Supporting nurses' mental health during the pandemic

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Abstract: During the COVID-19 pandemic, healthcare facilities have established new policies affecting nursing care, often with little input from the nurses who must implement them. These changes have led to mistrust and an altered sense of safety among nurses. This article focuses on how changing institutional policies affecting personal protective equipment and family visitation have affected nurses' mental health and offers practical suggestions for supporting resilience and mental health in nurses during this unprecedented public health crisis.

Keywords: COVID-19, end-of-life care, family visitation, moral distress, pandemic, resilience, secondary trauma

IN THE SPRING of 2020, US healthcare organizations began preparing to face the threat of the COVID-19 pandemic. The focus was on ensuring the availability of ICU beds and ventilators, setting up external sites for testing, and acquiring adequate personal protective equipment (PPE) for hospital staff. Under pressure, organizational leaders made decisions regarding family visitation and PPE use. Information changed daily on many issues, including the effectiveness and appropriate use of PPE and the risk of viral transmission. As a result, organizational policies changed frequently.

On March 10, 2020, the CDC announced changing PPE requirements from N-95 masks to simple surgical masks. According to the American Nurses Association, this decision was based on supply chain issues rather than concerns for nurse safety.[1] The change contributed to mistrust and an altered sense of safety among healthcare workers.

In addition, elective surgeries were canceled and nurses were reassigned. Normal patient volumes declined.

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Nurses were thrust into unfamiliar work environments and away from familiar coworkers. In some cases, nurses whose areas were closed were forced into unpaid time off, adding economic worries to their psychological distress.

Not until well into the influx of patients with COVID-19 did we begin to hear of the emotional and psychological toll on healthcare providers.

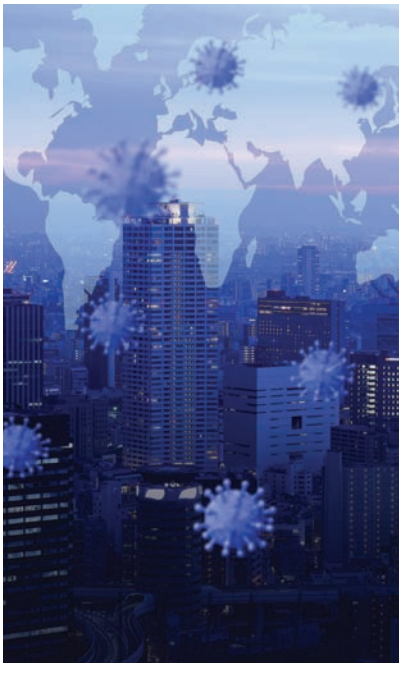
Alterations in visitation

One of the most significant changes hospitals made in their operational response to COVID-19 was the alteration in family visitation. Many studies support the importance of family presence at the bedside, and the value is clear.[2,3] Positive patient outcomes related to open visitation include more rapid recovery times and decreased length of stay, reduction in anxiety and delirium in ICU patients, and reduction in medical errors attributed to family advocacy.[4-7] The abrupt absence of family support at the bedside has had a profound effect on patients and nurses alike, particularly in end-of-life situations like those created by the pandemic.

Another unintended consequence is that patients who should be seeking medical care are not. In one multicenter study, emergency visits for cardiovascular care fell by 38%.[8]

New roles for nurses

When caring for patients at the end of life, the nurse's role changes. Traditionally the nurse is either the proxy for a family that cannot be present or is the support for both the patient and the family as they transition through the end-of-life journey. In normal times, the nurse can usually maintain a healthy space while also taking the role of a nursing professional with a vital advocacy function. Such norms are altered in these challenging times by well-meaning, but perhaps not well-thought-out, rules prohibiting family support at the bedside.



Public attention on the nurse as a "hero" may put pressure on the nurse to manifest the qualities of a hero despite real vulnerabilities.

For the first time, the nurse may be continuously performing as both a proxy for family and a clinical practitioner. The nurse is holding a dying patient's hand while dialing up the vasopressors. The nurse is balancing a computer screen in front of a patient so a mother can say final goodbyes to her daughter, or so a husband can thank his partner for their 35 years of marriage. The nurse witnesses a 12-year-old telling her grandfather that he will be remembered—all while optimizing positive end-expiratory pressure.

When the nurse steps out into the hall, only tear-filled eyes of colleagues are there for comfort. The knowledge that even a simple hug could be dangerous is palpable. We all know to keep our distance.

Few organizations provide the time or space for debriefing or collegial support. The burden of being both nurse and end-of-life support is harming the psyche of nurses.

It is doubtful that frontline nurses or their representatives were involved in the decision-making regarding visitor restrictions or rationing of PPE as organizations ramped up their pandemic response. However, frontline staff were left to implement these decisions. The ED nurse must tell the family to leave their loved one at the door, no matter the reason for the visit.

The ICU and other units are likewise closed to family support. Even hospice units were closed to visitors—all in a unilateral way, giving nurses no opportunity to appeal. In fact, some nurses have reported that speaking up has been met with threats to their employment.[9]

All these circumstances contribute to moral distress, which occurs when nurses feel powerless to take actions they know are ethically correct.[10,11] Feeling overwhelmed by patient care has been identified as a source of moral distress, which leads feelings of guilt, fear, anger, and frustration.[12] The addition of anticipated and predictable shortages of PPE and other supplies increases stress.

As the crisis continues, healthcare organizations are finding that the bottom line is suffering. Nurses in some regions are beginning to experience layoffs, workforce reductions, or furloughs. Some of these come with unclear information about returning to their familiar jobs. Uncertainty about their financial future adds to the growing stress.

Mental health in the age of COVID

Mental health symptoms were highly prevalent in a cross-sectional study of 1,257 healthcare workers who

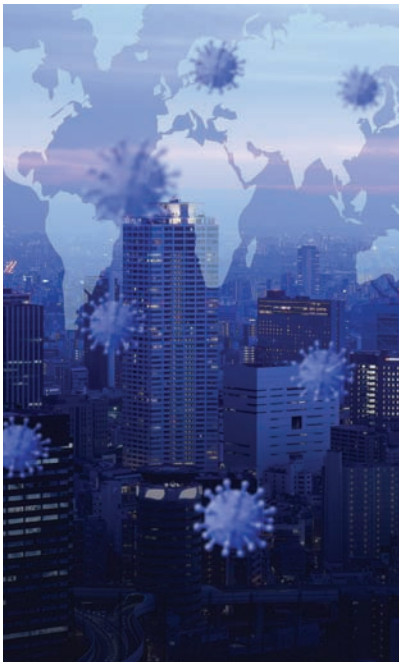
cared for patients with COVID-19 in multiple regions in China.[13] Healthcare workers reported experiencing symptoms of depression (50%), anxiety (45%), insomnia (34%), and psychological distress (72%). Contributing factors were concerns that they would fall victim to COVID-19, fear of carrying it home to their families, a sense of vulnerability and loss of control, changes in work, and isolation.[13]

Nurses are attempting to cope in various ways (see *Clinical skills as a coping mechanism*). For example, they engage in self-talk, telling themselves that this is part of the job and that they have dealt with death before. They try to pretend that this is no different. But it is different: different in the nurse's inability to separate professional roles from the need to stand in for the absent family, different in the loss of a support system, different in the application of ethical and moral standards, and different in the background noise that says, "You could be next."

Anxiety may be heightened by public attention on the nurse as a "hero" and the need to manifest the qualities of a hero despite real vulnerabilities. Feeling a loss of control and vulnerability is enhanced when nurses are expected to maintain professionalism and a brave front.

Practical interventions to support nurses

Interventions to support resilience and mental health for nurses in this new climate will require a multidimensional approach. The size of the organization and the number of patients with COVID-19 must be considered in the approach. Organizations must also recognize that all nurses are affected, not just those who directly care for patients with COVID-19.



Under financial pressure, nurses may feel compelled to work more hours than is healthy. Organizations should offer support for assistance.

The following recommendations are gleaned from the literature, best practices on support for nurses and other healthcare workers, and the experiences of some hospitals that have implemented frontline psychological support systems.

- When PPE is not in short supply, allow family support at the bedside.[14] Consider whether issuing that one mask and one gown for one family member per patient is a significant drain on supplies.
- Establish programs to provide smartphones and tablets to patients to enable them to communicate with families remotely.[14]
- Mobilize all staff with palliative care experience to the hospital's COVID-19 units and provide brief education for frontline staff on symptom management.[14]
- Designate nonnursing staff whose primary role is facilitating communication between family and patients.[14] Clearly separate the roles of family-patient liaison and nurse.
- Educate staff about palliative and end-of-life nursing care. In one study of 438 clinical nurses, researchers found a significant increase in nurses' confidence in their communication skills after they participated in an online module specific to palliative and end-of-life issues.[15] By applying palliative care communication skills, the healthcare team learns about the patient's priorities and values, and the patient and the patient's family better understand the disease prognosis and treatment options.[16] Education to support end-of-life skills should include the affective/emotional aspects of nursing care.
- Establish organizational policies and procedures that recognize and prevent risk factors for secondary traumatic stress, the emotional distress that may develop when individuals learn about the traumatic experience of others.[17,18]
- Provide education on mental hygiene, making mental health services accessible to all staff and promoting mental health services as compassionate care for the caregiver. Accessibility means available locally or

Clinical skills as a coping mechanism

Nurse researchers have identified a high occurrence of posttraumatic stress disorder in critical care nurses and ED nurses.[20,21] The classic work of Menzies Lyth described a nurse's focus on technical expertise as a defense mechanism against anxiety.[22] In some cases, confidence in technical skills may counterbalance feelings of fear and powerlessness in the face of tragedy.[23] Within the COVID-19 environment, however, the distancing barriers of technical expertise and clinical skills are absent as the nurse serves the dual role of caregiver and proxy for family support.

virtually. An overwhelmed caregiver will not consider accessing care that involves a 2-hour drive or care that is not available via self-referral.

- Recognize that many healthcare workers are the sole support of others in the family who may have lost employment. Under financial pressure, nurses may feel compelled to work more hours than is healthy. Offer financial counseling or support for assistance.
- Implement mechanisms to assess the mental wellness of staff in real time. One hospital utilized the unit-based clinical nurse specialists, all of whom were certified critical incident stress debriefers, to round on the units and talk with nurses. In brief interactions, they were able to assess general stress, primary and secondary trauma, and specific concerns nurses were facing. Another organization utilized chaplaincy and social workers to specifically ask, "Do you feel mentally okay to work today?" Those answering "no" had the option of taking a "no judgment" pass and could be reassigned to another area or go home. This solution was implemented by reassigning nurses from non-ICU areas and up-staffing the COVID-19 units to enhance nurse-to-patient ratios. Two ICU nurses served as the patient's primary nurses with the support of two non-ICU nurses.
- Increase communication. Begin the shift with a huddle that includes departmental administrators to field questions and to hear about real-time concerns.
- Establish a hotline staff can use for any type of need or concern; for example, lack of equipment, emotional support, short staffing, or financial counseling.
- Operationalize existing critical incident stress debriefing (CISD) teams provided for professionals exposed to highly stressful and traumatic events.[19] If the facility does not have a CISD program, reach out to the local CISD team, which can be contacted via the International Critical Incident Stress Foundation. Visit https://icisf.org or call 410-313-2473 for information and support. CISD should be a part of a network of services such as preevent education, follow-up services, and referral to professional care and postincident education programs.[19]

Going beyond pizza and coffee mugs

Nurses today are in the midst of a stress storm. A nurse's ability to survive in these difficult times depends on healthcare organizations understanding that this is not business as usual, and that the crisis is ongoing. Organizations must plan for the inevitability of psychological harm to professional caregivers and provide meaningful support. This must go beyond TV ads of thanks, pizza in the breakroom, and coffee mugs. Offering early and unlimited access to mental health care that is readily available and offered without reproach will be the key to survival for many nurses impacted by this tragedy.

Focusing on retaining and supporting nurses during and after the pandemic is essential for the future of nursing and the safety of the public. ■

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