Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Self-Care for Health Professionals During Coronavirus Disease 2019 Crisis

Judith Haefner

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A B S T R A C T

Health care providers are coping with unprecedented deaths, decisions for which patient receives a lifesaving ventilator, and the personal fear of contracting a virus that presently has no known treatment protocol. This article discusses the concepts of moral injury; compassion fatigue; experiencing secondary stress associated with a continuous demanding daily work environment; and the idea of giving your patient a "good death" during a time when even if family and friends are present during the dying process, there is no touching, kissing, or ability to offer physical comfort. Suggestions for self-care for yourself and colleagues are discussed.

Nurses are at the front lines to deliver health care during the coronavirus disease 2019 (COVID-19) pandemic. As the largest group of health care providers,[1] they directly provide care in close proximity and often may be directly exposed to the virus.[2] While being actively engaged in this pandemic fight, many are experiencing fear of the unknown and concern for protecting themselves and their family from the risk of being infected. They are also adjusting to a new work normal of putting on and stripping off personal protective equipment with every patient encounter, impairing any nonverbal communication with patients and colleagues. Nurses standing at a social distance are trying to have face-to-face communication with their face hidden behind a mask that often muffles their voice and also possibly hides any expression of sympathy.[3] A nurse practitioner with over 20 years of nursing experience stated, "I became paranoid, constantly washing my hands, when I returned home quickly dropping my clothes at the door and immediately showering. I refused to visit anyone, nor did I allow anyone to come over."

Nurses and other health care professionals are also dealing with patient death. Although not uncommon, it is at an unprecedented record. The expectation before the pandemic was perhaps 4 to 6 deaths a month in the intensive care unit (ICU),[4] with the emergency department staff seeing a few more deaths.[5] These pre–COVID-19 deaths are likely a result of an illness; age related; or, as in the emergency department, attributed to some sort of trauma. Even though health care providers might feel they are experienced in providing sad news to family, a nurse can begin to feel overwhelmed by the volume of deaths. As of November, 787 deaths are occurring each day due to the COVID-19 epidemic in the United States.[6] As of November, the US surpassed 250,000 deaths related to COVID-19. All age groups are impacted, with the majority of deaths being persons 35 and older.[7,8]

When a loved one is hospitalized with the virus, visiting restrictions at health care facilities are limited to scheduled times, with the visitor required to wear personal protective equipment and not allowed to touch or hold the sick and dying patient's hand. Grieving for a loved one requires social distancing, wearing a face covering, and modifications for funeral rites and memorial services.[9]

A family nurse practitioner in a private clinic in an urban area who has patients who may have COVID-19 reflected, "Thus far, this has been the most challenging clinical work for me. I have never felt more terrified. The feelings of gloom and doom overwhelm me at times." She continued to explain she only goes to work and refuses to visit family and friends, being fearful of accidently passing along the virus or contracting it from others.

The evaluation of how individuals respond to stress often begins with Lazarus and Folkman's seminal work of appraising threat and the coping response to the threat.[10] According to Lazarus and Folkman, the coping response is problem focused to solve the problem or master the situation and emotion focused with an attempt to reduce the negative feelings triggered by the threat. To reduce this feeling of threat, a person might withdraw mentally to avoid dealing with the situation or, in some cases, turn to alcohol or drugs to numb the feelings of threat. Other coping techniques include escape avoidance, self-blame, or confrontation.[11]

The purpose of this article is to discuss the concepts of moral injury, compassion fatigue and secondary stress, and the idea of a good death as it relates to health care providers during the COVID-19 crisis. An additional purpose is to offer suggestions on a personal

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and administrative level for understanding, monitoring, and managing the emotional and physical responses of nurses and other health care providers related to being repeatedly exposed to death and grief.

Moral Injury

The term *moral injury* (MI) originated in the military and is not a mental health descriptor such as depression or posttraumatic stress disorder. MI comes from the psychological distress when someone violates his or her personal moral or ethical code either from one's own personal actions or from regret of nonaction. It occurs when people find themselves in highly challenging situations that can trigger feelings of guilt or shame when carrying out the orders of a superior or leader.[12]

Many health care professionals may be experiencing MI when trying to decide who receives the limited resources between severely ill patients who are equally needy. They are confronting conflicting professional values such as deciding how to balance their own fear of contracting the virus and possibly passing it along to their family and friends and their duty to patients and the patients' family and friends to provide effective health care. These MI conflicts may lead some providers to experience mental health problems.[11]

A seasoned nurse with over 8 years of experience in a large suburban hospital described the behaviors she observed during the early days of treating patients who likely had the COVID-19 virus. She recalled the fear and hesitation of staff during the early days of the pandemic to tend to the needs of patients, saying the doctors were reluctant to enter the rooms and stood at the doorway asking questions and giving orders and that some respiratory therapists verbalized their fear of their close contact with the patients' breath.

Mantri et al[13] recruited 272 health care providers from Duke University Health Systems to measure 10 dimensions of MI using the Moral Injury Symptom Scale-Health Professional (MISS-HP) version. The MISS-HP assesses guilt, betrayal, shame, moral concerns, religious struggle, loss of religious/spiritual faith, loss of meaning or purpose, difficulty forgiving others, loss of trust, and self-condemnation. From a range of 10 to 100, a score of 36 or higher indicates significant functional impairment that likely requires further clinical evaluation and treatment. A positive MISS-HP test score of 36 was identified in 86 (7.8%) of the 181 completed surveys, indicating impaired social or occupational functioning that was clinically significant for MI symptoms. The researchers found that MI symptoms were positively associated with the medical errors in the previous month, suggesting that MI may be the cause or the result of these medical errors. Using the Patient Health Questionnaire-9, Mantri et al[13] also stated MI was positively correlated with suicidal thoughts among the health care professionals surveyed.

Compassion Fatigue, Moral Distress, and Secondary Stress

Compassion fatigue (CF) is the emotional, spiritual, and physical fatigue health care professionals experience due to constant use of empathy in caring for seriously ill or traumatized patients.[14] CF, which was first identified in the early 1990s, can occur when caregivers experience demanding and continuously disappointing situations in which they believe they have a reduced ability to experience and demonstrate compassion.[15] CF is depersonalization and emotional exhaustion with a sense of reduced accomplishment after being repeatedly exposed to suffering that is beyond the person's ability to recuperate.[15]

CF is most likely seen in a relatively new registered nurse who is female and younger than 40 years old.[16] The Professional Quality of Life Scale was sent to 835 registered nurses at a large metropolitan hospital in Arizona. Of the 315 nurses who returned the survey, 43% were at moderate to high risk for CF, with 10% of the nurses in the highest-risk profile. The nurses reported feelings of hopelessness and that their efforts did not make a difference.[16]

Health care providers also can experience secondary traumatic stress after the experience of being persistently emotionally aroused from patients' traumatic experiences. Measuring CF, researchers sent surveys to a sampling of social workers in New York City, followed by a survey to assess psychological health to look at the emotional exhaustion from working with traumatized patients. The researchers concluded the social workers experienced secondary trauma of psychological distress and CF with symptoms of flashbacks, troubling dreams, and intrusive thoughts that were related and could be connected to working with their traumatized clients.[11]

Van Mol et al[15] investigated ICU unit nurses and physicians for CF. They reported these ICU professionals were emotionally affected by the end-of-life issues, ethical decision making, and observing the continuous suffering of patients. These aspects of the ICU environment could lead to moral distress, avoidance behavior, and emotional distress. Physical warning signs of CF were headaches, sleep disturbance, low back pain, stomach ailments and mental responses of irritability or hostility, poor concentration, decreased self-confidence, and emotionally labile.[15]

Burgess et al[11] contend hospitals have always been an environment of significant stress and often demanding work sites for nurses. The authors believe that from a physical perspective, a work environment with excessive demands will also impact most bodily systems, increasing the likelihood of severe acute or chronic physical health problems. Their exploratory study looked at the relationship of a nurse's personality with workplace stress among ICU unit nurses. They distributed 83 Nurse Stress Index and Brief Coping Orientation to Problems Experienced questionnaires with a 46 (55%) response rate. The findings were that nurses with higher levels of openness and extroversion also reported lower levels of stress when dealing with difficult patients. They also reported nurses with personality traits of openness were more likely to be able to reframe a problem by actively addressing the factors causing the stress and thereby moderating the effect of the stress. The positive coping strategies of the nurses effectively managing their stress were 1) actively planning the process of patient care, 2) positive reframing of the situation, and 3) seeking support from clinical supervision.

In a meta-analysis by Zhang et al,[17] they reported secondary or indirect traumatic stress was present in nurses with emotional symptoms, including mood swings, restlessness, and depression. The close contact with other people's suffering or trauma yields an almost identical set of symptoms to those of posttraumatic stress disorder, including avoidance of reminders and cues, hyperarousal, distressing emotions, cognitive changes, and functional impairment.[18] Emotional exhaustion occurs when the clinician's emotional reserves are depleted by the chronic needs, demands, and expectations of their patients, supervisors, and hospitals. A cynicism can develop that is negative, depersonalized, and detached. A nurse can feel inadequate and one's sense of personal accomplishment diminished.[19,20] With CF, the very unique resources the nurse brings—empathy and compassion—become depleted.[21]

A cross-sectional survey (N = 283) of moral distress among nurses in the medical, surgical, and ICU units found the highest level of moral distress was associated with providing treatment and aggressive care to patients who were not expected to benefit from the nursing actions.[22] The researchers concluded that these nurses experience an overall moderate level of moral distress most days.

Ways to prevent or lessen CF include self-care, such as exercise, good nutrition, sleep, social organization and spiritual support, and activities for creativity.[23] Coping strategies during the current COVID-19 pandemic from nurses include encouragement to each other so there is not a sense of being alone and breathing exercises to relax while wearing the protective clothing.[24]

A Good Death

A good death is "one that is free from avoidable distress and suffering, for patients, family, and caregivers; in general accord with the patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards."[25(p1)] A good death is timely, peaceful, and dignified. A dying person is surrounded by family and friends.[26] A good death "remains more a hope than a standard medical practice for all patients."[27]

The good death involves patients and their families and friends as well as health professionals. A key component to the nurse's sense of self-worth and professional role is helping a patient achieve a good death.[27] Important to a nurse is having time with the patient's family to give education on the symptom management and the disease process, also building a relationship between the nurse, patient, and family.[28] Nurses reported regret when they could not provide a good death for a patient[29] that provided what the nurses perceived were the psychological aspects of a good death[30] with an end of life that allowed time to prepare to meet the appropriate clinical, spiritual, and ethical standards. Nurses validate a good death as dying with dignity and maintaining personal comfort and control.[31] Although not always attainable, from the nurse's perspective, a good death is something to work toward. It is an ideal situation for all concerned in the dying process.[31] McNamara et al[27] asserted the socially responsible individual is one who quietly slips away, thus supporting the philosophies and the goals of the hospital and community organizations that all that could be done appears to have been done. Therefore, a good death establishes a degree of stability within institutions of care by providing precedents relating to normative behaviors surrounding death.[27] However, the rigidity of the definition of a good death presents challenges during the current epidemic.

The authors conducted a literature search in English language, peer-reviewed qualitative and quantitative studies to provide a definition that a "bad death" could be considered a failure by health professionals when it is unplanned or unmanaged.[32] It occurs when the patient is not able to participate in decision making, the family needs are unmet, and the health care team cannot manage the symptoms.[33] A bad death is sudden and unexpected, dying alone or isolated from people who care for the patient, and the family feeling they had limited control over the death event.[34] For nurses, a bad death was traumatic and one that they felt they had limited control over the event. They felt guilty about not providing a good death, leading to a negative impact to the nurse's morale and sometimes causing conflicts between nurses and physicians about how decisions were made.[35]

Self-Care and Care for Colleagues

Nurses and other health care providers are making unprecedented choices of who qualifies for a respirator and who will go without. The high mortality, the nature of the death, and witnessing multiple deaths despite aggressive nursing actions can lead to individual nurses experiencing negative emotional reactions similar to grief, stretching the emotional limits of all health care professionals. During times of crisis, health care providers can jeopardize their own well-being because of the high volume of critically ill patients. Fatigue can increase the likelihood of work-related injuries such as needle sticks, relaxed safety protocols, and patient care errors.[36]

Active monitoring of staff for signs of depression or acute stress disorder is recommended by the National Institute for Health and Care Excellence.[37] Recommendations from the National Institute for Health and Care Excellence include having staff be aware that signs of working less effectively may be signs of depression. Supervisors should reach out to health care staff who seem to be neglecting their mental health and well-being by saying they are "too busy" or will participate "later" in discussions that involve sensitive topics. A nurse reflected, "I received a phone call from a dear friend crying because one of her young and healthy employees was diagnosed with the virus and had been vented."

The clinician takes on some level of their patients' emotional pain as they provide treatment with kindness and empathy, all while experiencing an indirect exposure to trauma that has significant risk for emotional and behavioral changes to the clinician.[38] To work with vulnerable and suffering patients, clinicians must actively use their own psychological resources of empathy and compassion, which is a unique job requirement not required as part of the skill set of other professions.[39]

Schwartz Center for Compassionate Healthcare designed a forum called Schwarz Rounds for staff/teams to discuss and reflect on the emotional and social challenges caring for patients.[40] This forum is a means to provide an outlet for reflections, even during times of overstretched health care, which is necessary for the well-being of the staff. During Schwarz Rounds, the panel, 3 or 4 staff from a variety of professions who have been trained in the process, present a story or experience that had a significant impact on them. The audience is invited to share their own perspectives on the case and related issues. Schwarz Rounds aims to improve relationships and communication between staff and staff and staff and patients.[41] Organizations using Schwarz Rounds report it has a positive impact for improving psychological well-being, and staff report feeling less stressed or alone in their experiences.[42]

Strategies suggested by the Centers for Disease Control and Prevention (CDC)[36] for managing clinicians' anxiety and stress include taking care of basic needs such as food, hydration, sufficient sleep, and enjoyable exercise. The CDC recommends staying connected to others through clear communication with colleagues to decrease isolation, fear, and anxiety and to monitor yourself for difficulty sleeping, intrusive/troubling thoughts, or feeling hopeless, which could be early symptoms of depression.[36] Give yourself permission to take a break from patient care and take a walk or talk with a friend. The agency recommends remembering to value your profession for the important work you are doing during a time of national crisis. Other suggestions from the CDC[36] for hospital managers include communicating daily with your staff on the need for using self-care strategies and giving staff personnel at least 10 hours off between shifts and breaks every 2 hours during the shift. Monitor your staff for signs of fatigue such as difficulty concentrating, being emotionally labile, or making flawed decisions.[36]

Conclusion

Nurses are the frontline health care professionals who work across acute care hospitals, long-term care agencies, nursing homes, schools, community, and government health care agencies. During outbreaks of new infectious diseases such as COVID-19, uncertainty, anxiety, and panic spread as the overall situation changes quickly, particularly while the disease is not yet under control. Although every hospital has an emergency plan in place, no one could predict and plan for the swiftness and intensity of COVID-

19 with admissions for these patients surging to overwhelm all operational, clinical, and procurement goals. Shortages for personal protective equipment, drugs, and beds altered expectations for workflow, role delineation, and other unique challenges that had no precedent to support formulating a rapid response. Many facilities are developing protocols for new treatment strategies that try to balance patient safety while navigating uncharted medical territory managing unanticipated problems that need immediate resolution. The anxiety generated during the early days of the COVID-19 pandemic triggered fear, a sense of helplessness, and an inability to control the dying process for many patients. Deaths came suddenly with patients being alone without family, isolated, and viewed with fear for contagion. In the beginning, the information pouring out of the CDC, the World Health Organization, numerous hospital organizations, and other sources was at times information overload.[43]

High patient mortality, the nature of death, observing patients die despite aggressive measures, and sudden changes in pace of work are some factors that contributed to psychological distress, CF, and a sense that patients were not experiencing a good death with respect for the patient and family's values and cultural beliefs.

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Judith Haefner, DNP, PMHCNS-BC, PMHNP-BC, is an associate professor at the University of Michigan Flint School of Nursing in Flint and can be contacted at jhaefner@umflint.edu.

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