human and financial resources in clinical settings, increasing evidence suggested that HCPs, who we defined as working directly with patients, were experiencing significant negative psychosocial and physical consequences. Indeed, notably higher rates of mental health issues, such as insomnia, anxiety, stress, fatigue, burnout, depression, somatization, obsessive-compulsive symptoms and post-traumatic stress disorder, have been reported among HCPs since the onset of the pandemic (Abbas et al. 2021; Bansal et al. 2020; Crowe et al. 2021; Greenberg et al. 2021; Lapum et al. 2021; Pappa et al. 2020; Tiete et al. 2021). One study of registered nurses providing critical care to COVID-19 patients found that 38% of participants had symptoms of post-traumatic stress disorder, 57% had mild to severe depression and 57% had anxiety (Crowe et al. 2021). Alarming, in another study, nearly one in five nurses and more than one in seven clinicians in intensive care units reported thoughts of self-harm or suicide (Greenberg et al. 2021). The declining psychosocial and physical state of HCPs is particularly concerning as prior to the pandemic, these groups were already considered vulnerable to occupational stress and burnout (Stelnicki et al. 2020). Understanding the sources of these challenges is crucial for pandemic recovery.

Studies that explored HCPs during the second and third waves reveal no abatement of psychological burden or burnout in HCPs (Gonçalves et al. 2021; Nishimura et al. 2021a, 2021b; Tan et al. 2020). There is growing concern that the protracted crisis may cause lasting harm to HCPs and the health system (Greenberg and Raferty 2021; Lorente et al. 2021). The mental health and psychological well-being of front-line HCPs has been attributed to workplace issues such as work overload, reduced or insufficient staffing, lack of infectious disease experience or training, personal protective equipment (PPE) shortages, compassion fatigue and shared trauma (Arnetz et al. 2020; Greenberg et al. 2021; Iheduru-Anderson 2021; Khajuria et al. 2021; Manzano García and Ayala Calvo 2021; Werner et al. 2020). Perceived fear regarding occupationally acquired infection and bearing responsibility for the health of one's family, friends and colleagues is common among HCPs. Moreover, as the pandemic has progressed, HCPs have faced additional occupational strains from an influx of patients with higher clinical acuity as a result of cancelled or delayed procedures (Abbas et al. 2021; Gomez-Ramiro et al. 2021; Hartnett et al. 2020).

Healthcare policy decisions that were made during the pandemic impact psychosocial and physical health, social harms and opportunity costs (Crowe et al. 2021; Gilson et al. 2020; Glover et al. 2020). Policies created at the national, provincial and institutional level to shield people from the risk of COVID-19 and to avoid overwhelming the healthcare system altered the healthcare environment (Glover et al. 2020; Gomez-Ramiro et al. 2021; Limoges et al. 2021). For example, there were policies restricting visitors in all patient care areas and those restricting mobility such as the stay-at-home order and the six-foot physical

distancing requirements, whereby patients could not leave their rooms or units even for fresh air and that prevented any type of patient group exercise or psychological therapy. Additionally, there were also government orders/directives, such as those requiring hospitals to manage long-term care and retirement facilities in outbreak, that placed strains on health-care workers. Given that the work environment has a strong influence on nurse burnout and patient outcomes such as patient mortality, failure to rescue and prolonged length of stay (Schlak et al. 2021), added burdens from the pandemic responses are concerning.

This qualitative study included participants from two distinct parts of a non-urban health system: a large psychiatric hospital and a large acute care community hospital, both located in Ontario. These two facilities were chosen because they are the two largest healthcare facilities in the region, they represent different types of healthcare services and the researchers had access to these facilities. We opted to use two distinct types of facilities knowing that this would enable a detailed analysis of the local and extra-local factors influencing HCPs during the pandemic. The purpose of the study was to describe HCPs' experiences with the pandemic and to understand their education and support needs. The research findings are used to generate recommendations and strategies to support policy development, implementation and evaluation for the pandemic recovery. Now – more than two years into the pandemic – leaders, policy makers and health system planners need knowledge to deal with the fatigue, burnout and negative health outcomes during the current state and prepare for pandemic recovery.

Method

One-to-one semi-structured interviews and online open-ended questionnaires were used to elicit perceptions and experiences of HCPs working during the COVID-19 pandemic to answer the following research questions:

1. What are the experiences and psychological needs of HCPs that have arisen from the COVID-19 pandemic restrictions?
2. How have the COVID-19 experiences of HCPs influenced professional practices, relationships with patients and inter- and intraprofessional collaborations?
3. What types of educational interventions and supports could address the needs of HCPs during the pandemic recovery period?

The online open-ended questions were similar to the interview questions and were offered as a way to promote participation and flexibility for shift workers (Box 1). The questions were modified slightly to reflect the name of the facility and type of care provided; otherwise, the questions were very similar. The research questions were used to write the interview and online questions in a way that would enable participants to use their own words to explain their experiences and ideas.

BOX 1. Sample interview questions from the online questionnaire

- What were your experiences with the COVID-19 pandemic and the restrictions?
- What changed for you in the way you interact with patients and other HCPs as a result of the pandemic restrictions?
- How have the pandemic restrictions impacted you and your professional practice?
- What strategies and supports would assist you at this time and as the pandemic ends?

Recruitment and participant description

Participants were recruited from the Waypoint Centre for Mental Health Care, a 301-bed specialty mental health hospital located in Penetanguishene, ON, and the Royal Victoria Regional Health Centre (RVH), a 408-bed acute care community hospital located in Barrie, ON. All actively employed and/or affiliated HCPs from Waypoint ($N = 740$) and RVH ($N = \sim 2,500$) were invited through e-mailed invitations to participate in the study. Through convenience sampling, 30 people were interviewed, and 88 people answered open-ended questionnaires online (see Table 1 for participant breakdown). Those from Waypoint participated in the study between August 18, 2020, and November 18, 2020, which was after the first wave of the pandemic, while those from RVH participated between December 23, 2020, and February 15, 2021, during the second wave of the pandemic. Informed consent was obtained prior to data collection. Participants received an e-gift card as a token of appreciation. The study was approved by the Research Ethics Boards of RVH, Waypoint Centre for Mental Health Care and Georgian College (Ref R20-006, HPRA#20.07.02, and #1920-97, respectively).

Methodology and analysis

Qualitative data came from transcripts of the semi-structured interviews and written answers to the online open-ended questions. Analysis of the qualitative data was informed by Thorne's interpretive description, a pragmatic method well-suited to knowledge production for health practice disciplines (Thorne 2016). Interpretive description enabled an analysis of how the pandemic was influencing the participants' experience, disciplinary epistemology, practice and practice setting. Analyses with interpretive descriptive methods involve exploring broader social experiences, including personal and social relations and policy. When participants described their experiences, if further clarification on the influences to the experience were required, probing questions were asked.

Open coding and peer debriefing guided the comparison of memos, codes and salient categories. RQDA (a qualitative analysis software application) was used to organize the data and to provide an audit trail of coding and data analysis. Participant data were read and re-read until agreements on common themes and understanding of the experience were reached by two independent researchers. Methodological and investigator triangulation enhanced the trustworthiness, credibility and reliability of the findings (Thorne 2016). Triangulation was carried out with interviews and online open-ended questionnaires, coding and analysis by an interprofessional research team and by data collection at two distinct sites over two different

TABLE 1. Participant demographics

Variable		Questionnaire		Interviews		Total
		RVH (Community hospital)	Waypoint (Psychiatric hospital)	RVH (General hospital)	Waypoint (Psychiatric hospital)	
Profession	Nursing	36 (76.6%)	34 (82.9%)	11 (73.3%)	9 (60.0%)	90 (76.3%)
	Physician	2 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.7%)
	Other	3 (6.4%)	4 (9.8%)	1 (6.7%)	0 (0.0%)	8 (6.8%)
	Allied health	6 (12.8%)	3 (7.3%)	3 (20.0%)	6 (40.0%)	18 (15.3%)
	Total	47 (100%)	41 (100%)	15 (100%)	15 (100%)	118 (100%)
Age	<30	13 (27.7%)	14 (34.1%)	0 (0.0%)	1 (6.7%)	28 (23.7%)
	31–50	29 (61.7%)	15 (36.6%)	9 (60.0%)	6 (40.0%)	59 (50.0%)
	51–65	5 (10.6%)	12 (29.3%)	6 (40.0%)	8 (53.3%)	31 (26.3%)
	Total	47 (100%)	41 (100%)	15 (100%)	15 (100%)	118 (100%)
Experience (total)	<5	16 (34.0%)	14 (34.1%)	1 (6.7%)	2 (13.3%)	33 (28.0%)
	6–10	11 (23.4%)	12 (29.3%)	3 (20.0%)	1 (6.7%)	27 (22.9%)
	11–15	7 (14.9%)	5 (12.2%)	4 (26.7%)	4 (26.7%)	20 (16.9%)
	16–20	8 (17.0%)	6 (14.6%)	4 (26.7%)	2 (13.3%)	20 (16.9%)
	>20	5 (10.6%)	4 (9.8%)	3 (20.0%)	6 (40.0%)	18 (15.3%)
	Total	47 (100%)	41 (100%)	15 (100%)	15 (100%)	118 (100%)
Experience at site	<5	24 (51.1%)	16 (39.0%)	4 (26.7%)	2 (13.3%)	46 (39.0%)
	6–10	14 (29.8%)	10 (24.4%)	3 (20.0%)	1 (6.7%)	28 (23.7%)
	11–15	2 (4.3%)	1 (2.4%)	4 (26.7%)	4 (26.7%)	11 (9.3%)
	16–20	5 (10.6%)	8 (19.5%)	2 (13.3%)	2 (13.3%)	17 (14.4%)
	>20	2 (4.3%)	6 (14.6%)	2 (13.3%)	6 (40.0%)	16 (13.6%)
	Total	47 (100%)	41 (100%)	15 (100%)	15 (100%)	118 (100%)
Race/ethnicity*	White	42 (89.4%)	36 (90.0%)	14 (93.3%)	12 (92.3%)	104 (90.4%)
	N	88		30		118

*Small numbers in race/ethnicity have not been presented to protect identity.

time points wherein the region was in different levels of lockdown and with different infection rates. The data were analyzed inductively using answers to individual questions while considering the data as a whole to find individual and common experiences. The findings reflect common themes on how the pandemic restrictions impacted HCPs and their perceptions of helpful strategies to navigate the pandemic and the pandemic recovery.

Findings

Analysis of the data at the individual and group level revealed common experiences and yielded three findings. First, the common experiences and struggles of HCPs that are linked to

policies are described. Second, the impact of policy implementation strategies, communication techniques and frequent policy revisions on HCPs is detailed. Third, participant needs and recommendations related to policy development and implementation are discussed.

Demographic characteristics across both sites were similar and are provided in Table 1. Most participants identified as white, female, working-on-site nurses, were between 31 and 50 years of age and lived with other people, such as children or a spouse.

Policies driving pandemic fatigue and burnout

When participants were asked to describe how the pandemic influenced their personal and professional lives, they provided detailed accounts of their challenges. As expected, they recounted the fear of the contagion, especially at the very beginning of the pandemic and during periods of high COVID-19 infection rates. With the protractedness of the pandemic, their concerns multiplied. HCPs named and linked various policies as the source or antecedent to their deepening fatigue, emotional upheaval and mounting distress and anxiety.

The participants explained how government policies that limited mobility (such as the stay-at-home orders and six-foot physical distancing) led to agency policies that required the cancellation of group therapy and recreational activities and the requirement for all patients to remain in their room. Patient confinement, with few opportunities to exercise, move freely or socialize, had a negative impact on patient health. Mobility restrictions were particularly challenging for patients with paranoia and/or depression, yet all patients had to comply with the policies. Witnessing patient hardship exacted a high toll on HCPs, with many discussing burnout, fatigue and stress. This quotation explains the toll:

Staff call in sick more, staff are stressed more, [there is] more crying, [they are] more upset [and there are] more thoughts of inability to care for people ... It's almost [as if] you think you are not good enough. Staff feel like they [are] alone and isolated in that they do not have help. Even though we are all there.

The physical distancing requirement directly impacted HCPs in a surprising way. While necessary to limit the spread of COVID-19, it disrupted social patterns and the taken-for-granted emotional support provided during rest breaks. Participants indicated that social time was so important to de-stress during difficult times. Without these small social exchanges, work began to feel like a grind. A participant explained as follows:

It [has] been really hard, it's like [this]: wake up in the morning, go to work, come home and then go to sleep, and it starts all over again because I do [not] have time, and I do [not] even have colleagues that I used to have. It's not easy to do this type of job in the way that it [is] happening.

Another policy that had impacted the well-being of HCPs, particularly those in the acute care hospital, was the no visitor/no volunteer policy. Witnessing patient loneliness and lack of social supports during serious and sometimes life-altering hospitalizations alone was emotionally draining. A participant stated as follows:

Whenever they have a life-changing situation, whether it is great news or bad news, they do not have the people they want at the bedside. I cannot even imagine the torment that [it] is for patients. Yes, I can support the patient, and I want to be able to support the family as well. And yet I cannot.

Furthermore, HCPs had to intensify their work pace so that they could provide their usual care in addition to providing supports that would typically be given by visitors/family members. HCPs were already taxed by the heavy workload, short staffing and extra requirements from donning and doffing PPE. A nurse participant from the community hospital explained, “When they stopped families from being able to visit, it made things really challenging. We’re like the patient’s link now.” HCPs quickly realized that they could not even come close to replacing the essential supports offered by close family and friends. This caused them to question the merits of policy decisions:

It makes me question some of the decisions that are being made from a pandemic perspective. I am sure some of the decisions are based in science and some of them are based on logic, [but] some of them are based on fear, [such as] the visiting hours and the visiting protocols. I really think that we have underestimated the gravity of our work, and I really do not think having a loved one at the bedside should be a choice to be honest. I really do not. It is not right. It was a mistake to restrict families.

HCPs were challenged to see patients suffering alone, felt pressure from intense and unrelenting workloads and felt strained from witnessing the negative effects of loneliness and boredom in patients.

The pandemic pay policy was particularly impactful for the allied health participants (such as physiotherapists and social workers). The pandemic pay policy was implemented in Ontario to recognize and reward HCPs with a four-dollar-per-hour pay increase. Yet, for many, it had an unintended consequence. Participants, such as physiotherapists and social workers, who did not receive pandemic pay said that their exclusion made them feel devalued. During a time when HCPs were all sacrificing and working strenuously with patients, feeling devalued was difficult to cope with. A participant explained:

The nurses got pandemic pay [and] the housekeeping staff did, but the dietary staff didn’t. How is that fair? They’re in the front line[s] too ... People just want to feel

valued and that someone [has] actually paid attention to what they're doing. And I don't know how to solve that part. If I knew how to solve that, I'd bottle it and sell it. I think that the biggest piece is for people to feel valued and connected and appreciated.

HCPs relayed how the pandemic was impacting every aspect of their practice as seen in this quotation:

It is every moment we breathe, every moment we do anything at work – it is [a] pandemic. You can see the stressors on our leaders too. It definitely does [affect] them. Patients ... how they are reacting ... [y]ou can see anxiety [they face]. Not having family or their supports within the hospital – they have to face [the] illness and surgery by themselves now. And of course, it is being reflected upon us. Our restrictions [stretch] as far as where we have our luncheons ... everything has changed for us. It is very stressful – your temperament can be very short sometimes. There are times whe[n] I have cried, which I have never done at my job before. I cannot say enough about [the] stress of what the pandemic has put on the workplace.

Policy communication and implementation-shaped experience

Regardless of when someone joined the study, strong emotions were linked to the ways in which the policies were communicated and implemented during the initial days and during the continuation of the pandemic. This quotation explains the same:

What we need are consistencies. I find some of the messaging that we got were inconsistent. And that is what really causes angst.

The pandemic itself created a situation of low control, and participants felt little was done to address these feelings during the implementation of the policies that were meant to support safe practice. This quotation shows the common experience with policy-driven changes:

At work, it's extremely stressful. The two biggest things that I found [are] that the restrictions changed day to day and they seemed to be reactive and arbitrary decisions. All the changes made it stressful. [The way] management [communicated] to the front lines was a very directive approach.

HCPs were not always sure that they were doing things right. A participant explained, "Nobody was really sure if they were [donning] PPE [the right way]. From day to day, everything changed hospital wide and we were really unsure if we were doing the right thing. [That was] [s]tressful."

They also relayed feelings of insecurity and lack of confidence in the development of the policies, pondering whether they were carefully developed with evidence or common sense. In situations where there was already a lack of trust, the frequent changes in policy fuelled strong feelings of concern and anxiety. A participant explained:

It feels like the rules and the policies change constantly. One example I have, where I used to feel safe and now I do not, is about a month ago, we could not cohort COVID patients in a room because they told us [there] was too much viral load in one area for staff members, and [they say] it is not safe. But now we are out of rooms, and so now they have changed the policy, and it is completely safe now to cohort four patients. And they do cohort up to four COVID patients. So it feels like they change the policy whenever they feel like it. They keep telling us we're safe, but they keep changing, and so it is hard to believe them. I find that super frustrating.

The constant changes in policy and the lack of HCP input into policy creation, implementation or evaluation were stressful to HCPs. Participants relayed how trying to stay current with changing policies was exhausting and anxiety provoking.

HCPs' needs vis-à-vis policy

All participants understood the need for the pandemic restrictions and associated policies, and all participants were willing to follow the rules. However, HCPs struggled because policies were solely focused on controlling the spread of COVID-19 and did not adequately address holistic patient care or the practice environment. In general, HCPs found that patient suffering was extreme and very distressing to witness. Participants wanted a process where they could provide their expertise during policy development so that the policies could be "least restrictive." HCPs also wanted a concurrent strategy to develop new care approaches to mitigate the impact of policy on practice. They wanted an opportunity to engage in clinical innovation to counteract the negative impact of policy. This quotation reveals the need to focus on patient care and patient health outcomes: "If all we are thinking about is COVID, then we are not spending enough time working on the day-to-day care delivery that is necessary for the patient." Participants anticipated that had they been able to develop new care strategies to counteract the restrictive pandemic policies, the situation would have been better for patients and, therefore, themselves. This quotation illustrates the need to consider more than just COVID-19: "They [patients] can't put their health on hold."

Participants understood the reasons for the one-directional policy development and implementation at the very start of the pandemic. But with the duration and mounting evidence showing the psychosocial, physical and emotional harm to patients and HCPs, they wanted to move from emergency crisis mode to a mode of sustainable health delivery that would address high-quality patient care and burnout. This change would require their input into policy.

Discussion

The ongoing pandemic is having widespread and profound impact on HCPs practising in mental health and acute care settings. The similarity of perceptions and experiences between HCPs working at two distinct hospital settings and across different time points in the pandemic (Anzola et al. 2022) prompted an exploration of the data for extra-local reality constructors. Importantly, the impact of policy, policy implementation and policy evaluation emerged as strong influencers to HCP experiences. Policies developed at the government level, such as the emergency stay-at-home orders, led to institutional policies that restricted visitors and required new practices for infection control, such as the six-feet physical distancing measure. Other government policies, such as the pandemic pay policies, directly impacted HCPs and their sense of belonging to the team. Ultimately, the government and institutional policies shaped clinical practice, the work environment and the HCP and patient experiences. The lasting impact of the early pandemic period, the ever-changing policies and the poor communication of policy changes between decision makers and HCPs at the point of care requires consideration. Burnout and stress transcend the fear of the COVID-19 contagion and the challenges of caring directly for patients diagnosed with COVID-19 (Crowe et al. 2021; Tiete et al. 2021). The findings from this study highlight unintended negative consequences linked to policies and how HCPs could contribute to policies aimed at pandemic recovery.

Policy makers at the provincial, federal and institutional levels faced a significant challenge when making pandemic decisions and policies to curb the spread of COVID-19. Information was evolving rapidly about the infectiousness and seriousness of COVID-19, and decisions had to be made quickly. As we move to pandemic recovery and prepare for the next crisis or pandemic, recognizing policy as discourse and as a constructor of experience is essential. Furthermore, challenges following policies during the pandemic were linked to major depression in front-line health workers (Hennein et al. 2021). HCPs felt frustrated by the pandemic response and often felt abandoned. A similar finding was reported by Crowe et al. (2021). Recognizing the lasting impact of policy on wellness and experience signals its powerful influence on HCPs, and ideally this would be addressed at the government and institutional level during policy development. Alternative decision-making patterns can guide transparent policy making that includes a balanced perspective that can support better policy and policy outcomes (Berger et al. 2021).

The findings from this study can be used to initiate a more collaborative and relational approach to policy development and implementation to include input from the individual, institutional and government levels. Regular communication and support can increase confidence in decisions and feelings of control, both of which were associated with lower burnout rates during the current and past pandemics (Goulia et al. 2010; Manzano García and Ayala Calvo 2021; Nickell et al. 2004). By recognizing the interconnections among policies, the work setting and HCP experience, networks of collaboration can be formed to ensure that the intended effects of policy are achieved with minimal negative consequence (Gilson et al.

2020; Hennein et al. 2021). Addressing the fact that nurses who carry the burden of front-line work and who are mostly removed from policy development can be an important step (Anders 2021). Their front-line knowledge and experience of implementing policy can and should be utilized by policy makers (Anders 2021). Nurses can advocate for patients as they have firsthand knowledge of the patient experience, are widely trusted as professionals and would be a credible source of knowledge. Nurses and other HCPs from the point of care need to play a larger role in developing workplace policy (Anders 2021).

Participants in this study revealed high levels of occupational fatigue, poor inter-shift recovery and loneliness while at work. There is evidence validating the cumulative negative impact from the subsequent waves of the pandemic as well (Nishimura et al. 2021a, 2021b; Tan et al. 2020), which align with our findings. Additionally, participants in the study explained how the lack of social interaction with colleagues made work feel more arduous and lonelier. Loneliness during the pandemic has been associated with higher rates of depression in HCPs (Wang et al. 2021). High acute and chronic fatigue levels are associated with higher occurrences of care left undone (Min et al. 2021) and, thus, is a concern in healthcare that should be addressed. As such, pandemic fatigue is a significant concern for pandemic recovery, employee resignation and the sustainability of our healthcare system. Bettering health and well-being and addressing workplace challenges can enhance the quality of care and the sustainability of working conditions (Yildirim et al. 2021), which can ultimately influence workforce retention. Good work environments can attenuate the relationship between nurse burnout and patient mortality, failure to rescue and length of stay (Schlak et al. 2021). Developing, implementing and evaluating policies with HCPs from the point of care and ensuring mitigation strategies, such as clinical innovation and new skills development, can offset the changes to the healthcare environment that impact patients and HCPs (Anders 2021; Hennein et al. 2021).

Changing the approach to policy development, implementation and evaluation so that it includes the experience and expertise of HCPs from the point of care is an important step needed to recover from the pandemic. Engaging HCPs in policy requires a multi-pronged strategy involving short- and long-term interventions. The YoderWise Framework for Planned Policy Change was shown as a useful model to support nurses to engage in policy during the COVID-19 pandemic (Anders 2021). Well-developed protocols and standard operating procedures at the government and institutional level will ensure that even during times of crisis, adequate consultation with those who practise at the point of care is used. HCP perspectives are essential to properly inform policy makers and policy for health system reform, regulatory changes, care coordination and policies for pandemic recovery.

There are practical strategies that can support stronger collaboration during policy development and implementation, and these are particularly important to consider during the pandemic recovery phase. HCPs are exhausted, and many are contemplating resignation and early retirement. Clear signals that the system and the policies that drive the system are changing could support retention and the sustainability of the health system. At the institutional

level, this could occur by recruiting members from policy and procedure committees to obtain input from HCPs on policy needs, the impact of policy implementation and strategies to mitigate unintended consequences. Rapid cycle improvement teams, usually located in institutional quality and safety departments, can be deployed to engage HCPs in processes to identify and implement innovations to offset policy consequences. Traditional and social media strategies can be used to gather feedback from HCPs, patients and stakeholders to inform policy. At the government level, ensuring that practising HCPs are consulted in the earliest phases of policy development can support impactful policies. A longer-term strategy involves additional education of HCPs during undergraduate and graduate education for crisis management and policy development, with opportunities to participate in each step in the policy process.

Learning from the COVID-19 pandemic and previous infection control challenges, such as the severe acute respiratory syndrome (SARS) outbreak in 2003 and H1N1 influenza pandemic in 2009, can ensure greater preparation for future crises. The COVID-19 pandemic experiences reported in this study are similar to the situations with H1N1 and SARS, such as issues related to information sharing. In previous pandemics, the importance of clear information and direction was raised, showing how clear information sharing was associated with lowered stress (Goulia et al. 2010; Matsuishi et al. 2012; Nickell et al. 2004). A repeat of these less-than-ideal practices, now over three pandemics, points to the need for integrated and system-wide change. Policy makers at the local, government and institutional level, as well as healthcare managers, need to consider how workplace factors, such as availability of PPE, staff training prior to re-deployment and mental health supports, can improve the experience and well-being of HCPs. This is crucial in the event of future COVID-19 waves and other pandemics (Khajuria et al. 2021). The lack of preparation for an inevitable pandemic, especially after recent experiences with SARS and H1N1, may have lasting implications (Brophy et al. 2021). Additionally, given the historical experience and the association of known stresses with providing healthcare during a pandemic (Goulia et al. 2010; Matsuishi et al. 2012; Nickell et al. 2004), pre-empting the next crisis is important (Brophy et al. 2021).

Conclusion

This study explored the experiences of HCPs who work in two distinct health sectors and covered two different time points in the pandemic. The professional practice and well-being of HCPs have been significantly impacted by the pandemic and pandemic-related policies. The duration and magnitude of the COVID-19 pandemic is compounding the need for health system planners, policy makers and health leaders to consider sustainable strategies to support healthcare providers. The pandemic is often described as an unprecedented event, yet during two previous pandemics (SARS and H1N1), HCPs had similar experiences and researchers had reported findings and recommendations similar to those discussed in this paper.

In the very early pandemic period, health leaders and governments were alerted to the dramatic impact that the pandemic would have on health system capacity and HCPs. Ensuring that the lessons learnt from the COVID-19 pandemic are implemented is crucial.

This article highlights the need for a policy development, implementation and evaluation cycle at both the government and institutional level that includes the HCPs from the point of care, so that they can provide input into policy and mitigation strategies. Policy developed with and for HCPs can reduce pressure and ensure a sustainable workforce and health system. The findings in this study can support recovery from the COVID-19 pandemic and guide inter-pandemic capacity building. There are opportunities to integrate the findings from this study in undergraduate and graduate education, leadership and policy development programs and use them for health leaders involved in institutional and government policy development. The lessons from this pandemic can inform pandemic preparedness policies and protocols, which will ultimately support HCP and patient well-being and a sustainable health system. The following is an overview of recommendations for practice:

- Develop clear communication channels and supports for HCPs to ensure that they are aware and confident of policy changes.
- Include HCPs from the point of care in policy development, implementation and evaluation.
- Develop a concurrent process for clinical innovation and HCPs' education/training to mitigate the negative consequences of policies on patients and HCPs.
- Develop systematic approaches to collect data on HCPs' intent to leave/resign and engage in collaborative strategies that support pandemic recovery.
- Ensure that lessons from SARS, H1N1 and COVID-19 outbreaks are included in education programs that prepare leaders and policy advisors/writers.

Acknowledgement

The authors thank Muskaan Karwal for her assistance during this project.

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