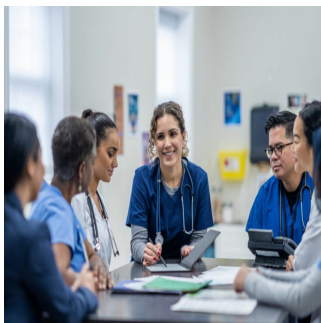


Positive Communication Programme Cuts ICU Staff Burnout



Burnout among intensive care unit (ICU) professionals remains a persistent concern, with earlier reports indicating levels approaching 60% in these settings. The Hello trial tested whether a pragmatic, unit-wide programme designed to support organisational culture and team climate could reduce burnout across a broad international network. Conducted in 370 ICUs spanning sixty countries, the trial compared a four-week, multicomponent intervention with usual care and evaluated effects on burnout using the Maslach Burnout Inventory (MBI). Secondary measures included work satisfaction, ethical climate and intention to leave. By focusing on routine, low-burden behaviours that encourage positive communication and visible team support, the programme sought to achieve measurable improvements within weeks while remaining feasible to implement at scale.

Pragmatic Design Across 370 ICUs

The trial used a 1:1 cluster-randomised design, with randomisation at ICU level to avoid contamination and reflect real-world implementation. Allocation was stratified by unit size, country and 2023 mortality and conducted centrally with concealed ICU identities. Sites obtained institutional review board approvals according to local regulations, and participation by healthcare professionals (HCPs) was voluntary. No patient or family data were collected.

Data collection occurred twice using a de-identified, five-minute online survey: before intervention (1 September to 10 October 2024) and after intervention (15 November to 15 December 2024). The primary outcome was burnout prevalence measured by the MBI Human Services version, with validated translations available in nineteen languages. Burnout was defined as high emotional exhaustion (≥ 27) and/or high depersonalisation (≥ 10). Secondary outcomes were continuous scores for the three MBI subscales and six visual analogue scales (VAS) assessing satisfaction at work, patient- and family-centredness, ethical climate, intention to leave and feeling of safety at work. Analyses were adjusted for clustering using mixed-effects models with the ICU as a random effect and intention-to-treat principles. Predefined subgroup assessments explored centre, country, region, professional role and adherence.

Before intervention, burnout prevalence across 15,891 respondents was 59.4% with no difference between trial arms. After intervention, 4,966 HCPs in intervention ICUs and 4,602 in control ICUs completed the MBI. Approximately 60% of respondents were nursing staff and 30% medical staff. Demographics were broadly similar pre and post, and protocol deviations were not reported.

Intervention Content and Implementation

The four-week intervention was designed to embed brief, repeatable actions that reinforce positive communication and team cohesion during routine ICU activities. Six elements were deployed together: posters featuring “Hello” in local languages placed at twenty locations per ICU to prompt greetings, weekly email nudges on teamwork, greetings during morning huddles to set a constructive tone, a box for colleagues to leave positive messages, role modelling by leaders to demonstrate desired behaviours and two noticeboards per ICU dedicated to positive messages, drawings or photos for all ICU HCPs.

Must Read: [Enterprise Content Management to Ease Healthcare Burnout](#)

Intervention ICUs received a short explanatory video and had opportunities for questions and answers with trial investigators. Site leaders were provided concise implementation guidance for the “lead by example” component, no formal training was mandated. The active intervention period ran from 14 October to 10 November 2024, with a later booster planned. Total programme cost was 105 K€, including 47 K€ for preparation, printing and shipping of materials. Adherence scoring was collected weekly across the six components. All 192 intervention ICUs submitted adherence in week 1, with 72–75% continuing through weeks 2–3 and 66% in week 4. An interaction was observed between adherence and intervention effect without a dose–response gradient. Control ICUs were informed they would receive the programme in early

Measured Outcomes and Limitations

After the intervention window, burnout prevalence was lower in intervention ICUs relative to controls, 52.2% versus 63.3%, corresponding to an adjusted odds ratio (OR) of 0.56 (95% CI 0.46–0.68; $P < 0.001$). All three MBI subscales favoured the intervention: lower emotional exhaustion and depersonalisation and higher personal accomplishment. The approximated difference-in-difference for burnout prevalence between baseline and follow-up was –7% (95% CI –4 to –10; $P < 0.001$) in favour of the intervention.

Secondary outcomes showed consistent patterns. At follow-up, all six VAS measures were more favourable in intervention ICUs, including higher satisfaction at work, stronger perceptions of patient- and family-centred care, a better ethical climate, improved sense of workplace safety and lower intention to leave the ICU. The reported number of colleagues with whom respondents felt in conflict did not differ between groups. Centre and country effects were present, and interactions suggested regional variability in efficacy. No significant interaction was detected by job category.

The trial's discussion highlights several limitations relevant to interpretation. Burnout was assessed with the MBI, a widely used instrument with recognised constraints regarding thresholds and categorisation, although the emotional exhaustion and depersonalisation domains correlate with consequential outcomes. Score differences, while statistically significant, were modest at the individual level but meaningful at population scale. The intervention lasted one month, assessments occurred once shortly thereafter, and durability of effect was not evaluated. Health professional perceptions of specific components were not collected, and the programme did not address structural drivers such as workload, contractual terms or staffing. Further enquiry could test longer or repeated delivery, explore component preferences and assess impacts on retention.

In a large, international, cluster-randomised evaluation across 370 ICUs, a brief, low-cost programme that embeds positive communication into daily routines reduced burnout prevalence and improved multiple indicators of workplace climate among ICU staff within weeks. Effects were consistent across core MBI domains and complementary well-being measures, with lower intention to leave and no change in perceived conflicts. While structural pressures remain outside its scope, the intervention's simplicity, scalability and pragmatic design suggest potential for broad applicability. Services considering organisation-level support for ICU teams may view this approach as a feasible addition to wider strategies aimed at staff well-being, care quality and stability of the workforce.

Source: [Intensive Care Medicine](#)

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