



Nurse Compassion Fatigue

An Unintended Consequence of the COVID-19 Pandemic

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The COVID-19 pandemic has catalyzed many changes in the delivery of health care. These changes range from time-intensive infection control routines to family visitation restrictions for patients admitted to acute health care facilities. While these changes aim to protect patients and health care workers from contracting COVID-19, these new protocols have unforeseen ramifications on registered nurses.

In particular, nurses need to focus on preventing medical complications associated with COVID-19, which may cause them to question their ability to compassionately provide holistic care to the patient. As a result, nurses caring for COVID-19 patients are at high risk for experiencing compassion fatigue. Compassion fatigue is the physical and mental exhaustion and emotional withdrawal experienced by those caring for sick or traumatized people over an extended period of time. Compassion fatigue differs from burnout in that it results from emotional agony rather than daily administrative stressors. Compassion fatigue can impact the art of nursing as it is practiced by an individual nurse.

Barbara A. Carper's *Fundamental Patterns of Knowing* is often associated with the art of nursing. These patterns consist of empirics (the science of nursing, evidence-based practice); ethics (moral obligations); personal knowledge in nursing (authenticity in interpersonal relationships); and aesthetics (knowing what is significant in a patient's behavior).¹ Compassion fatigue has a direct impact on personal knowing, aesthetic knowing and ethical knowing patterns. The moral anguish that leads to nurse desensitization in compassion fatigue can impact the nurse's ability to establish authentic relationships with COVID-19 patients.

Consequently, the RN may not be able to astutely identify significant changes in a patient's behavior. Patient care issues, which we will delineate in the following paragraphs, can impact the art of nursing and increase the risk of compassion fatigue for nurses working with patients on a dedicated COVID-19 unit. We'll conclude by discussing ways to prevent compassion fatigue.

RAMIFICATIONS OF NEW COVID-19 PROTOCOLS

The many COVID-19 infection control and patient assessment protocols can be very tedious to follow. For example, nurses adhere to strict infection control protocols to protect their patients, themselves and their families from becoming infected with COVID-19. Time taken to don and doff personal protective equipment (PPE) can take time

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away from the patient's bedside. Diminished time at the bedside could cause fears of missing an acute change in the patient's condition that would lead to a life-threatening event.





Additional changes in the delivery of care to COVID-19 patients include the “clustering of care” where nurses plan the delivery of care so that they can minimize their time in and trips to the patient’s room. While the intent of clustered care is to minimize exposure to the virus, this practice also diminishes the time spent with the patient. As a result, nurses experience difficulty in developing authentic relationships with the patients that would allow them to identify significant changes in behavior related to spiritual or mental health needs. Subsequently, many nurses worry that they are not providing adequate individualized holistic attention to their patients that could result in the neglect of spiritual and/or mental health needs. This situation can cause frustrating mental conflicts where the RNs worry about their ability to attend to physical versus spiritual needs of their patients. The continued exasperation in facing this emotional struggle on a daily basis can result in feelings of defeat and desensitize the ability to feel compassion when delivering care.

Delays in the delivery of care also contribute to the mental exhaustion nurses experience when caring for patients infected with COVID-19. For example, many hospitals prohibit keeping care supplies in patient rooms to minimize cross-contamination of the virus. Nurses need to plan their patient interventions and ensure that the appropriate care supplies are in the room. Often, unanticipated situations may cause nurses to need items such as linens, oral care kits or alcohol swabs as they are attending to the patient. In these situations, the nurses delivering care cannot leave the room. They are dependent on other nurses to deliver the needed supplies to them and this takes time, especially when the unit is understaffed. The resulting frustrations from lack of care supplies can easily cause nurses to need to focus more on the physical care of the patient to effectively manage their time. Therefore, the time management frustrations further limit their capability to develop authentic relationships with the patients. Delays in care and time management issues may prohibit nurses from developing authentic relationships with their patients that further fuels worry regarding their ability to address all of their assigned patients’ personal, spiritual, and/or mental health needs.

CHANGES IN FAMILY VISITATION POLICIES

Many hospitals limit the number of patient visitors or began to prohibit visitation completely during the pandemic. This is a necessary measure to limit COVID-19 exposure to hospital employees, patients and visitors. However, the change in visitation policies creates frustration in family members and significant others because they cannot be with their loved one and witness their loved one’s response to the COVID-19 infection. They experience immense fear about their loved one’s ability to recover from COVID-19 and often feel as though their loved one is the only person going through this experience. These feelings are heightened by media reports that may sensationalize the illness. As a result, family members and significant others often become angry when denied visitation privileges. Due to the lack of sound protocols or systems for maintaining transparency in patient care to loved ones, family members may call and take out their frustrations on the nurses. These frustrations felt by family members have led some of them to make threatening calls to nurses in response to limited or prohibited visitation policies, face mask requirements, or the critical condition of their loved one.

Although nurses do their best to educate family during phone conversations, their ability to

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interact with family is limited by distance and/or time. Nurses working on dedicated COVID-19 units have to prioritize their patients’ care over answering telephone calls. They need to ensure that patients in severe conditions have the care they need to optimize the patients’ health outcomes. The inability to help the family unit can cause an emotional conflict for these RNs because they were taught that holistic nursing care includes supporting patients and families. Nurses experiencing any of these situations can experi-

ence an array of emotions ranging from anxiety to fear because they cannot practice nursing according to their ethical and professional standards. The negative turmoil associated with a limited ability to help the family unit places these nurses at a higher risk for compassion fatigue.

LIFE-THREATENING PATIENT EVENTS

Patients hospitalized with COVID-19 infections have many critical health needs. The life-threatening situations these patients experience commonly result in calling a rapid response or code blue. However, rapid response and code blue care can be delayed because the interdisciplinary health team members are unable to go directly into the patient's room to provide advanced life support. They need to stop in the hall and don the proper PPE prior to entering the patient's room. In the meantime, the nurse in the room is doing his or her best to help the patient overcome the life-threatening health complications. The stress of this can cause a nurse to emotionally withdraw as a means of self-preservation.

In addition, the number of response team members may need to be restricted to minimize cross contamination of the virus. Hospital infection control protocols may limit interdisciplinary response teams to one doctor, one respiratory therapist and two RNs. The limited number of response team members may lengthen the time to administer oxygen therapy and medications needed to ideally convert the patient's critical status to a stable condition. The increased time for responding to and conducting rapid responses or code blues can demoralize a nurse, particularly when the patient does not survive the event.

Working on a dedicated COVID-19 floor is almost a guarantee that the nurse will have at least one rapid response each day they work on the unit. This reality can cause dread and anxiety at home when thinking of or planning to go to work. Nurses working on COVID-19 units may become preoccupied with worrying about life-threatening events on future work days. This preoccupation could result in detachment from others at work and home. The continued exposure to this anxiety and the apprehensions described earlier could easily overwhelm RNs and set them up for the mental and physical exhaustion associated with compassion fatigue.

PREVENTION OF COMPASSION FATIGUE

In the midst of the pandemic crisis, it has been very difficult to prevent compassion fatigue in nurses. At the beginning of the pandemic, the scientific community did not know much about the COVID-19 virus. As we learned more about the virus, hospitals adapted their protocols to limit its transmission and to prevent hospital-acquired infections of COVID-19. This was a time of flux and rapidly changing protocols. The unknown coupled with the changing evolution of protocols were enough to generate fear and worry that could lead to compassion fatigue.

Now that the health care community has learned more about the virus and treating infected patients, protocols have been solidified in the treatment of COVID-19 infections and curtailing the transmission of the virus. Although the protocols are not perfect, they are helping improve patient outcomes. Nurses and health care leaders can review the protocols in relation to adverse situations that occur in the implementation of the patient care protocols to identify what antecedents to compassion fatigue can be avoided. For example, there may be ways to safely store common care supplies in patient rooms. This would minimize care interruptions caused by waiting for someone to deliver supplies needed for addressing an unexpected patient event. Another way to minimize care interruptions could include the use of a designated nurse or nursing assistant to act as a "runner" and bring supplies to their co-workers delivering care in patient rooms. The runner nurse or nursing assistant would not have a patient assignment, so would be able to deliver care supplies to patient rooms with little delay.

Additional measures to minimize anxiety and fears in patient families and nursing staff include formal family support services. While it is the hospital's obligation to prioritize the treatment of the patient, family units often have little formal support. A support system for the family or a patient's loved ones could be developed and serve to educate the family on COVID-19, transmission of the virus and the care their loved one is receiving. This education would encompass teaching the rationale for increased infection control measures, routinely providing information on the patient's condition and treatment, and providing the family with contact numbers and names for answering questions or addressing concerns. The director



of nursing could spearhead the development of this support system by leading an interdisciplinary team with representation from clinical leaders and various hospital departments. Departments such as patient services, pastoral care, infection control, emergency services, admissions and social services could provide different perspectives in family support and education that would help family members from the time the patient is admitted to discharge. Holistic, proactive education may prevent feelings of frustration and anger in the family.

Finally, an emotional support system should be available to the RNs that would help them learn about compassion fatigue and identify ways to prevent it. This support service could be given through existing employee assistance programs. Counselors in these programs could help nurses learn how to use personal boundaries, coping skills and resiliency skills to prevent compassion fatigue. Nursing administration could also help nurses understand the importance of self-care (for instance, proper sleep, work-life balance) in the prevention of compassion fatigue, and try to adjust schedules that allow for nurses to spend

more quality time with their families. This would help nurses identify ways to increase their ability to engage in activities such as exercise, prayer and/or meditation at home and at work. The improved ability to support the emotional and physical well-being of nurses can help mitigate compassion fatigue and subsequently improve the delivery of quality care to patients diagnosed with COVID-19.

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NOTES

1. Barbara A. Carper, "Fundamentals of Patterns of Knowing in Nursing," *Advances in Nursing Science* 1, no. 1 (1978): 13–24, <https://doi.org/10.1097/00012272-197810000-00004>.
2. Emily Peters, "Compassion Fatigue in Nursing: A Concept Analysis," *Nursing Forum* 53, no. 4 (2018): 466–80, <https://doi.org/10.1111/nuf.12274>.

QUESTIONS FOR DISCUSSION

Camille Wendekier is a nurse educator and Kristyn Kegerreis is a practicing nurse who has been caring for COVID-19 patients. Together they are concerned with compassion fatigue among nurses dealing with the pandemic and other stressful circumstances that nurses aren't always prepared to handle. Compassion fatigue is defined as the physical and mental exhaustion experienced by those caring for sick or traumatized people over a long period, often resulting in emotional withdrawal from patients, colleagues and family members.

1. What are the dangers to the nurse, the patient and the relationships among other clinical and professional staff when nurses don't recognize their own compassion fatigue? What are the signs of compassion fatigue that nurse administrators and colleagues should be able to identify? What measures discussed in the article can help prevent compassion fatigue? What is your system doing to prevent compassion fatigue?

2. Nurses who've been trained to uphold holistic care and to support the family members are struggling to carry out what they've understood their role and mission to be. As nurses struggle to care for patients under extreme COVID restrictions, what aspects of holistic care may be in danger? What can health care leaders do to support families while protecting nurses who oftentimes find themselves faced with unhappy family members or stressful communications?

3. In addition to supporting nurses on the floor and in the COVID units, what can schools of nursing do to ensure that curriculum better prepares the emerging nurse work force for this and future pandemics? Can you think of ways to improve the relationship between Catholic health ministries and nursing schools to develop more focused training for nurses getting ready to enter practice?

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