

# The potential for COVID-19 to contribute to compassion fatigue in critical care nurses

As of April 2020, more than 2 million people worldwide had tested positive for COVID-19, and more than 200,000 deaths are attributed to this virus. It is estimated that around 15% of patients diagnosed with COVID-19 will develop severe health complications, and around 5%–10% will require intensive level care due to the seriousness of the symptoms and the high mortality risk (3%–5%) (Baud et al., 2020; Murthy, Gomersall, & Fowler, 2020). At the time of writing, COVID-19 has caused the need for hospitalisation of thousands of people due to the serious pneumonia type symptoms that result in extreme breathing difficulty. Critical care units in hospitals around the world are treating people experiencing potentially life-threatening COVID-19 symptoms. In some of these settings, the pressure on staff is compounded by a lack of adequate personal protection equipment (PPE) and staff shortages, as well as shortages of beds and mechanical ventilators.

Despite the challenges, nurses who work in critical and intensive care units deliver the care required and we have witnessed their courage in recent media reports, with nursing and medical personnel describing the difficulties they face on a daily basis in providing care to these very ill and infectious patients. The current situation has generated a range of stressors that could negatively impact nurses and other health workers (Jackson et al., 2020; Usher, Durkin, & Bhullar, 2020). Critical care nurses may be particularly affected by severe emotional distress which has been associated with the development of compassion fatigue (CF) and/or burnout (Alharbi, Jackson, & Usher, 2020). Indeed, Li et al. (2020), caution against ignoring vicarious traumatisation caused by the COVID-19 pandemic.

There is a known emotional impact for nurses' witnessing prolonged suffering of patients in environments such as intensive and emergency care units (Alharbi, Jackson, & Usher, 2019). This impact is particularly related to their perceived inability to alleviate the suffering of those in their care. Research evidence shows that health professionals can experience various psychological problems when working in high-pressure and high-risk scenarios, such as in times of disaster and pandemic. Kang et al. (2015) found an increased risk for the onset of post-traumatic stress disorder symptoms among rescuers following the 2010 Yushu earthquake in China. The contextual factors surrounding COVID-19; such as the ease of transmission, lack of immunity among global populations, delayed testing, limited medical equipment, uncertainty of the pandemic trajectory and the general level of anxiety within the community all combine to place increasing pressure on health and welfare systems (Centers for Disease Control & Prevention, 2020).

CF and its related symptoms are a particular issue for critical care nurses in disaster contexts because the expectation to confront and cope with the need for care can exceed the ability to provide it, potentially (indirectly) leading to emotional distress in staff (Mathieu, 2014). In addition to witnessing/experiencing patient suffering and death more frequently; having the responsibility for decisions related to resource rationing and utilisation means critical care nurses are at heightened risk of developing CF and moral injury during pandemics (Doherty & Hauser, 2019). Moreover, nurses working under COVID-19 conditions (like so many other healthcare workers) are vulnerable to exposure to risk of infection, and have the added concern of potentially contracting the virus themselves or unknowingly exposing family members and friends to heightened risk. The concern about being infectious can lead to a reluctance to seek out assistance from family or friends and may reduce the capacity to be compassionate in the workplace (Wallace, Wladkowski, Gibson, & White, 2020). Craigie et al. (2016) refer to the "cost of caring" or the occupational hazard of working in critical care settings. The literature has clearly established that burnout and CF are high among all health professionals but especially so for those who work in environments where they are confronted daily with large numbers of people for whom the outcome is dire; such as the case for those diagnosed with COVID-19 and requiring admission to emergency or intensive care units (Wallace et al., 2020).

Burnout is not just a term for being overworked; rather, it is a measurable condition that takes a heavy personal toll on health care providers, leads to lower quality care and increased errors (Alharbi et al., 2020). Similar to burnout, CF carries a heavy personal toll, including isolation from others, excessive drinking and over-eating, drug use and other detrimental coping measures. CF also increases absenteeism and turnover, and lowers morale (Alharbi et al., 2020). Importantly, it is known to be linked to situations where nurses believe their actions will not make a difference (Portnoy, 2011). This is unfortunately potentially the case for many patients with COVID-19 as once they are admitted to critical care units, events have shown us that many will not survive.

Evidence to gain empirical insights into the impact of COVID-19 on nurses is only just beginning to emerge, with some unexpected findings. Wu et al. (2020) recently conducted a study of 220 health professionals (physicians and nurses) to compare the frequency of burnout between those professionals working on the COVID-19 front line in Wuhan province ( $n = 110$ ) and those working in their usual hospital wards in hospitals ( $n = 110$ ). Notably, the authors

reported that burnout frequency was in fact lower among health professionals working on the COVID-19 front line compared to those working their usual wards (13% versus 39%, respectively (Wu et al., 2020).

Although these results were somewhat unexpected, the conclusion drawn by the researchers provides an interesting insight into the nature of burnout and CF. They theorise the lower-level of burnout among the front-line workers may be the result of these health professionals having to place all of their focus on achieving positive outcomes for patients (Wu et al., 2020). This explanation, however, arguably implies that the nurses' focus is not on their own emotional well-being. Moreover, as discussed previously a leading risk factor for the development of CF among intensive care nurses is their tendency to put the care needs of the patient above their own needs. According to Wu et al. (2020), the focus of front-line carers on what they are trying to achieve rather than the personal impact of what they are trying to achieve may explain the more favourable outcomes for this group.

For the nurses working in critical care environments, such as intensive care units, there is no escaping the daily parade of seriously ill patients with predicted poor outcomes in times such as those we are currently witnessing. We have seen and read of nurses describing situations where all patients have died on a unit during the course of an evening. It is hard to imagine the effect this has on the nurses working that shift. For many of the nurses in this situation, there may be little support.

Hendin et al. (2020) have developed a framework for the provision of end of life care by nurses to patients faced with immediate death from COVID-19 or similarly highly transmissible acute respiratory infections. At the centre of the framework is naturally a focus on minimising risks of transmission to nurse professionals. However, the authors also recommend the framework be underpinned by the "imperative for workplace colleagues to support each other and to perform frequent debriefs" (p. 3). This, they conclude, is vital to reduce the risk of front-line nurses developing psychological problems including CF, burnout and vicarious trauma (Hendin et al., 2020). Furthermore, as Horesh and Brown (2020) argue, the most concerning aspect of the health care sector (as opposed to healthcare worker) response to COVID-19 for critical care nurses is the lack of a clear set of guidelines on how best to manage self-care and well-being. Current recommendations to front-line healthcare workers are to ensure work-life balance, practice deep breathing, facilitate mindfulness and support other when possible are modes of therapy or coping that independently or in combination can provide a positive effect (Van Zyl & Noonan, 2018). However, these fall short of a formal and set of guidelines (supported with resources) that critical care nurses can refer to specifically to direct their self-care efforts to manage their well-being (Horesh & Brown, 2020). At the very least, improved self-care, both in and out of the hospital environment, is necessary to help critical care nurses to reduce the risk of developing CF.

In conclusion, large-scale public health events such as the COVID-19 pandemic require a dedicated and highly demanding

response from critical care nurses. To support these nurses, the broader response to COVID-19 must include multiple stakeholders including, but not limited to, senior nursing staff, government policymakers, technology designers, hospital administrations, as well as members of the broader community. The decision and actions of stakeholders can play a central role in assisting nurses to manage the competing care demands caused by increased acuity, increased patient numbers, clinical uncertainty and limited access to necessary equipment. Hence, in addition to critical care nurses doing all they can to protect their own and their colleagues' well-being, they need to work with other stakeholders to mobilise beneficial partnership and collaborate on developing creative solutions. Only through a collaborative effort can any risks associated with CF and burnout in the critical care nurse workforce be identified and mitigated.

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