Creating and sustaining work–life balance while providing skin and wound care 6 months into a global pandemic: second survey findings

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The data in this paper comes from survey two of a serial qualitative study, designed to describe and learn from the experiences of wound care clinicians working to meet the needs of patients amid the COVID-19 pandemic. This paper highlights results from data gathered during the second of five surveys emailed to clinicians in September 2020. Three themes emerged from the responses to the second survey:

1. Clinician perspectives: working conditions and work–life balance
2. Location-specific policies and their impacts within hospitals, long-term care facilities, and community home care
3. Technology as an asset and/or barrier.

The results from the first survey were published in 2021 (Kuhnke et al, 2021). Findings from the first survey allowed us to appreciate some of the complexities of the coronavirus pandemic, including far-reaching influences on healthcare professionals' efforts to deliver skin and wound care services to patients. In survey two, we also began to understand how the pandemic was influencing home lives and work–life balance. This article provides an overview of the impact of this dynamic reality on the ability of healthcare professionals to deliver care to patients, as well as the consequences on psychological health, professional confidence, educational development, and importantly, work–life balance.

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To date, there is no longitudinal, well-developed body of research describing how an ongoing global pandemic influences healthcare providers and the provision of skin and wound care services. Nor is there a well-developed series of recommendations for best fit practices during an ever changing, global pandemic. Therefore, one of the authors' goals is to contribute to the development of the literature.

Throughout the period of this study, wound care clinicians — who represent a diverse group (including nurses, physicians and allied healthcare professionals) in various roles — were required to adapt and modify the delivery of services, in all types of healthcare settings and private homes. Reduced or altered access to medical and nursing services — along with the rapid introduction of new digital technologies — contributed to challenges to care delivery for persons in need of skin and wound assessment, treatment and long-term management.

As well as delivering skin and wound care services in constantly changing conditions, healthcare providers also described difficulties and efforts to maintain their personal and familial health and wellness. While most families and employees were adhering to stay-at-home orders, clinicians were continuing their practices (Ruiz-Fernandez et al, 2020).

The results from the first survey in our study were published in May 2021 (Kuhnke et al, 2021).

Five themes emerged from survey one:

1. Increased use of virtual-care technology during the pandemic
2. Unequal clinician access to, and expertise with, virtual care technology
3. Unequal patient access to, and expertise using, virtual care technology
4. Increased clinician flexibility
5. Lack of skin and wound education.

These findings from the first survey allowed us to appreciate some of the complexities of the coronavirus pandemic, including far-reaching influences on healthcare professionals' efforts to deliver skin and wound care services.

Aim

The original aim of the study was to understand how the COVID-19 pandemic is a shaping influence on the delivery of wound care services over time. This second of five surveys, which included the same questions as survey one, sought to report on how clinicians working in Canada experienced their work, 6 months into the global pandemic.

It is important to note that data from survey two included participants commenting on how they and their families were being impacted. Participants described struggling to respond to changes not only at work, but also at home and in their communities.

Ethics and informed consent

The study followed standard ethics and consent protocols and was subject to review and approval by the Cape Breton University Research Ethics Board (Sydney, Nova Scotia, Canada).

Methods

Frameworks guiding this study

This article reports on data collected from the second of five surveys in a serial study designed to understand the experiences of clinicians, through time, as they provided wound care services during an ongoing coronavirus pandemic. Survey circulation dates were: April 2020, September 2020, December 2020, March 2021 and July 2021.

A qualitative descriptive methodology was utilised, as it allowed us to explore and describe the phenomena under study (Braun and Clarke, 2013; Salmons, 2015; Braun et al, 2021) from the perspectives of multiple participants within various contexts.

Online surveys were carefully selected because the research team understood there were "multiple versions of reality … and that these are very closely linked to the context they occur" (Braun and Clarke, 2013). Moreover, online surveys were the best fit during a global pandemic to gather data from national, provincial/territorial and individual perspectives.

Gaining a broad understanding was important because the surveys were circulated nationwide, and potential participants represented a diverse group of wound care clinicians (nurses, physicians, managers, administrators and unregulated healthcare providers) providing wound care in acute, community, rehabilitation and home care settings. As well, this diverse group was often working under divergent public health orders, which influenced participants' responses. Therefore, we required a methodology that could account for the diverse physical locations, diverse public orders and the diverse healthcare providers.

Furthermore, this methodology allowed for the research team to bring "their views, perspectives, frameworks for making sense of the world … into the research process" (Braun and Clarke, 2013). This was important because the research team includes experts with a broad range of experiences providing wound care services. As well, it includes members who were actively involved with the skin care of older family members.

Our goal was to capture, describe, and analyse participant responses in efforts to understand how wound care providers were constructed by and constructors of their reality (Braun and Clarke, 2013; Braun et al, 2021).

Survey methodology

Wounds Canada emailed the research survey to 12,204 potential participants for stage two of this serial research study. The list consists of individuals who previously agreed to receive invitations from Wounds Canada to participate in research. The survey utilised was identical to the one circulated in stage one and the instructions were also identical. Open-ended and closed questions were utilised. Descriptive data were collected using a Likert scale. Qualitative data were collected from individuals, who provided additional narratives below many of the questions.

Sixty-seven (n=67) participants completed this second survey (September 2020). This contrasted with the 217 participants who completed the first survey, distributed in May 2020. In total, 12,204 surveys were emailed for a response rate of 0.66% (survey two) and 2.5% (survey one). *Table 1* contains data describing location and job type of participants.

Table 1: Summary data of participants in survey two (*n*=67) and survey one.						
	Practising regulated healthcare provider (frontline clinician)		**Manager or administrator for a healthcare organisation**		**Practising unregulated healthcare provider**	
Participant location	**May 2020**	**Sept 2020**	**May 2020**	**Sept 2020**	**May 2020**	**Sept 2020**
Alberta	24	7				
British Columbia	14	2	1	1		1
Manitoba	21	2		1		
New Brunswick	9				1	
Newfoundland	2	2				
North West Territories	3	2				
Nova Scotia	14	2	7	3		
Ontario	116	39	11	3	2	
Prince Edward Island	1					
Quebec	6		1	1	2	
Saskatchewan	6					
No response	1	1	1		1	
Total	**217**	**57**	**21**	**9**	**6**	**1**

Analysis

As data were analysed, the intention was to temporarily "reflect on, and step outside [our] cultural membership, to become a cultural commentator — so that [we could] see, and question, the shared values and assumptions that make up being a member" of the skin and wound care community (Braun and Clarke, 2013). Leaning into Braun et al (2021), we used reflexive and arts-based approaches as we analysed the data. Raw data were formatted and emailed to the researchers. Data were organised by question number. The researchers read the data, making jot notes in the margins, asking questions, and making connections to the literature. The researchers also engaged in a reflexive practice consisting of artwork, journalling and photography (Finley, 2011). This was done in part to provide an additional layer of understanding, while pushing the boundaries of text-centric reports. This process was engaged repeatedly, individually and later collaboratively.

Through these processes themes emerged. This allowed the team to fit individual data elements into individual themes. As we sorted, we repeatedly moved back and forth between the data and existing research. We thought deeply about the details wound and skin care clinicians shared, the contexts of workplaces and society, including the global pandemic. Furthermore, we regularly referenced the multi-year, community nursing experiences of one of the researchers (Kuhnke) and the familial experiences of three others.

This process of moving backward and forward within the data, the research literature, and the researchers' experiences did as Braun et al (2021) described, provide "a wide-angle lens … useful when the population of interest is large, diverse, or indeed unknown. Or when perspectives from different groups within a wider population are sought" (p3). As a result of these processes, three themes emerged from the data.

Findings and themes

In the next sections, we will describe and summarise what participants shared, using quotations in the responses.

1. Clinician perspectives: working conditions and work–life balance

Approximately 6 months into the pandemic, clinicians shared their perspectives on the tensions experienced as they struggled to maintain work–life balance. Tensions were divided into two categories: those occurring at work and those occurring at home. Work-related tensions included: employers requesting overtime, staff deployment, staff shortages, personal safety concerns, inconsistent availability of personal protective equipment (PPE), a decrease in the number of healthcare settings where one could work and the resulting decrease in income. All these tensions, however, were secondary to an ongoing focus on the wellbeing of patients and efforts to meet wound care needs in ever-changing environments.

A second category of tension was linked to clinicians' efforts to establish and maintain work–life balance. Participants described complex and ever-changing childcare demands, school closures and the resulting need to supervise children learning at home, concern for the wellbeing of vulnerable family members — particularly a fear of bringing coronavirus home — and the impacts of decreasing income.

The following quotes highlight some of the tensions clinicians shared.

"Working too much overtime. This makes planning anything after work difficult. Job is great; however, it would be even better if there was time to take a break and make plans."

"Any nurses working in multiple facilities had to make a choice and reduce their [number of] employers to one. [Being] limited to one location resulted in reduced income and benefits."

"Nurses with childcare requirements were particularly affected, as they could not work with school closures. Others lived with vulnerable persons and could not continue to work; they took a leave. This left the remaining staff overworked within a COVID-19 environment. Hiring was impossible, because interviews could not be done."

These quotes are included to highlight how COVID-19 was not limited to the direct provision of care. It also impacted the lives of clinicians before and after they arrived at work, if they could come to work, where they could work, and how they worked.

2. Location-specific policies and their impacts within hospitals, long-term care facilities, and community home care

Tensions were also reported that were specific to individual settings. Three settings were noted: long-term care facilities, hospitals, and community home care. The tensions are summarised and grouped below.

Challenges specific to clinicians working in long-term care settings

The data highlight ongoing challenges to the delivery of wound care services. Participants described existing, pre-pandemic challenges related to the completion of wound assessments, referrals for consultation, and how the pandemic exacerbated both. Time — specifically not having enough — was repeatedly noted as a concern. Furthermore, participants also noted the lack of trained wound care professionals and sufficient resources, which also negatively impacted the provision of skin and wound care services. Finally, participants working in long-term care facilities described difficulties with finding, utilising, and maintaining the technology required for virtual support and consultations.

"Generalist staff are too busy to dedicate the time required to care for wounds. They are rushed and frustrated. They do consult with the nurse specialised in wound, ostomy and continence [NSWOC] virtually, but it's not the same as having in-house expertise."

"The staff continued to provide wound care; however, general care declined."

"The workload increased, but the resources available decreased as we are down to less than half our registered staff."

Challenges related to acute care settings

Participants working in acute care discussed challenges related to staff deployment and the use of technologies. Licensed practical nurses (LPNs) were deployed to COVID-19 screening clinics. Staff were placed in cohorts on specific units and not permitted to move. NSWOC staff were also reassigned. This movement of nurses, including those specialised in skin and wound care, resulted in a loss of expertise and, therefore, a resulting loss for patient skin and wound care.

Participants also described how closures and the movement of nurses resulted in a loss of technology. Specifically, they described how clinicians using wound-related technologies lost the ability to access and utilise some of their tools, while others reported an uptick in the use of technologies and the resulting benefits. From this, we understand how policies and technology influenced healthcare professionals' abilities to provide skin and wound care.

"Outpatient clinics were cancelled, causing delays in treatment and deterioration in multiple wound types that require NSWOC services."

"Since the pandemic started, the workload has increased, and wound care is not as on task as it was. Some of the wounds are deteriorating because staff are not taking the time with them."

"We have more technology to do remote/virtual care. Access to videos, two monitors in certain rooms to document as we talk to patients."

"Currently some GPs are more easily accessible virtually."

Challenges related to home care and community-based wound care clinics

Within the home and community care environments, participants described challenges when triaging, organising, and managing the provision of wound care services. They also described how hospital policies impacted their work. They reported receiving referrals from hospitals for patients with complex needs who appeared to have been discharged from acute care settings prematurely.

They also reported how kindergarten to grade 12 school closures resulted in immediate increases in the demand for home care services. Students with health-related needs (e.g. tube feeds, skin and wound care) required their school care to be moved home. The need for the provision of services for students in their homes fluctuated in response to ongoing changes in public policies and varied by geographic locations and COVID-19 hotspots.

From these challenges, we understand there was a deluge of changes that clinicians were constantly navigating. When we hold this

proclivity for unscheduled changes against what we know to be best practices for skin and wound care, we appreciate the complexity of the work, the potential for loss, and the mounting stress and subsequent need for work–life balance described by participants.

"Hospitals are discharging patients that should not be sent home. This led to an increase in home care patients."

"COVID-19 brought about many challenges, including the closure of our nursing wound clinic, which had over 200 patients. As well, we were responsible for the provision of services to patients in the kindergarten to [grade] 12 schools. School-based patients needed to be incorporated into our community nursing team within 48 hours of school closures. This resulted in significant challenges. Supplies had to be ordered and delivered by nurses. As well, we had issues with the availability of appropriate PPE."

As clinicians worked to navigate the ongoing changes and challenges, they also described improved access to physicians and wound specialists via technologies. The issue of technology was, however, inconsistently reported. Some participants described it as an asset, while others experienced it as a frustration and/or a hindrance to the provision of care, particularly as it related to wound assessment and debridement.

Participants also described a movement towards identifying those patients and families who could perform wound care independently or with a nurse supervising their care using phone calls, texts, photographs, emails and videos.

"We triaged patients differently. Patients with fewer complex wounds were told to do their own wound care (e.g. performing a simple dressing change). Some of these patients required infrequent palliative care services and had excellent family support."

"Patients were willing to reduce to self-care; however, virtual care for follow-up (with video assessment) was not always available."

"Communication with patients was via email, including attached photographs. We also used the telephone. As well, we were only able to see patients one day a week because of limited staff. This was extremely difficult, because the patients coming into the clinic had complex wounds and no help. We did not have a receptionist to check people in. Starting in June [2020], we saw a limited number of patients daily. It is challenging to decide who to see in person and who to follow up with email, attached photographs, and the telephone. We gradually increased the number of patients we see in-person, but numbers are still limited."

"Wound debridement was a challenge virtually … It was solely dependent on the receiving party's (registered nurse, nurse practitioner) ability to perform the debridement that I was directing virtually."

"[We were] able to contact specialists and obtain virtual direction in debriding wounds."

Clinicians were gathering data (in person and virtually) and making decisions. For some of their decisions, there were no best practice guidelines (e.g. deciding who would receive care at home). Moreover, virtual visits, which kept clinician and patients safe from COVID and quickly became a service modality were reliant on expertise, equipment and technologies that clinicians and patients did not always possess. This mention of the quick adaption of technology was further detailed when participants were asked specifically about technology and how it impacted their work.

3. Technology: as an asset and/or barrier

Data regarding technology were thickly descriptive. Wound care providers who lived rurally and had long-standing experiences with the use of technology as part of the assessment and care provision processes continued providing care and assessing wounds remotely. For this group, the pandemic and the resulting need for technology did not result in significant challenges. Skin and wound care clinicians with no or limited experience with technology did not fare as well. For this group five main sub-themes were repeatedly described:

- Issues related to the privacy, security, and confidentiality of data being transmitted
- A lack of training to utilise the technology
- Effectiveness of the technology in terms of assessment and communication
- Availability of technology
- Confidence and willingness to use technology by clinicians, patients, and families.

Privacy, security and confidentiality of data

Participants described concerns related to how data were shared and how potential breaches (privacy, security and confidentiality) were possible. Participants reported using social media accounts to communicate with patients and other clinicians. The extent to which they were used, and the specifics of the usage were not provided. Nevertheless, it is concerning, given that data stored on social media accounts is often stored outside of Canada and often

sold to other, for-profit, companies. The selling of data is most often unknown to the users. Other described benefits to communication that resulted, with caveats.

"A work mobile phone with data for the wound specialist was not available. Email and personal cell phones were used to transmit data, including photos. This was insecure."

"We hope the methods of communication (apps and technology) will continue. However, we will need limits on the use of social media for privacy and confidentiality concerns."

"We need more discussion about the most secure methods to ensure confidentiality."

Training to utilise technologies

The ability to use technology quickly became a central concern when providing care during a global pandemic and the resulting COVID-related protocols. Concerns were experienced by wound care providers, patients, and families.

Wound care clinicians concerns

There was a discrepancy between wound care clinicians who utilised technology prior to the onset of COVID-19 pandemic and those who had not previously required technology to deliver wound care services. The first group experienced only minimal impacts to their wound care service delivery. The second group, however, experienced challenges. The following quotes highlight the challenges.

"The facilities (and staff) that were requesting and using virtual care had very poor working knowledge of how to use the technology (internet and hardware). There was always confusion as to how to set things up, etc."

"Not all staff are comfortable with the new technology."

"Because of the COVID-related staff shortages and resulting staff turnovers, we are having to do training."

Family-related concerns

Survey participants also shared descriptions of trying to educate patients and family members about self-care for their wounds, and how the use of a phone or technology was not sensitive to those "hard of hearing or with language barriers". In addition, they described how "more patients chose to be taught how to do the wound care so that there were minimal people coming into their homes".

There were challenges when triaging and identifying patients and their caregivers who were best fit to conduct self-care, especially if the care was reliant on consistent technology. There were also issues related to a lack of integration between service providers. This was a concern because wound care clinicians perceived they were losing track of patients.

"Patients were willing to reduce to self-care. Not all patients had family members to support them with technology and video assessment, yet the technology was not always available through the agency."

"There was increased use of video, telehealth and telemerge to see the patients' wounds; it was helpful to see patients' reactions."

"At times, the internet connections could be lost."

"Technology systems do not talk. It was easy to lose track of patients with wounds. As well, patients were unsure where to go for wound care with provincial [clinic] closures."

Effectiveness of the technology

Wound care clinicians who utilised technology described the limitations of the technology they were expected to use.

"Wounds cannot be assessed properly by phone, and this was the main medium agencies were using."

"Would prefer to have 'eyes' on the wound. Cameras, pictures, and video conferencing can be misleading depending on the quality of the camera and the position of the residents when the pictures are taken."

"Photo colour is not always accurate, usually a redder tint."

"Sometimes the photos are unclear and there is no video access, only email or phone calls."

"In some cases, nurses are speaking to people on the phone, but aren't able to actually see what is going on. This causes things to be missed. In some cases, pictures can be exchanged that help with this issue. But when video conferencing is used this seems to work better, as things can be seen and discussed right away."

Again, from these responses we understand healthcare providers worked to integrate the technology; however, it is clear the patient-clinician interactions were often less reliable and less informative than face-to-face visits.

We also imagine this lack of reliability as an added stressor for clinicians, patients, and families, considering how quickly changes to status of skin and wounds can occur. Moreover, we wondered if the burden of wound deterioration and amputations is always hovering in the background when face-to-face visits are prohibited and access to wound clinicians is not possible or limited.

Figure 1. Healthcare workers described efforts to create work–life balance while attending to the well-being of self, patients, vulnerable family members and children.

Discussion

"For many [healthcare professionals]… tensions are thought to have a negative valance, that is, tensions are something to be avoided or smoothed over … [we acknowledge] how deeply we have learned to deny or cover over the tensions we … experience" (Clandinin et al, 2010). The researchers therefore acknowledge the courage of survey participants who movingly described tensions they are experiencing as they provide skin and wound care during a global pandemic.

This study was designed and implemented during an ongoing global coronavirus pandemic, when the delivery of care, as well as patients and clinicians, were impacted by "clinicians' ability to see patients, including closure of outpatient wound clinics" (Wound Health Society, 2020).

This second survey of the serial qualitative study was circulated after we had been living with COVID-19 for approximately 6 months. Data from survey one reflected the efforts of clinicians working creatively and adaptively to establish processes so patients could receive wound care services. From survey two, we noted changes to the data. After thorough and careful analysis, three themes emerged:

1. Clinician perspectives: working conditions and work–life balance.
2. Location-specific policies and their impacts within hospitals, long-term care facilities and community home care.
3. Technology as an asset and/or barrier.

Data from the second survey shows a growing concern by clinicians for their psychological and physical wellbeing and their efforts to create and maintain balance between work and home (*Figure 1*; De Kock et al, 2021). This added a new layer of concern into an already crowded, complex and constantly changing environment. Participants shared fears of acquiring the virus and/or transmitting it to others, especially their children, vulnerable family members or immunocompromised people. These concerns were also reported in a study by Cabarkapa et al (2020) who reported "psychological implications are largely negative and require greater attention to be mitigated." Psychological safety, including consistent and ongoing access to personal protective equipment, remained an issue (Dominguez-Salas et al, 2021).

To help mitigate these concerns, Zhao et al (2020) suggest inclusive leadership to reduce stress and anxiety, which may reduce psychological distress. In turn, this may contribute to the development of a psychologically safe work environment. Issues related to safety and work–life balance will continue to be monitored in surveys three, four and five.

From the data, it was clear clinicians have deep understandings of how COVID-19 is resulting in increased risks to already vulnerable patients — and, therefore, there is a heightened need to provide timely and reliable care. They know patients living with skin and wound issues may also have comorbidities. The existence of wounds and comorbid diseases puts individuals at risk for infection, hospitalisation, and emotional distress (Peiper, 2009; Wilson, 2012; Bondini et al, 2020; Oropallo, 2021). Moreover, delays in the delivery of wound care may exacerbate skin and wound conditions (Hsiseh et al, 2020).

This professional knowledge was described regardless of where a clinician was working; however, policies and changes to policies were experienced differently depending on location. For example, some patients did not want nurses to visit them at home, others did not want to leave their home or have family members present to support their wound care (European Wound Management Association, 2020). Some locations experienced extreme shortages in staff because of policies that forbade workers from reporting to more than one location. There were others who reported advantages in that, due to the decreased number of patients coming to clinics, clinicians were able to spend more time

with individuals. Some of the extra time was used to educate patients.

From the data, a single narrative or response to the pandemic did not emerge and location and location-specific policies were factors that impacted how care was provided. This is important because it helps us to understand that the locations where one works can influence the care provided, the care received, the carer, and the cared for.

A third theme that was brought forward from survey one and expanded upon in survey two relates to the use of technology to provide skin and wound care *[Figure 2]*. Despite a reported increase in the use of technologies, some components of evidence-based wound care, such as wound debridement, could not be performed. Moreover, several participants described the limitations of the technology compared to in-person visits. This was particularly true when it came to using emailed photographs of wounds to make decisions related to care.

Participants also reported difficulties finding, utilising, and maintaining secure virtual technology that could assist their work. This was further exacerbated when patients were unfamiliar with technology and/or were reluctant to use it. Technologies continued to be an unresolved challenge 6 months into the pandemic and may have contributed to the increased psychological pressures.

Moving forward

The responses to survey two have highlighted a number of questions to address as health systems continue to operate in a pandemic environment. These include:

- How would the data be different if skin and wound care needs were deemed to be an essential service by pandemic and endemic planning teams?
- How might the experiences of clinicians and patients have been different if healthcare organisations and leaders had established policies to support delivery of skin and wound care services during a pandemic?
- The data suggest clinicians, families, and patients are suffering. From Berg and Seeber (2016), we understand work–life balance is a "legitimate goal, a balance particularly tenuous for … [healthcare professionals] whose commitment and love for their … [work] can make drawing the line between work and life more difficult". How many more additional, COVID-related complexities and the resulting negative psychological implications can frontline colleagues endure as the pandemic continues *[Figure 3]*.

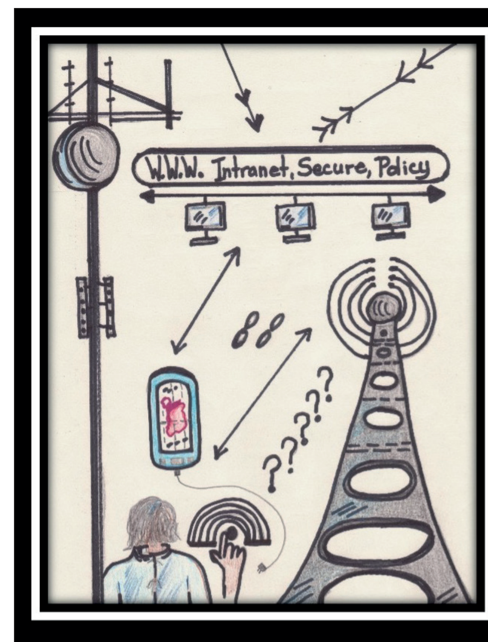

Figure 2. Participants were uncertain as they attempted to navigate technology, security of data, and associated policies and procedures within ever-changing environments.

These are important considerations as we continue to provide wound and skin care during a pandemic.

Conclusion

This study reports on the second of five surveys of a serial qualitative study designed to describe and learn from the experiences of wound care clinicians working to meet the needs of patients during the COVID-19 pandemic (Kuhnke et al, 2021). Wound care clinicians remained committed to the delivery of skin and wound care despite the pandemic. Though this study obtained a smaller sample size than survey one, the data did reveal ongoing challenges and opportunities related to the delivery of skin and wound care. From survey two data, the authors begin to see concerns for psychological safety, including efforts to establish and maintain work–life balance.

Other research that healthcare professionals indicated barriers related to access to PPE, work–life balance, increased case complexity, lack of available resources and competency in leveraging available technology (Adams and Walls, 2020; Cabarkapa et al, 2020).

A lack of prioritisation and appreciation by policy makers of the complexity of skin and wound care was also evident in the data.

Figure 3. The unpredictable elements (wind, snow, ice, and water) of this photograph (Jack-Malik, 2018) help us to imagine the complexity and uncertainties healthcare providers are enduring as they attempt to provide skin and wound services during a global pandemic.

This may have complicated and brought into focus clinician concerns for their work–life balance and safety. Organisational research has demonstrated that when organisations support employees and care about their wellbeing, those employees will be more engaged in their work. Employees who feel valued by their organisation will actively pursue the organisation's goals and exhibit behaviours such as increased job engagement. WINT

References

Adams JG, Walls RM (2020) Supporting the health care workforce during the COVID-19 global pandemic. *JAMA* 323(15): 1439–40

Berg M, Seeber BK (2016) *The Slow Professor*. Toronto: University of Toronto Press

Biondini CM, Sage S, Wilson BP et al (2020) Modified telehealth for care of chronic wounds during the coronavirus disease 2019 pandemic: a rapid literature review of alternative care modalities. *Int Wound J* 17(6): 1960–7

Braun V, Clarke V (2013) *Successful Qualitative Research: A Practical Guide for Beginners*. Thousand Oaks, CA: SAGE Publishing

Braun V, Clarke V, Boulton E et al (2021) The online survey as a qualitative research tool. *Int J Soc Res Methodol* 24(6): 641–54

Cabarkapa S, Nadjdia SE, Murgier J, Ng CH (2020) The psychological impact of COVID-19 and other viral epidemics on frontline healthcare world and ways to address it: a rapid systematic review. *Brain Behav Immun Health* 8: 100144

Clandinin DJ, Murphy SM, Huber J, Orr AM (2010) Negotiating narrative inquiries: living in a tension filled-midst. *J Educ Res* 10(3): 81–90

De Kock JH, Latham HA, Leslie SJ et al (2021) A rapid review of the impact of COVID-19 on the mental health of healthcare workers: Implications for supporting psychological well-being. *BMC Public Health* 21(1): 104

Domínguez-Salas S, Gómez-Salgado J, Guillén-Gestoso C at al (2021) Health care workers' protection and psychological safety during COVID-19 pandemic in Spain. *J Nurs Manag* 29(7): 1924–33

European Wound Management Association (2020) Wound care essentials during COVID-19. Available from: https://ewma.org/fileadmin/user_upload/EWMA_Conference/EWMA_2020/Material/WOUND_CARE_ESSENTIALS_DURING_COVID-19_BY_EWMA_PODCASTS.pdf (accessed 02.02.2022)

Finley S (2011) Critical arts-based inquiry. In: Denzin NK, Lincoln YS, eds. *The SAGE Handbook of Qualitative Research*. Thousand Oaks, CA: SAGE Publishing, 435–50

Gefen A, Ousey K (2020) Safe and effective wound care during the COVID-19 pandemic. *J Wound Care* 29(11): 622–3

Kuhnke JL, Jack-Malik S, Botros M et al (2021) Early COVID-19 and the experiences of Canadian wound care clinicians: preliminary findings. *Wounds International* 12(2): 14–9

Oropallo A (2021) COVID-19: Issues related to wound care and telehealth management. *UpToDate* Available from: https://www.uptodate.com/contents/covid-19-issues-related-to-wound-care-and-telehealth-management/print (accessed 02.02.2022)

Pieper B (2009) Vulnerable populations: considerations for wound care. *Ostomy Wound Manage* 55(5): 24–37

Salmons J (2015) *Qualitative Online Interviews*. 2nd edn. Thousand Oaks, CA: SAGE Publishing

Wilson M (2012) Managing patients vulnerable to pressure ulceration. *Wound Essentials* 1: 45–8. Available from: https://www.woundsme.com/uploads/resources/content_10449.pdf (accessed 02.02.2022)

Wound Healing Society (2020) COVID-19 guidelines. Available from: https://woundheal.org/COVID-guidelines.cgi (accessed 02.02.2022)

Zhao F, Ahmend F, Faraz NA (2020) Caring for the caregiver during COVID-19 outbreak: does inclusive leadership improve psychological safety and curb psychological distress? A cross-sectional study. *Int J Nurs Stud* 110: 103725