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RESEARCH

OCCUPATIONAL STRESS RELATED TO THE COVID-19 PANDEMIC: THE DAILY LIFE OF AN EMERGENCY CARE UNIT

ESTRESSE OCUPACIONAL RELACIONADO À PANDEMIA DE COVID-19: O COTIDIANO DE UMA UNIDADE DE PRONTO ATENDIMENTO

ESTRÉS OCUPACIONAL RELACIONADO CON LA PANDEMIA COVID-19: LA VIDA DIARIA DE UNA UNIDAD DE ATENCIÓN DE EMERGENCIA

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ABSTRACT

Objective: to analyze the daily work of health professionals in an Emergency Care Unit (ECU), with an emphasis on occupational stressors related to the COVID-19 pandemic. **Method:** qualitative case study, based on Michel de Certeau's theoretical-methodological framework about everyday life, carried out in a ECU size II in the countryside of *Minas Gerais*, Brazil. Data triangulation was performed, with observations, interviews with 31 professionals and document analysis. Data were organized in MAXQDA2020® and submitted to Bardin's content analysis. **Results:** the daily life in the ECU was changed by the pandemic and the institution underwent adaptations to attend to suspected or confirmed cases of COVID-19, with new operating strategies and redefinition of the assistance map. The occupational stressors identified were lack of clarity in the initial information about the disease, fear of contaminating themselves or family members, use of personal protective equipment (PPE), testing, removal and overload of professionals, risk of lack of medication and stigmatization of professionals of health. On the other hand, availability of PPE, drop in the number of visits, guidance and training were protective factors against stress. In addition, some professionals have adopted tactics to alleviate the stressors arising from the pandemic. **Conclusion:** the routine of the ECU has changed and the occupational stress related to the pandemic affects health professionals. Mental health protection measures are necessary so that they can face the serious health crisis, with a view to preventing suffering, better quality of life at work and better working conditions and service to users.

Keywords: *Occupational Stress; Health Personnel; Emergency Medical Services; Pandemics; COVID-19.*

RESUMO

Objetivo: *analisar o cotidiano de trabalho dos profissionais de saúde de uma Unidade de Pronto Atendimento (UPA), com ênfase nos estressores ocupacionais relacionados à pandemia de COVID-19.* ***Método:*** *estudo de caso qualitativo, fundamentado no referencial teórico-metodológico de Michel de Certeau acerca do cotidiano, realizado em uma UPA porte II do interior de Minas Gerais, Brasil. Foi realizada triangulação de dados, com observações, entrevistas com 31 profissionais e análise documental. Os dados foram organizados no MAXQDA2020® e submetidos à análise de conteúdo de Bardin.* ***Resultados:*** *o cotidiano da UPA foi alterado pela pandemia e a instituição passou por adaptações para atender os casos suspeitos ou confirmados de COVID-19, com novas estratégias de funcionamento e redefinição do mapa da assistência. Os estressores ocupacionais identificados foram falta de clareza nas informações iniciais sobre a doença, medo de se contaminarem ou a familiares, uso de equipamentos de proteção individual (EPIs), testagem, afastamento e sobrecarga de profissionais, risco de falta de medicamentos e estigmatização dos profissionais de saúde. Por outro lado, disponibilidade de EPIs, queda do número de atendimentos, orientações e treinamentos foram fatores protetores contra o estresse. Ademais, alguns profissionais adotaram táticas para amenizar os estressores decorrentes da pandemia.* ***Conclusão:*** *o cotidiano da UPA foi alterado e o estresse ocupacional relacionado à pandemia acomete profissionais de saúde. Medidas de proteção da saúde mental são necessárias para que possam enfrentar a grave crise sanitária, com vistas à prevenção do sofrimento, melhor qualidade de vida no trabalho e melhores condições laborais e de atendimento aos usuários.*

Palavras-chave: *Estresse Ocupacional; Pessoal de Saúde; Serviços Médicos de Emergência; Pandemias; COVID-19.*

RESUMEN

Objetivo: *analizar el trabajo diario de los profesionales de la salud en una Unidad de Cuidados de Emergencia (UCE), con énfasis en los estresores ocupacionales relacionados con la pandemia de COVID-19.* ***Método:*** *estudio de caso cualitativo, basado en el marco teórico-metodológico de Michel de Certeau sobre la vida cotidiana, realizado en una UCE tamaño II en el interior de Minas Gerais, Brasil. Se realizó triangulación de datos, con observaciones, entrevistas a 31 profesionales y análisis de documentos. Los datos se organizaron en MAXQDA2020® y sometidos al análisis de contenido de Bardin.* ***Resultados:*** *la vida cotidiana de la UPA fue modificada por la pandemia y la institución fue adaptada para atender casos sospechosos o confirmados de COVID-19, con nuevas estrategias operativas y redefinición del mapa de atención. Los estresores ocupacionales identificados fueron falta de claridad en la información inicial sobre la enfermedad, miedo a contaminarse o de familiares, uso de equipo de protección personal (EPP), pruebas, baja y sobrecarga de profesionales, riesgo de falta de medicación y estigmatización de los profesionales de la salud. Por otro lado, la disponibilidad de EPP, la disminución del número de consultas, la orientación y la formación fueron factores protectores frente al estrés. Además, algunos profesionales adoptaron tácticas para aliviar los factores estresantes resultantes de la pandemia.* ***Conclusión:*** *la vida diaria de la UCE cambió y el estrés laboral relacionado con la pandemia afecta a los profesionales de la salud. Las medidas de protección de la salud mental son necesarias para que puedan afrontar la grave crisis sanitaria, con el fin de prevenir el sufrimiento, mejorar la calidad de vida en el trabajo y mejores condiciones de trabajo y servicio para los usuarios.*

Palabras clave: *Estrés Laboral; Personal de Salud; Servicios Médicos de Urgencia; Pandemias; COVID-19.*

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INTRODUCTION

COVID-19, caused by the new coronavirus (SARS--CoV-2), was declared a pandemic by the World Health Organization (WHO) on March 11, 2020.[1-2] It represents one of the most serious health problems in recent decades, constituting a global public health emergency.[2] The disease has evolved rapidly, exhausting the response capacity of health systems, and changing people's daily lives.[1] Facing the pandemic has gained emphasis among the essential functions of public health, with actions aimed at the population and groups at high risk of contamination, such as health professionals.[3]

The pandemic challenged governments to carry out an accelerated and unprecedented structuring of health services to assist the growing number of patients and to rethink the individual and collective protection of workers. In addition, it highlighted the role of health professionals to guarantee the lives of populations and demanded responses from services to demands for which they were not prepared. The pressure on professionals grew exponentially and the organization of work underwent changes in terms of working hours, overtime, and work rhythm.[4]

The work of professionals on the front lines of patient care was highlighted. Difficulties that can be considered stressing agents, posing a risk to workers' health, were reported. Although fundamental, health care and safety actions for professionals were not always incorporated in the face of the pandemic, with an increase in the emotional and physical burden. The feeling of vulnerability, fear that something bad could happen to themselves and others, demand on services and loss of control over events have repercussions on the workers' psychic and cognitive functioning.[5]

This pandemic context increases the risk of occupational stress for health professionals, the object of this study. It is worth mentioning that occupational stress is the body's effort to adapt to the situations imposed on it, resulting from the relationship between psychological demand and control associated with work. This type of stress can be caused by the high workload and insufficient staff in daily work. In this way, it affects the health of the worker and can cause absences, physical and emotional exhaustion, and work accidents.[6]

The COVID-19 pandemic introduced changes in the daily life of health services, including ECUs, which caused the emergence of stressors. For Certeau, everyday life are routine issues that make up daily events and can be evaluated through conversations, facial expressions, and gestures. It is composed of events that deserve to be studied, articulating social practices, strategies, and tactics. As for strategies, they systematize and impose order. They contain authority and can be institutions, laws, ordinances, norms, and rituals. Tactics, on the other hand, are the 'ways of doing it', they arise to respond to unresolved needs through strategies and hide behind an appearance of conformity. They do not confront strategies, as tactics aim to complement strategies.[7]

The author also presents the concepts space and place, map, and route. In the more stable place, the law of the normatized itself prevails. The space is alive, it is the 'practiced place', it corresponds to the way of doing of each subject and their interactions that go beyond the established norms and rules. Place 'retains its own' and corresponds to strategies, while space refers to tactics.[8-9]

The map is determined by the strategies and establishes the sequence of 'things' and the spatial order, it is static and structured. In turn, the path is constructed by the actions of the subjects, it is not static. It is associated with space and tactics and comes from different ways of doing things, from choices according to opportunities and needs. It is variable and breaks with the flow determined by the map.[7]

Therefore, the pandemic, as a recent event, caused changes in the daily life of the Emergency Care Unit (ECU). However, there is still a lack of studies on the subject, which represents knowledge under construction. Thus, this study is important, mainly because it addresses the operation of an urgency and emergency health service and the stress of professionals. Its relevance is centered on the possibility of demonstrating the changes in daily life due to COVID-19 and promoting a reflection on occupational stress related to the pandemic.

In this direction, the daily work of a ECU was analyzed, based on the assumption that it had been changed by the pandemic. During work, health professionals can be surprised by difficulties and challenges that are configured as occupational stressors, with repercussions on their activities, on interpersonal relationships and on their professional and personal lives. Therefore, the objective of this study was to analyze the daily work of health professionals in a ECU, with an emphasis on occupational stressors related to the COVID-19 pandemic.

METHODS

This study is a part of a doctoral research, whose methodological aspects were described according to the Consolidated Criteria for Qualitative Research Reports (COREQ).[10] This is a qualitative case study based on Michel de Certeau's theoretical-methodological framework about the everyday life.[7] It is an investigation

strategy by which the researcher collects detailed information and deeply explores a program, event, activity, process, or individuals. It involves collecting data from the participants' environment, analyzing them, and interpreting their meaning.[11]

It was developed in a ECU in the interior of Minas Gerais, Brazil, located in a health micro-region composed of 20 municipalities, with an estimated population of 264,233 people.[12] It is a 24-hour ECU, size II, in which, according to reports between July 2019 and December 2020, 58,558 consultations were performed (monthly and daily averages of 3,253 and 108 consultations, respectively).[13] It is an easily accessible service for researchers who are interested in studying the daily life of a ECU during the pandemic.

There were 95 health professionals working at the unit. Its physical structure, where users are cared for, is divided into sectors: reception, three medical offices, one for risk classification, orange, yellow and red rooms (care/stabilization of critical patients), dressing, hygiene, observation, medication, radiography, and a pediatric observation.

Data collection took place from August 2020 to January 2021. Observations, interviews, and document analysis were carried out, which allowed data triangulation. With unsystematic observation, we sought to collect data on professionals, the interaction between them and with users, the organization and working conditions and the structure and functioning of the ECU. The observation started two weeks before the interviews and lasted until the end of data collection and favored the insertion of the researcher in the field and the interaction with the professionals. Data were manually recorded in a free field diary.

The interviews were conducted by the main researcher, a doctoral graduate student, during working hours, in a private place. The researcher identified herself with the participants who, upon agreeing to participate in the research, read and signed the Free and Informed Consent Term (FICF). The inclusion criteria were being a health professional and working in the ECU care for at least six months. The exclusion criterion was being on vacation or away from work during data collection.

Thirty-one professionals participated in the study and the sample size was defined during the course of the research, meeting the criterion of data saturation, when the information becomes repetitive, adding little to the material already obtained.[11] We sought the participation of all categories and of two shift workers. Participants were randomly selected by category, repeating the invitation until saturation. In the category with only one professional, this one was invited, which happened with the social worker and the pharmacist. Two managers were also invited, health professionals, considered key informants, as they hold strategic information. To preserve anonymity, the names were replaced by alphanumeric combinations 'P1', 'P2'..., where 'P" refers to a participant.

The semi-structured script was prepared based on the literature and study objectives. A pilot study was carried out with two professionals who were not part of the sample and adaptations were made to the questions. The sociodemographic and occupational variables investigated were gender, age, marital status, schooling, professional category, work sector, time working in health care and in the ECU, working regime and hours, and employment relationship. In this study, the answers to the following questions were analyzed: 1) How are you dealing with the COVID-19 pandemic? 2) Were there changes in the day-to-day activities of the ECU? 3) Has the pandemic changed the stress at work at the ECU?

The audios were transcribed up to 48 hours after the interviews and checked by two people. The researcher returned the transcript to the participants and none of them requested changes to their reports. Reports with ECU care indicators were also analyzed, in addition to routines, laws, ordinances and rules on the regulation of urgent and emergency care. These documents helped the analysis and interpretation of the data.

Data from observations, interviews and reports were organized in the MAXQDA® software, version 2020, and submitted to thematic content analysis based on Bardin's framework.[14] In the pre-analysis, the material was skimmed and prepared; in exploration, exhaustive reading; and using the MAXQDA®, clippings were made in the registration units that, grouped by thematic similarity, became the two analyzed categories. In the treatment and interpretation phase, inference and interpretation of information were performed.

This research followed Resolution No. 466/2012. It was approved by the Research Ethics Committee of the Federal University of *Minas Gerais* (COEP/UFMG), Opinion Report No. 4,088,516.

RESULTS

Sample description

The 31 interviews totaled 9 hours and 46 minutes, with an average of 18 minutes. Of the participants, 20 were female (64.5%), mean age was 36 years, ranging from 22 to 58 years, and most were single (61.3%). Among the

graduates (51.6%), eight were doctors (25.8%), six nurses (19.4%), one pharmacist (3.2%) and one social worker (3.2%), with 14 had a *Lato sensu* postgraduate degree (45.2%). Of those who completed high school (48.4%), 10 were Nursing technicians (32.3%), three pharmacy assistants (9.7%) and two radiology technicians (6.5%).

The average time working in health was nine years and eight months and, in the ECU, four years and eight months. Most worked in shifts of 12x36 hours (58.1%) and during the day (67.7%). The weekly workloads of the participants' contracts varied between 12 and 44 hours, with an average of 36 hours and 50 minutes. All were hired by the Municipal Health Department. Three Nursing technicians refused to participate in the research without specifying the reason.

Adaptations in the ECU to face the COVID-19 pandemic

The ECU was not a reference for COVID-19 care, because it continued to meet the urgency and emergency demands of the municipality and region and its physical structure would not have the necessary adaptation for additional care for suspected or confirmed cases of the disease. However, it was often sought after by people with flu-like symptoms, who were attended to because the ECU was "open-door". According to professionals, some patients and family members hid their real health condition, for fear of not being treated, which brought insecurity to the workers.

> *The family member happened to hide it* (...) *they saw that he got worse, then they said that they thought he had COVID, because he had taken a test three days ago and it was negative, but four people in the family tested positive and he had contact with them* (P2).

In this way, the institution had to undergo adaptations to serve people with flu symptoms. Strategies were defined, with new protocols. The service map was modified to avoid exposing users and professionals. Two isolation rooms were created, one with a respirator and another bed in the red room, which had only two.

> *We had to change everything, right? Not only in the* ECU, *but in life. Wearing a mask, washing hands all the time* (...) *It changed everyone's lifestyle* (P26).

Visits were prohibited, and caregivers were only released by the doctor. The nurse gave news of the inpatients in bulletins at 10 am and 10 pm. Users should wash their hands and wear masks. Measures were taken to prevent agglomeration of employees in the pantry and each one should bring their personal items, such as utensils and bedding.

> *We changed our form of contact; we didn't hug to greet our colleague. Cleaning girls have to equip themselves even more when it's suspicious... it's changed a lot* (P20).

Attending to suspected or confirmed cases has become a priority to avoid exposure of professionals and users. After screening, users were taken to an outpatient clinic created due to the pandemic, being isolated until tested or transferred. If the test was positive, but the patients did not show severe symptoms, they were placed in home isolation. Otherwise, they were under observation, registered with SUSFácil and transferred to a COVID-19 referral hospital in the municipality.

Occupational stress related to the pandemic

For most professionals, the beginning of the pandemic was difficult, painful, and stressful. Everything was unknown, a new virus, a new disease and new care protocols.

> *When the patient arrived, at the beginning, he/she would say: 'Ah, he is suspected of COVID.' It looked like an ET was coming in. We were afraid, today it is very peaceful* (P17).

> *At first it was tense. Because it's a new thing. We never went through this. At first, when one arrived and said he/she was a suspect* [for being contaminated with the coronavirus], *and he/she was... we got tense* (P22).

The fear of being contaminated was reported by many workers, especially at the beginning of the pandemic, in addition to some having comorbidities, which increased their stress. One participant stated that the risk of infection is inherent to Nursing work and for others the concern has decreased over time.

> *It feels like it's at the end of the world. It changed a lot. The corona* [virus] *is doing this. It's making people more stressed, more anxious than the corona patient, I think it's having psychological, even psychiatric repercussions* (P13).

> *From the moment you graduate as a Nursing, you are susceptible to any disease, which can be contagious. I took this business naturally, naturally in quotes. I said: 'we worry about COVID, but we treat tuberculosis, meningitis. Will this kill us?' It's no use, we have to protect ourselves* (P21).

Several professionals mentioned the fear of taking the disease 'home' and contaminating family members. For some, this fear was greater than that of being contaminated. Others avoided meeting with relatives of COVID-19 risk groups. A nurse asked not to work in her favorite sector, the red room, because of her son, and a Nursing technician considered resigning.

> *The main problem is taking it and transmitting it to our family that is close by. I live with my parents and nephews. The fear of transmitting. Me being asymptomatic, famously asymptomatic, transmitting and them feeling the consequences. And me nothing. This is the biggest fear* (P5).

> *Most of us here are women, women nurses, women technicians, talking about Nursing that is more on the front line and many of us are mothers* (...) *when I came back everything was changed, I didn't want to stay. I wanted to resign because I have a young daughter, my mother is 80 years old and, look, she has comorbidity, my husband has varicose veins. I was afraid, not to face it, but to transmit it on to them* (P9).

> (...) *I'm not going to visit my grandparents for a long time, because sometimes I'm asymptomatic and I'll take it to them, they'll have a major* [health] *complication* (P6).

For some, the drop in the number of calls at the beginning of the pandemic was the 'most notable' change. The reasons cited were the fear of people contaminating themselves in the ECU, less movement of people, closing of bars and restaurants, with a reduction in accidents, a decrease in work accidents and the demand for certificates due to remote work. According to reports, between March and April 2020, when the greatest variation occurred, calls for patients classified as emerging (red) decreased by 33.33%; of those screened as very urgent (oranges), 39.79%; urgent ones (yellow), 46.59%; the less urgent ones (green), 57.85%; and non-urgent ones (blue), 56.00%.[13]

> (...) *the ECU was empty, and we could take it easy, because everyone was very tired, and everyone was freaks scared. The shifts were quiet and now the staff has lost their fear, the* ECU *is getting busy* (P2).

> *People say that the user was afraid to come... The COVID, in a way, cured the diseases, you know? There was a lot of movement here at the* ECU (P4).

> (...) *with the quarantine and the patients needing to stay at home, they stopped coming to the* ECU. *First, accidents in general have greatly reduced. Traffic accidents, fights outside the house, on the street, all this has decreased a lot in the city as a whole* (P7).

Among the strategies to protect workers, the use of PPE and frequent hand hygiene were implemented. There was enough equipment, as one nurse said, 'just don't use it if who don't want to'. Some felt safer, which was a protective factor against stress, but others mentioned the discomfort caused by PPE as a stressor. Some reported that they would protect themselves more before coming into contact with suspected or confirmed cases of COVID-19 and others that the use of PPE would become more common.

> *My fear of getting caught here is less than in the supermarket, because here I know I'm attired, I'm going to wash my hands all the time, I'm going to apply alcohol, I'm not going to scratch my nose...* (...) *on the street we are more exposed than here* (P6).

> *At first, I was very stressed to get used, having to wear a mask, having to attire. People are used to being freer. But now I'm used to it, wearing a mask will become an obligation* (P1).

Another strategy was the removal of professionals with symptoms of COVID-19 or if they had had contact with a positive case until they were tested, which caused overload and stress for those who remained working. In March 2020, professionals from the risk group were removed, but in August of the same year, they returned to work and only two pregnant women remained away, performing teleservice.

> *We sometimes joked: 'let's see who will receive the COVID trophy here at the ECU', because several people who were far from here were walking on the street without a mask, as if nothing had happened* (P21).

> *We're here and we joke that we're heroes of the resistance because we haven't walked away for a moment. Everyone is very tired, exhausted* (P22).

The time of work leave depended on the performance of the tests. At the beginning of the pandemic, when there were not many places for testing, the material collected was sent to Belo Horizonte and the result took days. One worker reported experiencing 'bias' while waiting for the result. As of July 2020, fluorescence immunoassays began to be performed in the municipality's own laboratory, which reduced the time for carrying out the tests.

> *I had that prejudice. 'Wow, could he be contaminated?' Then, the person asks if you're okay and says: 'He's okay, but am I? I was close to him...'* (P23).

The lack or delay in testing was a stressor. Some would like to be tested frequently; others do not. The ECU followed the protocol of the Ministry of Health, guided by the epidemiology and municipal health surveillance sector. By September 2020, three serological antibody screenings were performed for all professionals, three of whom had tested positive.

> *The only flaw I think is that we should have a blood test every 15 days. The failure that is not from the ECU, but the city hall. But we are getting along well* (P2).

> *There are always some who are more afraid, right? Want to take the direct test, others don't. I don't want to take the test, maybe I'll find out about this thing* [to be tested positive] (P6).

Some doctors were resistant to testing, as they were paid on shifts and, if they tested positive, they would be removed. It was a specific problem for the category since the others received a monthly salary. A doctor was observed complaining that she did not want to be tested as she was asymptomatic. 'Who will pay my bills?' She got the answer that no one was forced to test themselves.

Pharmacy professionals and a doctor were afraid of a possible lack of medicines, aggravated by the pandemic. They identified as causes the change in the repertoire of medicines used in the unit, lack of supplies to manufacture some medicines, prioritization of reference hospitals in COVID-19 and bureaucracy for acquisition in a public institution.

> *The sedation is precarious, and we have already made the purchase and they will send it to XX have to be intubated. There are days when we have a hard time, especially on weekends and YY first* (...) *they forget that it is not just COVID that will need intubation* [of a patient], *there are other diseases that* [the patient] (P23).

> *We see on television that there will be no medicine for intubation. I get worried, because you don't know who will need it, it could be your mother or a grandmother* (P12).

Stigmatization for working in the ECU was mentioned by two professionals. It was related to the prejudice of the population, including relatives, afraid of contagion, especially at the beginning of the pandemic, and which was a stress factor.

> *We started to face prejudice on the street, in the bakery... Even from our own family. People arrived and commented, they kept looking at me, they didn't want to be close, the family doesn't want contact... Imagine you arrive at a place, and everyone leaves, they look at you as if you were an ET, it even set you apart* (P2).

> *Sometimes we wore the* ECU *shirt, the person was on the sidewalk, they crossed, they didn't stay on the same sidewalk. Thinking we were in contact* [with the contaminated patients]. *I said: 'You want to enter a place, and everyone leaves, just go with the* ECU *clothes and everyone leaves'* (P23).

Also. at the beginning of the pandemic there was controversial information, because knowledge about COVID-19 was (and still is) being built. Strategies for aligning ECU professionals in the fight against the pandemic were constantly changing, which was a stressor factor. However, the training and guidance received were identified as protective against occupational stress.

> *We are well informed, well prepared, because there is no lack of guidance. And now I see more serenity in the employees about all this. It is easier now to resolve* (P1).

> *I think we are having a very good confrontation. Very peaceful. We have the SOP, we have the training, we have the PPE* (P14).

After a few months, after the difficult and troubled start, most participants commented that the situation was under control. Some used the term 'quiet' to characterize the moment of the pandemic when the collection was carried out. This was related to the greater understanding of COVID-19, care to prevent contamination, in addition to the promising vaccine research that was underway at the time.

DISCUSSION

The pandemic was a complex crisis that required changes in health systems, as they began to care for an increasing number of people with a new and unknown disease. It transformed the daily work of institutions, whose structure, distribution of beds and care flows were changed, new procedures, learning strategies, care and support practices emerged.[15]

Daily life is more than a routine work scenario, it is a space for the production and reproduction of social practices. It contains "circumstantial situations" that awaken in the subjects' new ways of doing to create and adapt their own reality in the face of the dynamics of life,[7] as

occurred in the ECU with the COVID-19 pandemic. Its daily routine was changed, and the unit had to adapt to serve suspected or confirmed COVID-19 patients, based on the definition of a new service map within the unit. Strategies determine the map that is structured, which indicates the order of places and prescribes actions.[7] It was inevitable because, although it was not the reference, it was often sought after by these users, who, through tactics, made their own route within the health care network.

In this way, new strategies were implemented, with updates of protocols and maps with the flow of care within the institution to prevent contamination of professionals and other people. In health services, strategies assume the existence of prescriptive rules of conduct so that the expected care occurs and are adapted to the context.[16] In addition, the pandemic exposed health professionals to factors that made them more vulnerable to occupational stress, such as exposure to pathogens, long working hours, psychological suffering, fatigue, professional burnout, stigmatization, and physical and psychological violence.[1,17]

The adaptation of the ECU was necessary, since SARS-CoV-2 is transmitted between people, in close contact, by droplets produced by coughing, sneezing, and speaking. There is also airborne transmission, as it is viable in aerosols generated in procedures for at least three hours.[18] The increase in the number of patients and care for severe cases have made health professionals a high-risk group for acquiring the infection, which are between 4 and 12% of the reported cases, with a prevalence above 10%.[19]

Infections are associated with inadequacy or failures in precautionary measures and protection against the disease, scarcity of PPE, crowds, contact with asymptomatic patients, among others.[20] The main strategy to avoid contamination of professionals was the availability of PPE. However, the use of this equipment was a stressor for some, who considered them uncomfortable.

If there is a high risk of becoming infected, there is a risk of transmitting the coronavirus to their contacts. Thus, professionals resorted to tactics, moving away from family members and close people and their support network, which can increase mental suffering.[15] The fear of contaminating them is a relevant psychosocial risk. Security measures, such as accommodation outside the workplace, have been implemented in some countries, in addition to providing exclusive transport to work.[5]

Another tactic adopted by professionals who considered PPE stressful was observed. Some dispensed with them when they were away from patients, as in the ECU rest area, or dressed "better" when caring for patients with flu-like symptoms. Therefore, in the small gaps in everyday life, they tried to alleviate the stress related to the use of PPE. Tactics are tricks operated 'blow by blow', 'blow by bid', as creative and ephemeral ways of doing things that coexist with strategies, but that hide behind the appearance of conformity.[7] These are tricks that arise from the worker's sense of occasion in response to everyday demands.[16]

The professionals' refusal to use PPE at certain times was, in fact, a form of resistance to the constant 'surveillance' of how they should carry out daily practices, creating ways to escape the rules of the power structure determined by the strategies, giving meaning to their practice. way of thinking and acting in everyday life.[7] It is noteworthy that there were enough PPE, and this was a protective factor against stress for some, as they felt safer.

This was not, however, the reality in many health services in Brazil and in other countries. The guarantee of safe working conditions is a starting point and sine qua non and cannot be relaxed or improvised.[5,19] There were complaints from professionals and unions about precarious working conditions, inadequate hygiene, strenuous working hours, lack of training and insufficient PPE.[3] In addition to preventing contagion, workers' physical safety, working conditions and emotional and psychological stability should also be considered.[21]

Strategies to prevent the transmission of SARS-CoV-2 among health workers should include serological screening based on symptomatology, with improved testing of symptomatic patients, work leave, and non-punitive sick leave, more flexible and in accordance with public health guidelines.[22] Testing everyone, regardless of symptoms, is another infection containment strategy for health professionals.[18]

Testing also allows for more speed in the reconstitution of the workforce, since workers on leave with flu syndrome and negative test for COVID-19 return to work more quickly. Furthermore, tracking asymptomatic workers interrupts transmission in the work environment and, consequently, absenteeism.[5,23]

The removal of professionals, although fundamental, overloaded those who continued working, who felt tired, worn out, increasing stress. Some thought that there was an excess of absences, with professionals taking advantage of the situation. It is noteworthy that, in a pandemic, it is common to work long hours, without breaks and under pressure, suffering fatigue and exhaustion.[4] They face increased workload, exposure to contamination and risk of accidents.[21] Long working hours reduce the level of work. attention and responsiveness, interfering with the quality of care. It is noteworthy that part of those affected

by COVID-19 are critical patients who require quick and accurate decisions and the full capacity of professionals.[5]

In addition, most health workers are women with an overload of assignments in the context of social distancing, as they accumulate concerns related to work, health, family, housework and, sometimes, having more than one job. Therefore, it is necessary that they have enough rest time to recover from the physical and psychological exhaustion.[5,24] Indeed, the social support given to them can interfere with their quality of life and health in general.[24]

As an attempt to reduce the deficit of health professionals, Provisional Measure No. 927/2020 was published, which allowed for an extension of the journey by up to 24 hours, with a reduction in rest time to 12 hours. Article 29 provides that cases of contamination by the new coronavirus will not be considered occupational, except upon proof of the causal link.[25] However, the initiative increases the burden of workers, as the undersizing of teams was already a reality in some Brazilian institutions even before the pandemic. It is a harmful measure for health workers, at this critical moment when basic supplies and PPE are lacking in various services.

Another stressor was the constant changes in the strategies adopted to face the pandemic, because the guidelines changed quickly, according to the knowledge disclosed. On the other hand, the professionals recognized the managers' efforts to promote training and guide them on the new care protocols. Such training was also identified as protective against stress, given that professionals felt more prepared. Professionals must receive adequate training, based on the best evidence of international knowledge and practices.[1]

Measures to reduce occupational stressors are crucial. There must be changes in the organization of work, such as: psychological support; reduction of working hours; professional enhancement; improvement of working conditions; social support actions at work; access to workers' health services; reduction of the stigma and segregation that the disease produces in sick people and in those who provide care; as well as minimizing the interference of the pandemic in family and social life, social distancing, isolation of workers and the loss of close people and family members.[1,5] Some of these changes have already been adopted by some institutions, however, others involve more contexts. broad, such as economic and social, for its effectiveness.

As this is a case study, its results are not generalizable, which is a limitation. However, it has application to the teaching, research and practice of health professionals when addressing stress in a ECU during the pandemic, as well as the adaptations that were necessary to face it. As future research, we suggest the comparison of occupational stress related to the pandemic in different emergency units and between institutions of different levels of complexity.

FINAL CONSIDERATIONS

The daily life of the ECU was significantly modified due to the COVID-19 pandemic, as well as occupational stressors related to the new health situation. New strategies were implemented, with a view to standardizing care and the operation of the unit. In addition, the map of assistance at the ECU was redefined to provide speed and safety during care for suspected or confirmed cases of the disease. However, users created their own path, adopting tactics to circumvent the new strategies and be served at the institution.

Thus, several stressful situations emerged for ECU professionals, with emphasis on the fear of contaminating themselves and contaminating close people, especially at the beginning of the pandemic, associated with the use of PPE, testing, removal of professionals, with overload of the remaining, possible lack of supplies and prejudice suffered. However, some professionals resorted to tactics to alleviate adverse situations. The availability of PPE, the drop in demand for the unit and guidance and training were highlighted as protectors against stress.

Occupational stress related to the pandemic affects several health professionals. The reflection on the theme contributes to the proposition of measures to prevent suffering, with better quality of life at work, promotion of better working conditions and service to users. The managerial implications for stress reduction must start from the recognition that the work environment can compromise the health of the worker.

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