T he COVID-19 pandemic has pushed the emergency care sector beyond its breaking point, exacerbating preexisting issues such as ED crowding, boarding, unsafe patient assignments, suboptimal/unacceptable work environments, and psychological distress.1-3 As this pandemic continues into its second year, the prevalence of psychological distress, moral injury (a phenomenon that often follows moral distress on the continuum of moral harm4), and stress-related disorders among nurses and health care workers are higher than ever before.5,6 Suicide rates, which were higher among nurses and health care workers before the pandemic, are likely to have increased.7-10 Collective grief, disillusionment, and weariness may remain present in disaster recovery efforts, despite vaccine administration.

As frontline workers, emergency nurses have experienced first-hand the mass occupational trauma that the International Council of Nurses refers to as unprecedented and complex.5,6 As health care organizations desperately try to conserve resources, many units are attempting to function at minimal staffing levels, further intensifying the physical, mental, and emotional demand on their already depleted workforce.11 Owing to increasing organizational demands, little (if any) organizational resources have been made available to emergency nurses within the United States at a systems level.2,3,11 The feelings of frustration and exhaustion in the nursing profession are palpable in departments across the nation and in mainstream news and social media channels. The International Council of Nurses predicts a substantial “COVID-19 Effect” on the overall nursing workforce: a mass exodus from the profession.5 This is a sobering prediction, given that globally we were expected to be 10 million nurses short in 2030...and this was a prepandemic prediction.5

Although general activities of disaster response (eg, meeting basic human needs, providing life-saving care) will continue within the emergency department, recovery efforts on a larger scale should focus on “how best to restore, redevelop and revitalize the health, social, economic, natural and environmental fabric of communities.”12 According to the National Disaster Recovery Framework (NDRF), it is not unusual for disaster recovery to begin while response is still occurring. Prioritizing psychological and emotional recovery, a core principle of the NDRF, is necessary to maximize the opportunity for successful disaster recovery.13 This core principle should be prioritized among emergency nurses and health care workers during COVID-19 recovery efforts. Dr. Karen Foli’s Middle Range Theory of Nurses’ Psychological Trauma13-15 provides a mental model for understanding nurse-specific trauma, something that is particularly relevant in disaster recovery efforts given the psychological ramifications of COVID-19 on the nursing workforce. This theory includes individual, professional, and system/organizational factors as influences on the allostatic load (physiological responses from chronic exposure to stress) of the nurse.14 Individual or humankind trauma refers to trauma outside of the nursing profession and work environment and includes potential traumas from adverse childhood experiences. At the professional level, types of nurse-specific trauma may be unavoidable (eg, vicarious trauma through patient care), but can be exacerbated or alleviated through organization and system factors. Examples of nurse trauma are provided in Table 1, and include workplace violence, system-induced or medically induced trauma, historical or intergenerational trauma, second-victim trauma (ie, medical errors), trauma related to disaster work, and insufficient resource trauma.14,16 Insufficient resource trauma, the most recent addition to this...
The Federal Emergency Management Agency’s definition of “resilience,” as defined in the NDRF, is “the ability to adapt to changing conditions and withstand and rapidly recover from disruption due to emergencies.” The very definition of resilience is strikingly similar to what emergency nurses have been experiencing is to name our experiences, creating and conveying the reality of what we as emergency nurses have been experiencing.

Table 1: Examples of types of nurse psychological traumas from the middle range theory of nurses’ psychological traumas

<table>
<thead>
<tr>
<th>Types of nurse psychological trauma</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Vicarious/Secondary trauma</td>
<td>Secondary traumatic experiences with patients who are dying without family members physically present; Witnessing the psychological and physical distress of other nurses and staff.</td>
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<tr>
<td>Historical trauma</td>
<td>Embedded institutional racism, evidenced by higher morbidity and mortality rates from COVID-19 among African Americans and ethnic minority groups; Nurses, as an oppressed group, being used by others to interface with patients, thus endangering their lives.</td>
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<tr>
<td>Workplace violence</td>
<td>Organizational dismissal of distress after a traumatic experience; Nurse physically or verbally abused by a family member who is upset when they cannot come into the hospital to see their family member.</td>
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<tr>
<td>System/Medically-induced trauma</td>
<td>A patient who suffers from a medical error or is in distress due to mechanical ventilation, or painful and invasive interventions.</td>
</tr>
<tr>
<td>Insufficient resource trauma</td>
<td>Lack of PPE; unmanageable patient assignments due to the number of patients or patient acuity; Non-critical care nurses assigned to care for patients without being adequately oriented and trained.</td>
</tr>
<tr>
<td>Second-victim trauma</td>
<td>The guilt a nurse experiences after a medical error or from believing nursing care is not meeting the patients’ needs because of insufficient resources (inadequate or ill-prepared staff).</td>
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<tr>
<td>Trauma from disasters</td>
<td>Engaging in crisis standards of care, not providing life-saving care to a patient who would have received resources outside of a disaster context; Having to decide which patients receive life-saving measures; Worrying about transmitting the virus to loved ones at home.</td>
</tr>
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PPE, personal protective equipment.

In a scoping review regarding the impact of COVID-19 on health care worker wellness, Shreffler et al recommend strategies to enhance health care worker wellness. Examples of recommendations include immediate/individualized access to mental health resources; quality, accessible personal protective equipment; and individual and organizational strategies to improve nutrition, exercise, sleep quality, and mindfulness, and to reduce burnout. On the basis of recovery efforts from previous disasters, simply creating a space for human connection to occur through sharing experiences can facilitate healing and subvert the stigma that may come with seeking mental health services. Understanding the experience of psychological and nurse-specific trauma during the COVID-19 pandemic is necessary to optimize a healthy recovery process and enhance the future resilience of those in the nursing profession. Restoring and improving the stability and resiliency of the health care system to optimize patient outcomes and enhance community well-being: along with implementing strategies to protect the safety and health of recovery workers from the effects of post-disaster environments are outlined as core capabilities under the Health and Social Services infrastructure system in the NDRF, necessary to achieve the National Preparedness Goal.

In this issue of the Journal of Emergency Nursing, Woo and Kim discuss secondary traumatic stress among nurses and emphasize that solutions at the structural level (ie,
administrative and leadership support) are needed to mitigate the negative effects of such issues. Emergency nurses within the US and around the world make up a unique community of interest, identity, and circumstance. Now is the time to collectively advocate through health care systems, hospital executives/leadership, nurse unions, federations and professional organizations like Emergency Nurses Association, and other avenues mentioned in Table 2 for tangible support of the nursing workforce as we recover from this pandemic disaster. As a specialty, we can harness the momentum within the context of disaster recovery to build guiding coalitions and advocate for healthier work environments, psychological support, and more equitable health care systems.

Author Disclosures
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REFERENCES


