


DISCURSIVE PAPER

Strategies and resources for nurse leaders to use to lead with empathy and prudence so they understand and address sources of anxiety among nurses practising in the era of COVID-19

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Abstract

Aims: Identify strategies and resources for nurse leaders to use to lead with empathy and prudence to improve quality of care and to ease the psychological toll on nurses caring for patients with COVID-19.

Background: In a 2020 report, clinicians caring for patients during the COVID-19 pandemic said their healthcare leaders needed to: 'hear me, protect me, prepare me, support me, and care for me'. These words provide an action plan for nurse leaders to communicate, educate and support nurses to practice competently and safely (physically and mentally) in the context of COVID-19.

Design: Discursive paper.

Method: Identification and inclusion of relevant international evidence with clinical discussion.

Findings: Nurse leaders can mobilise system and individual level strategies and resources to support nurses to manage pandemic-related issues including: anxiety due to the risk of infection, supporting anxious children, mitigating moral injury; providing safe and quality nursing care for patients with COVID-19 and end-of-life care as needed; supporting relatives who cannot be present with a dying relative and care for grieving relatives and colleagues. We categorise a selection of evidence-based, online sources providing current COVID-19 information, practice updates and resources to develop personalised self-care plans to ease anxiety and support renewal and resilience.

Conclusions: Nurse leaders must ensure adequate PPE supply, upskill nurses to provide safe, quality care for patients with COVID-19 and promote restorative self-care plans.

Relevance to clinical practice: The strategic actions nurse leaders take today can positively impact nurses' well-being and ability to provide safe and quality care for patients in the context of COVID-19.

KEYWORDS

COVID-19, empathy, end-of-life care, grief, leadership, quality nursing care, self-care, stress

1 | INTRODUCTION

The duration of the global COVID-19 pandemic and the extent of the devastation is uncertain. However, what we know for certain is that the actions nurse leaders take today can positively impact nurses' well-being, quality care of patients, and their healthcare organisation now, and in the aftermath of the pandemic. This is why nurse leaders are tasked with prudently managing the crisis in collaborative data-driven ways, while responding with empathy, honesty and fostering supportive relationships to ease nurses' anxiety and grief, now, and in the years ahead. We do not underestimate nurse leaders' challenges to manage staff ratios in clinical units and scarce resources in these unprecedented times. Their expressions of empathy, prudence and gratitude towards their staff are valued. Effective nurse leaders display courage, vision and provide critical opportunities for professional growth and development of their staff (Daly et al., 2020). Now, more than ever, nurse leaders and their staff must practise self-care to strengthen their resilience during these ongoing turbulent times (Duncan, 2020). As Mills et al. (2018, p. 10) explain: 'clearly an organisation cannot practise self-care on behalf of its workforce; however, it can enable and enhance self-care through corporate leadership and a variety of structural supports to foster positive workplace cultures that are conducive to self-care practice'. This is a joint responsibility that will result in benefits such as increased patient satisfaction and staff well-being (Mills et al., 2018).

The aim of this paper is to identify strategies and resources for nurse leaders to use to lead with empathy and prudence through the COVID-19 pandemic. A person who is prudent has 'practical wisdom, the ability to judge thoughtfully, make sound decisions, and act decisively under complex, ever-changeable conditions' (Kane & Patapan, 2006, p. 711). A person who is empathic has the ability to 'feel with' others, to imagine their emotions (mentalising) and to understand their perspectives and concerns (Singer & Klimecki, 2014). Understanding the perspectives of others includes understanding what they want, their point of view (rather than our own), and what is important for them.

Therefore, empathic conversations with front-line nurses are crucial so nurse leaders can understand their specific needs, sources of anxiety (e.g. risk of infection), and preferences for support. Such insights will inform planning of relevant (rather than generic) education and support strategies that will potentially have genuine impact and benefit (Shanafelt et al., 2020). Moreover, these insights about self-care are vital because anxiety affects nurses' well-being and can compromise their ability to provide quality care for patients (Bauer-Wu & Fontaine, 2015; Richardson et al., 2015). Nurse leaders therefore need to ensure front-line nurses are prepared to provide safe and quality care for patients with COVID-19, and end-of-life care (EOLC) as needed. This means personalised self-care plans must be a priority (Mills et al., 2020) to ease nurses' anxiety due to caregiving in the context of COVID-19.

To make our argument, we begin with a short story about how Admiral James Stockdale survived 2,714 days as a prisoner of war in the infamous 'Hanoi Hilton' and why nurse leaders could benefit from

What does this paper contribute to the wider global community?

- This paper demonstrates how online, evidence-based information and self-care resources can be applied in clinical practice during the pandemic to inform, educate and prepare nurses to provide compassionate, safe and quality nursing care for patients with COVID-19, and EOLC as needed.
- Nurse leaders who want to lead their staff to prevail through the pandemic must ensure nurses are aware of relevant online resources to ease anxiety and strengthen well-being.
- Leaders must respond with empathy to understand and address the sources of nurses' anxiety and provide tangible organisational compassionate interventions to support their well-being and clinical practice.

adopting his mindset during the pandemic. We provide a background to the pandemic, discuss concerns about the risk of post-traumatic stress disorder (PTSD) in the healthcare community and suggest how calls for support and compassion for front-line nurses needs to be understood, differentiated and met by nurse leaders. We then discuss a strategic communication approach to guide nurse leaders' conversations with nurses about issues such as anxiety due to the risk of infection and the risk of moral injury in their work. We describe five evidence-based requests that nurse leaders can use as a strategy to frame empathic conversations with their front-line staff to better understand their concerns, perspectives and needs. These insights can be used to tailor specific system-level interventions. Next, we outline a selection of evidence-based, online resources that nurse leaders and nurses can access for current COVID-19 information, practice updates and resources to develop personalised and restorative self-care plans. We then explain why nurse leaders need to facilitate the upskilling and professional development of front-line nurses so they can provide safe and quality nursing care for patients with COVID-19, end-of-life care (EOLC) as needed, and support for grieving relatives and colleagues. We conclude by drawing these themes together in a call for nurse leaders to have a plan to lead in the era of COVID-19 with courage and hope.

1.1 | Leading with hope to prevail

The Stockdale Paradox is a duality concept explained by Jim Collins in his book *Good to Great* (2001). It was named after Admiral James Stockdale who was held captive for over 7 years in the infamous 'Hanoi Hilton' prisoner-of-war camp during the Vietnam War. Stockdale found the way to stay alive was to acknowledge both the harshness and brutal facts of his reality intermixed with a positive belief and hope. He was able to 'confront and stoically accept the

brutal facts of his reality and prepare for the worst, and at the same time, retain an unwavering faith that he would prevail in the end, despite the challenges' (Collins, 2001, p. 83). Collins asked Stockdale:

Who didn't make it out?

Oh, that's easy, Stockdale said. The optimists.

The optimists? I don't understand," said Collins, now completely confused.

The optimists said Stockdale. They were the ones who said, 'We're going to be out by Christmas.' And Christmas would come, and Christmas would go. Then they'd say, 'We're going to be out by Easter.' And Easter would come, and Easter would go. And then Thanksgiving, and then it would be Christmas again. And they died of a broken heart. (Collins, 2001, p. 85)

Faith to prevail can help people to live with hope and to endure many months or years of challenges. What distinguishes people is not the presence or absence of challenges, but how they realistically and honestly deal with a crisis or difficulties. The Stockdale Paradox is a trait of individuals who create distinction, be it in leading their own lives or in leading others. Good to great leaders just focus on the few things that have the greatest impact. They operate from both sides of the Stockdale Paradox, never letting one surpass the other (Collins, 2001). These leadership lessons from Stockdale are relevant for nurse leaders who are striving to lead their nurses through this unprecedented crisis with empathy, honesty and hope that they will prevail.

2 | BACKGROUND

The current crisis began in December 2019, when a cluster of fatal clinical presentations resembling viral pneumonia were identified in Wuhan, China (Huang et al., 2020). There was a rapid spread of SARS-CoV-2, the virus that caused the 2019 novel coronavirus (COVID-19). In early March 2020, a pandemic was declared by the World Health Organization due to the global spread of COVID-19 (Duncan, 2020; Huang et al., 2020). The pandemic has abruptly changed daily life for healthcare professionals and countless others. As of June 2020, 188 countries/regions are affected by COVID-19. COVID-19 is a significant threat because healthy adults can die and older adults with pre-existing health conditions. Patients with COVID-19 may develop severe acute respiratory distress syndrome, may need admission to ICU and may die (Huang et al., 2020).

This international health crisis demands cooperation across borders to share best practice knowledge and health supplies (ICN, 2020a). Healthcare leaders and clinicians are working under unrelenting pressure, some in unsafe and under-resourced conditions. There have been unacceptable shortages of personal protective

equipment (PPE) that are fit for purpose, failures in supply chains and conflicting advice about reusing PPE (ICN, 2020a).

Many healthcare workers are currently separated from their families because of the fear of contagion and the risk of bringing the virus home (Lown, 2020). More than 600 nurses have died from COVID-19 worldwide and countless others have contracted the virus or required to self-isolate due to exposure in workplaces (ICN, 2020b). Strong relationships can exist between colleagues, so coping with the death of colleague can be anxiety-provoking and destabilising during the pandemic (Green, 2020).

In response, the International Council of Nurses (ICN) identified 12 priorities in a Call to Action to beat COVID-19. Each priority includes details to guide political and healthcare leaders' responses to support nurses' safety and well-being (ICN, 2020a). Priorities include maximising nursing leadership, protecting the health and well-being of nurses and other healthcare workers, ensure nurses receive appropriate COVID-19 training and prioritise access to quality PPE (ICN, 2020a).

Dr. Beth Lown, chief medical officer at the Schwartz Centre for Compassionate Healthcare in Boston said now is the time to prepare for a second wave of mental and behavioural health issues in the healthcare community. The risk for PTSD increases when a person cannot escape from the direct or indirect exposure to the trauma they are witnessing and get to safety, such as during this pandemic (Barello et al., 2020; Lown, 2020; Schuster & Dwyer, 2020). PTSD can occur in the weeks, months, even years after the traumatic experience. Lown (2020) is concerned because clinicians cannot escape the effects of the trauma, suffering, physical, mental and emotional exhaustion, and rapidity of work pace during the COVID-19 pandemic. Lown said we must challenge the stigma of feeling vulnerable and requiring support for mental health issues. Neglecting to ask for support will have significant negative outcomes for caregivers and healthcare delivery (Jolicoeur & Mullins, 2020).

Likewise, the ICN CEO Howard Catton said the fears and anxieties that nurses experience during the pandemic, and the risk of PTSD in the aftermath, must be met with support and compassion now. Support needs to be specific and relevant. Empathy is to feel with someone and understand their perspective (Singer & Klimecki, 2014). But it is critical to maintain the 'self-other distinction' which means not absorbing the pain of others as though it was our own, referred to as 'emotion contagion' (Singer & Klimecki, 2014, p. 875). Empathy skills are critical for teamwork, communication with patients, and for safe, quality patient care (Riess, 2018).

Compassion is characterised by the awareness of others' suffering, warmth and prosocial behaviours such as kindness and the intention to act to relieve their suffering (Sinclair et al., 2016; Singer & Klimecki, 2014). The intention to relieve and 'transform' suffering and distress in ourselves and others is one of the key features that distinguishes compassion from empathy (Vachon, 2016, p. 102). Acting with compassion is not only vital for quality patient care, health outcomes and satisfaction (Richardson et al., 2015), but also for reducing burnout and improving well-being and resilience in clinicians (Bauer-Wu & Fontaine, 2015). When empathic communication

and compassionate action are features of healthcare workplaces, clinical teams are more resilient and effective, morale is higher, patients receive better care and complaints are fewer (Christiansen et al., 2015; Lown, 2014).

Nurse leaders must initiate empathic conversations with front-line nurses to understand and address their needs and concerns. Nurses are providing good nursing care to patients with COVID-19 despite the circumstances. However, 'this problem is fundamentally an occupational health and safety issue rather than simply an infectious disease problem' (Dennis, 2020, p. 1). The additional health and safety requirements that are in place are essential, but create a sense of distance in providing care. Front-line nurses want assurances they will have adequate PPE to practice safely, and training to provide high-quality nursing care for patients with COVID-19 (despite their fears), and EOLC as needed.

Because the virus is highly contagious, nurses feel anxious and many are isolating from their families for long periods of time to avoid transmitting the virus (Lown, 2020; Wallace et al., 2020). Dr. Tracey Dechert, a COVID-19 intensive care unit lead, said she couldn't get the psychological support she would typically get from her husband during her isolation (Jolicoeur & Mullins, 2020). Physical isolation can have the unintended consequence of social isolation from support networks. This is a reason why nurses must practise self-care to manage their emotions, so they can continue to care for patients.

Further, nurses with coronavirus have isolated from their families and feel shame and also anger if hospital management did not provide adequate PPE (ICN, 2020a). It is important to remember that the familiar and predictable daily routines of children that make them feel safe and secure have been disrupted by the COVID-19 pandemic (Weaver & Wiener, 2020). Children may react to their parents' anxieties about potentially contracting the coronavirus, loss of financial security and health risks of older relatives, such as grandparents (Weaver & Wiener, 2020). Not surprisingly, lack of physical contact due to isolation can increase children's fears about their parent dying and exacerbate their vulnerability and risk of psychological harm (Weaver & Wiener, 2020). In this context, children of doctors, nurses and paramedics have felt deep anguish and some have written goodbye letters to their parents.

In response, nurse leaders should ask front-line nurses what specific support strategies and actions would make a difference (Shanafelt et al., 2020). Many nurses (who are parents) are concerned about their children and older family members during the pandemic, so leaders could suggest strategies to help. For incidence, leaders could suggest that nurses use simple language to talk to their children about the pandemic, be kind, sensitive and factual (according to age) about how children can be safe (Gaffney, 1988) and protect themselves by, for example, handwashing (Weaver & Wiener, 2020).

As a global response, researchers, professional bodies and leading healthcare organisations are producing up-to-date, reliable resources about the pandemic, clinical practice issues and self-care resources for caregivers. We outline a selection later in the paper.

3 | STRATEGIC AND HONEST CONVERSATIONS

Leaders can effectively motivate their teams in three ways. First, direction-giving: leaders need to clarify the organisational purpose and identify the steps to address problems and challenges. Second, meaning-making: leaders need to explain what actions are required to achieve the purpose. Third, empathy: leaders need to use empathic language to acknowledge the problems and challenges that people are asked to cope with and provide emotional support and guidance (Mayfield & Mayfield, 2017). These steps could be useful for nurse leaders.

With no end in sight, healthcare leaders are faced with managing resource and service-related shortages during the pandemic, and educating and supporting clinicians to care for patients and themselves. Wellness issues affect productivity. For example, nurses need to be prepared to provide compassionate, safe and quality care for patients in critical care and general ward settings, EOLC as needed, support relatives, and manage personal anxiety, exhaustion and grief (Rosa et al., 2020).

In the context of the pandemic, physicians are making triage decisions due to limited equipment and scarce resources (Greenberg et al., 2020). This means they have to decide which equally sick patients with COVID-19 will have access to critical and potentially life-saving equipment and which patients will not. These decisions about who does and who does not receive critical treatment will result in some patients dying because of the lack of resources in an overloaded system (Greenberg et al., 2020). Further, many nurses have been expected to work without adequate PPE which can lead to anxiety, fear, moral distress, and guilt when they refuse to provide nursing care in such unsafe circumstances (ICN, 2020a). Therefore, nurse leaders must raise awareness in frank conversations with their staff about these morally challenging issues and the risk of experiencing moral injury (moral distress) when caring for patients with COVID-19 (Greenberg et al., 2020). In particular, acts of 'commission and omission' (which can lead to moral injury) must be discussed to ensure nurses are prepared and supported by the organisation to cope with moral dilemmas that may arise in their work (Rushton, 2018).

Notably, if moral distress or outrage is not addressed and mitigated, then moral injury will result (Rushton, 2018, p. 66). A comment that illustrates potential moral injury is: 'We did our best with the staff and resources available, but it wasn't enough' (Greenberg et al., 2020, p. 1). Moreover, Greenberg et al., (2020, p. 1) explain: 'Moral injury is a term originating from the military, and can be defined as the psychological distress that results from actions, or lack of them, which violate someone's moral or ethical code'. Moral injury is a 'particular type of psychological trauma characterised by intense guilt, shame, existential crisis, and loss of trust that may develop when one violates his or her moral beliefs' (Jinkerson, 2016, p. 122).

But in some circumstances, there might not be a clear or 'correct course of action', so Morley (2018, p. 3443) said nurses need to develop skills to engage in moral reflection and ethical discussions with

colleagues to mitigate their moral distress. Morley (2018) suggested that nurse leaders can support front-line nurses to explore their moral concerns (and injury) arising from incidents in clinical practice in debriefing sessions and organisational interventions such as virtual Schwartz Rounds (see The Schwartz Centre for Compassionate Healthcare (2019) for an overview). Moreover, Rushton (2018, p. 53) stated, 'clinicians will be able to practice with integrity to the fullest extent only if organisations join with them to co-create conditions that allow them to be morally resilient and to deliberately develop systems and processes that enable ethical practice'. Stockdale said a major way to demotivate people is to ignore the brutal facts of reality (Collins, 2001, p. 89). Therefore, leaders who want to lead their staff to prevail through these brutal times must talk honestly about these problems as potential triggers for stress and moral injury (Duncan, 2020).

During the first week of the pandemic in the United States of America, sixty-nine healthcare professionals attended sessions to explore their concerns, what they needed from their leaders and identify tangible sources of useful support. Their eight concerns were organised into five requests to their leaders, namely 'hear me, protect me, prepare me, support me, and care for me' (Shanafelt et al., 2020, p. 2133). Nurse leaders could use these five 'requests' as a strategy to frame empathic and honest conversations with their staff to understand their anxieties and concerns and ask how to address with tangible resources. They must make proactive plans to protect the mental health and foster moral resilience in front-line nurses who face ethical challenges related to patient suffering, limited equipment and scarce resources (Rushton, 2018).

4 | ROADMAP OF EVIDENCE-BASED RESOURCES

It is normal to feel anxious, sad, stressed and angry when so much is beyond one's control. Clinicians are encouraged to access practical support to manage their anxiety, sadness, anticipatory grief and to ease the impact of the constant exposure to suffering and dying during the pandemic (Radbruch et al., 2020). Many global vanguard health organisations, local professional organisations and leading researchers are producing free, online pandemic-related evidence-based information, practice updates, self-protection information and self-care resources to educate healthcare leaders and caregivers to manage a range of clinical issues, ease anxiety and foster well-being. In addition, nurse leaders and nurses can investigate the resources available in their institution that are relevant to their specific needs.

Vachon (2016, p. 103) reminds us: 'the key to compassion is self-compassion, knowing and caring for ourselves'. Self-compassion and self-care practices are imperative now and in the aftermath of the pandemic. We first need to be compassionate towards ourselves and speak kindly to ourselves in order to be compassionate towards others. Pioneer researcher Dr Kristen Neff said self-compassion is treating yourself with the same kindness and compassion that you would give a good friend (2011). Dr Neff has provided specific pandemic resources and guidance on her website for caregivers to use to develop

self-care plans and self-compassion practices to cope with anxiety and fears that may arise when caring for patients with COVID-19.

Moreover, Mills et al. (2020, p. 2) recommends 'developing a personalised self-care plan' and explains that 'effective self-care practice involves self-awareness, self-compassion, and the implementation of a variety of strategies across physical, social, and inner self-care domains'. Self-care practices can minimise anxiety and the risk factors of PTSD (Barello et al., 2020). Being self-aware is the first step to selecting relevant support because there is no one-size-fits-all plan for nurses. The skills of self-compassion (i.e. mindfulness, self-kindness) can be practised in the workplace to reduce caregiver anxiety, improve job satisfaction and strengthen provision of quality care (Neff, 2011). Building compassionate cultures will benefit nurses and patients alike (Christiansen et al., 2015; Lown, 2014).

Nurse leaders and nurses can integrate self-care strategies and practices into the workday, rather than something only practised outside work hours. For example, 'The Pause' is a self-care strategy that is practiced globally in clinical settings when a patient has died. The purpose of The Pause is to honour a patient and the caregiver team. It is a 15–30 second period of silence shared by caregivers after a patient's death. During the Pause, caregivers can listen to their breathing, refocus and then move on to the next patient with calmness and readiness to care with compassion (Bartels, 2014). The Pause provides closure to the relationship between the caregivers and the patient and prepares the caregiver team to care for other patients. The Pause can be downloaded from the App Store. Other self-care practices can range from debriefing with colleagues after a demanding shift, to accessing support from employee assistance programmes if available in the workplace, to conversations with family and friends, or seeing a therapist for professional support (Mills et al., 2020).

4.1 | Resources for nurse leaders

The 'Rapid Guidance' flow chart (infographic) was developed by The COVID Trauma Response Working Group at The King's Fund in the UK. The flow chart is available on The King's Fund organisational website together with free online events and novel resources to support healthcare professionals to lead self and others, practise safely, self-care and maintain resilience during the pandemic. The purpose of the flow chart is to 'foster resilience, reduce burnout and reduce the risk of post-traumatic stress disorder' (2020, p. 1). The flow chart provides practical guidance for nurse leaders to respond to critical staffing issues through: (a) Good, clear timely communication, information and training; (b) Fostering team spirit and cohesion; (c) Promoting well-being through flexible, response resourcing; and (d) High-quality psychological and well-being services (COVID Trauma Response Working Group, 2020). Further, the 'Schwartz Rounds' is a system-level intervention that nurse leaders could implement in their organisation to promote resilience, to ease anxiety, grief and discuss concerns such as bringing the coronavirus into one's home (Jolicoeur & Mullins, 2020; The Schwartz Centre for Compassionate Healthcare, 2019).

4.2 | Resources for nurses

Nurses can access relevant pandemic-related information and resources from a wide range of local, national and global sources. There are numerous healthcare organisations and professional nursing organisations that are providing online, current, reliable, evidence-based information about the pandemic on organisational websites, such as The World Health Organisation (WHO), the International Council of Nurses (ICN).

The Schwartz Center for Compassionate Healthcare in Boston, USA is a respected vanguard organisation that offers a COVID-19 resource page on their organisational website with information to support healthcare professionals to manage challenges related to the pandemic. Caregivers are encouraged to maintain their resilience so they are prepared to provide quality care for patients with COVID-19. Moreover, The Schwartz Centre for Compassionate Healthcare is conducting the 'Virtual 2020 Compassion in Action Healthcare Conference'. All the Conference Program sessions are available online and scheduled between June and November 2020. The focus of the 2020 Conference is to firstly discuss strategies to manage the myriad of organisational and practice issues arising during the COVID-19 pandemic, and secondly to examine links between caregivers' self-care practices, their well-being, and their preparedness to provide quality care for patients with COVID-19. In addition, the library of 'Compassion in Action Webinars' can be accessed on The Schwartz Centre for Compassionate Healthcare organisational website. The free webinars address a broad range of relevant topics to strengthen compassionate care in healthcare organisations and to support and educate caregivers to provide quality health care.

Another organisation providing copious, online, evidence-based COVID-19 resources and practice guidelines to support nurses to care for patients with COVID-19 is The Royal College of Nursing (RCN) UK. Some patients with COVID-19 will require end-of-life care. In response, the RCN has produced a helpful resource for nurses called 'End of life care: Having courageous conversations by telephone or video during the COVID-19 pandemic: 10 top tips'. Moreover, the International Association for Hospice and Palliative care provides end-of-life practice resources and tips to manage anxiety and self-care on their organisational website. Palliative Care Australia launched 'Self-Care Matters' resources including guided meditations on their organisational website.

5 | PROVIDING SAFE AND QUALITY NURSING CARE FOR PATIENTS WITH COVID-19

The rapid spread of the COVID-19 pandemic and severity of symptoms has caused a 'tsunami of suffering' disruption, uncertainty and grief worldwide (Radbruch et al., 2020, p. 1). In midway 2020, there have been over 704,000 deaths globally from COVID-19, with an estimated 0.95 million people bereaved (Selman et al., 2020). The basics of empathic communication, compassionate end-of-life planning

and self-care practices are now more important than ever (Wallace et al., 2020). Every patient has the right to be cared for with dignity and respect.

The coronavirus can present as a mild illness in some patients, but may develop into severe acute respiratory distress syndrome causing massive alveolar destruction, respiratory failure and death. Older adults with comorbidities are considered to be at a higher risk of contracting the coronavirus (Huang et al., 2020). Nurses need to communicate with patients to ensure they understand the severity of their COVID-19 symptoms and discuss EOLC, if needed. Palliative care clinicians have a vital role to educate their colleagues in critical care units to palliate physical symptoms and to respond to the trauma and grief experienced by patients with COVID-19 and their loved ones (Rosa et al., 2020). The Royal College of Nursing (RCN) UK has developed an excellent practice resource to lead critical end-of-life conversations between patients and their families using technology such as the telephone or Zoom or FaceTime. This free resource can be accessed by nurses globally.

Nurses are witnessing increased suffering due to the physical distancing rules that have disrupted the usual way people comfort each other (Van Bortel et al., 2016). Patients with COVID-19 are isolated from their families' comforting presence to hold their hand or say goodbye (Radbruch et al., 2020; Wallace et al., 2020). The need for personal protective equipment and facial masks has disrupted nurses' ability to express empathy to patients through body language and facial expressions. It is harder to see and interpret facial expressions, cues and emotions that inform empathy and connection. Nurses finish their shifts with their cell phone battery in the red because they have used their phone to communicate the final moments between patients and their loved ones outside the hospital doors. Deaths during the COVID-19 pandemic have disrupted family-centred care and may lead to 'poor bereavement outcomes among relatives, as well as moral injury and distress in front-line staff' (Selman et al., 2020, p. e81).

Morris et al. (2020, p. e70) highlight potential concerns related to bereavement because: 'how a person copes after the death of a significant loved one is influenced by personality and coping style, the relationship with the deceased, and the circumstances of the death'. Relatives may reach out to nurses for support. People deal with loss through traditional grieving rituals, however, restrictions on the number of mourners permitted to attend viewings and funerals has further disrupted rituals and complicates mourning (Van Bortel et al., 2016). Funeral directors have conducted virtual viewings via FaceTime and live stream funerals for relatives and friends who are unable to attend in-person. Nurses can encourage relatives to participate by sending a significant item and a message that can be placed on the casket during the service. The pandemic has disrupted opportunities to hug and receive comfort in the usual way and is affecting normal grieving processes, religious and cultural rituals, and people's ability to access support (Van Bortel et al., 2016). These losses will deepen the emotional toll, regret and guilt so the need for bereavement support could be ongoing (Wallace et al., 2020). Moreover, the impact of bearing witness

to suffering and grief is significant and may trigger vulnerability and moral injury (Greenberg et al., 2020). For example, Dr. Tracey Dechert said she felt dread each day and it was impossible to leave sadness and grief behind at the end of a shift (Jolicoeur & Mullins, 2020). Nurse leaders could provide opportunities for nurses to share memories when grieving for a colleague who has died from COVID-19 (Green, 2020).

6 | CONCLUSION

The global COVID-19 pandemic has taught us that life is both incredibly fragile and immensely precious. Nurses are required to provide safe and quality nursing care for patients with COVID-19 so nurse leaders must ensure they are educated to provide compassionate EOLC, bereavement support and self-care. The scale of death is unprecedented for most nurses. Nurse leaders need to ask their nurses how best to respond to their need to be heard, protected, prepared, supported and cared for (Shanafelt et al., 2020). Nurse leaders can direct nurses to current COVID-19 information, and self-care resources to ease their anxiety, trauma, suffering, grief and the risk of PTSD which is now a global concern in nursing (Schuster & Dwyer, 2020). In these times of collective vulnerability, anxiety and physical distancing that has forced us to abandon many familiar and comfort routines, we must (more than ever) continue to talk to each other, express gratitude for each other's efforts and collaborate towards better outcomes for everyone. Let us continue to do our best each day, be proud of what we have learned and of how we have adapted, foster supportive collegial relationships and believe we will prevail.

7 | RELEVANCE TO CLINICAL PRACTICE

The COVID-19 pandemic has highlighted the critical importance of nursing in all communities. With no end in sight, nurse leaders have the moral responsibility to ensure nurses have access to adequate PPE, relevant education, and support strategies and resources to practice safely and stay socially connected. Nurses are traumatised and exhausted, so funding and support must be provided to restart normal healthcare services for people with chronic diseases following the pandemic (Jones-Berry, 2020). Further, as an urgent priority, nurse leaders must lead implementation of recommendations in the 2020 WHO landmark report to ensure a properly resourced, supported and educated nursing workforce in the years ahead (ICN, 2020c).

CONFLICT OF INTEREST

The authors declare that they have no competing interests.

AUTHOR CONTRIBUTIONS

AH drafted the manuscript. RT made critical revisions for intellectual content. Authors approved the final manuscript.

ETHICAL APPROVAL

None required.

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