J. healthc. qual. res. 2020;35(6):401–408

FUNDACIÓN ESPAÑOLA DE CALIDAD ASISTENCIAL

Journal of Healthcare Quality Research

www.elsevier.es/jhqr

LETTERS TO THE EDITOR

Working conditions and emotional impact in healthcare workers during COVID-19 pandemic

Condiciones de trabajo versus daño emocional en trabajadores de la salud que enfrentan COVID-19

Dear Editor

In the context of the global crisis caused by the COVID-19 pandemic, we are aware that healthcare workers are the first line of defence to combat this disease. Unfortunately, the face this health emergency with poor working conditions, due to the shortage of biosafety equipment, scarce of infection control systems, lack of recognition programs and work incentives, and finally physical and psychological abuse and discrimination by patients, which has an impact on their mental health.[1,2] These are well known stressors of work context that can be identified as psychosocial factors of work.[3] Its effects could be manifested as stress, depression, anxiety, due to insufficient information about the virus, the continuous care of patients with COVID_19, high workload, constant exposure to critical events such as death,[4] fear of being infected and infecting their families[2] and its consequences on their own health. Therefore, studies have been reported the presence of psychiatric symptoms[5] in a population without mental illnesses, such as depression, anxiety, post-traumatic stress and aggravation in those suffering from mental illness.

These psychological consequences weaken and incapacitate health workers, who are exposed to a greater risk due to inadequate working conditions. If this situation is not considered, the psychosocial consequences on their mental health are likely to be very serious; forcing many of them to quit their jobs. Certainly, the impact does not affect all countries at same manner; in Peru for example, with a fragmented health system, economical problems, geographic, and social problems due accessibility; deficiencies in infrastructure, lack of equipment and working conditions, has been suffering from the beginning of the pandemic. The literature indicates that the inadequate management of health services generates by stress affects good performance as well as influences quality of care and consequently putting at risk patient safety.[6]

If, COVID-19 brings exposure of health personnel to physical, biological and psychological risks, without having the basic conditions to control, mitigate and cope with serious and even irreversible consequences of the pandemic, then it could be considered as an occupational disease, due to the manifestations of occupational risk and its psychological consequences.[7]

It is evident that this pandemic has serious psychosocial effects on health workers as they are directly linked to the working conditions. Thus, if, their working conditions are inadequate, they will put their family's health at risk and, consequently, the impact on their mental health will be exacerbated.[8] It is interesting to consider that some studies showed that training with biosafety measures, a correct application of infection control procedures, as well as having personal protective equipment and recognition of their efforts at institutional and government levels, can generate a feeling of security and motivation to continue working[9].

Many studies focused on recognizing protective factors that would help health professionals performance and would improve their adaptation, given that there is a high physical and mental demand for their services in times of crisis. However, this capacity for adaptation and resilience is due to the protection and support provided by having adequate working conditions, with a decrease in psychosocial risk factors.

Consequently, it is necessary to be aware to specific needs of healthcare workers and implement a psychological intervention programs focused on the crisis and post-trauma care[10] and also make administrative and organizational changes to have an organized and quality health system, ensuring its sustainability and response capacity despite the crisis.[11]

References

1. Kang L, Ma S, Chen M, Yang J, Wang Y, Li R, et al. Impact on mental health and perceptions of psychological care among medical and nursing staff in Wuhan during the 2019 novel coronavirus disease outbreak: a cross-sectional study. Brain Behav Immun [Online]. 2020, http://dx.doi.org/10.1016/j.bbi.2020.03.028. S0889-1591(20)30348-2.
2. Huang JZ, Han MF, Luo TD, Ren AK, Zhou XP. Mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19. Zhonghua Lao Dong Wei Sheng Zhi Ye Bing Za Zhi [Online]. 2020;38:E001, http://dx.doi.org/10.3760/cma.j.cn121094-20200219-00063.
3. International Labour Organisation. Psychosocial factors at work: recognition and control. Report of the Joint ILO/WHO Committee on Occupational Health. Ninth Session, Geneva, Setiembre, 18–24 (Occupational Safety and Health Series, 56). Geneva; 1986. Available from: http://www.ilo.org/public/libdoc/ilo/1986/86B09_301_engl.pdf
4. Zhang W, Wang K, Yin L, Zhao W, Xue Q, Peng M, et al. Mental health and psychosocial problems of medical health workers during the COVID-19 epidemic in China. Psychother Psychosom. 2020;89:242–50.

5. Lima CKT, Carvalho PMM, Lima IAAS, Nunes JVAO, Saraiva JS, de Souza RI, et al. The emotional impact of Coronavirus 2019-nCoV (new Coronavirus disease). Psychiatry Res [Online]. 2020;287:112915, http://dx.doi.org/10.1016/j.psychres.2020.112915.
6. Pérez H, Beyrouty M, Bennett K. Chaos in the clinic: characteristics and consequences of practices perceived as chaotic. J Healthc Qual. 2017;39:43–53.
7. OIT. Las normas de la OIT y el COVID-19; 2010. Available in https://www.ilo.org/wcmsp5/groups/public/—ed_norm/—normes/documents/publication/wcms_739939.pdf
8. Khalid I, Khalid T, Qabajah M, Barnard A, Qusmaq I. Healthcare workers emotions perceived stressors and coping strategies during a MERS-CoV outbreak. Clin Med Res [Online]. 2016;14(1):7–14.
9. Cai H, Tu B, Ma J, Chen L, Fu L, Jiang YJ, et al. Psychological impact and coping strategies of frontline medical staff in Hunan between January and March 2020 during the outbreak of Coronavirus Disease 2019 (COVID-19) in Hubei, China. Med Sci Monitor [Online]. 2020;26:924171, http://dx.doi.org/10.12659/MSM.924171.
10. Huang L, Xu F, Liu H. Emotional responses and coping strategies of nurses and nursing college students during COVID-19 outbreak; 2020, http://dx.doi.org/10.1101/2020.03.05.20031898.
11. Salyers M, Bonfils K, Luther L, Firmin R, Blanco D, Adams E, et al. The relationship between professional burnout and quality and safety in healthcare: a meta-analysis. J Gen Intern Med [Online]. 2016;32(4):475–82, http://dx.doi.org/10.1007/s11606-016-3886-9.

A. Boluarte Carbajal[a,*], A. Sánchez Boluarte[b], A. Rodríguez Boluarte[c], C. Merino Soto[d]

[a] *Escuela de Posgrado, Universidad Norbert Wiener, Lima, Peru*
[b] *Universidad Peruana Cayetano Heredia, Lima, Peru*
[c] *University Diakin, Australia*
[d] *Universidad de San Martín de Porres, Lima, Peru*

* Corresponding author.

E-mail address: aliciabolucar@gmail.com (A. Boluarte Carbajal).
Available online 12 September 2020

https://doi.org/10.1016/j.jhqr.2020.08.002

Impacto de la pandemia SARS-CoV-2 en el inicio de las prescripciones

Impact of the SARS-CoV-2 pandemic on the start of prescriptions

Sra. Directora:

La llegada del SARS-CoV-2 a España y la declaración del estado de alarma han provocado la reorganización del sistema sanitario en tiempo récord. La atención primaria ha incorporado a la atención, cuidado y seguimiento habituales de los problemas de salud, las consultas relacionadas con la COVID-19. Para evitar desplazamientos innecesarios y la exposición a personas potencialmente infectadas, la atención primaria y las consultas externas de los hospitales se han reestructurado optando, en la mayoría de los casos, por la atención telemática. Esto se ha complementado con la asistencia presencial o domiciliaria, en caso necesario[1]. Es razonable pensar que esta reorganización habrá supuesto el aplazamiento de la atención de muchas enfermedades, lo que previsiblemente tendrá un efecto en la morbilidad debido a retrasos diagnósticos y demoras en los tratamientos[2].

Con el objetivo de conocer el impacto que esta situación excepcional ha podido tener en la prescripción se ha procedido a comparar las prescripciones iniciadas entre el 14 de marzo del 2020 (fecha de la implantación del estado de alarma) y el 13 de junio del 2020, con las realizadas en el mismo periodo del año anterior en nuestra organización. Se ha realizado un estudio observacional retrospectivo de corte transversal. La Organización Sanitaria Integrada (OSI) Bidasoa es una organización sanitaria perteneciente a Osakidetza, compuesta por un hospital comarcal y 3 centros de salud, que atiende a una población de más de 85.000 habitantes. Se han estudiado las prescripciones electrónicas iniciadas entre el 14 de marzo y el 13 de junio del 2020 y se han comparado con las iniciadas en el mismo periodo del año anterior.

En el periodo 14 marzo-13 de junio del 2020 se crearon en la OSI Bidasoa 40.069 nuevas prescripciones, un 30,3% menos que en el mismo periodo de 2019. El 59% fueron prescritas a mujeres y el 41% a hombres, sin apenas diferencias de un año a otro. La media de edad fue de 51,4 años, tanto en 2019 como en 2020. Del total de las prescripciones iniciadas, el 70,2% de ellas han sido agudas, el 18,9% crónicas y el 10,9% para administración a demanda, siendo también los porcentajes similares a los del año anterior.

Por grupos terapéuticos, dejando a un lado los grupos que tienen un número pequeño de prescripciones (L [antineoplásicos e inmunomoduladores], P [antiparasitarios] o V [varios]), las reducciones más importantes se han producido en el grupo M (musculoesquelético), 45% menos de inicio de tratamientos, grupo C (cardiovascular), 39% menos, grupo B (sangre y órganos hematopoyéticos), 38% menos, y los grupos S (órganos de los sentidos) y J (antiinfecciosos para uso sistémico), un 35%, respectivamente (fig. 1). Descendiendo a grupos más concretos, la creación de nuevos tratamientos con antiinflamatorios no esteroideos (AINE) (grupo M01A) ha sido un 46% menor, el de los inhibidores de la enzima conversora de angiotensina y de los antagonistas de los receptores de la angiotensina II (IECA/ARA-II) (C09: fármacos que actúan sobre el sistema renina/angiotensina) un 43% menor, el de antibacterianos de uso sistémico (J01), un 37% menor o el de inhibidores de la bomba de protones (A02BC), un 31% menor.