

A Multifaceted Approach to Combating Compassion Fatigue
in New Emergency Department Nurses

Josephine A. Smith

Rutgers School of Nursing

DNP Chair: Patricia Hindin, PHD, CNM, CLC, RYT 200

DNP Team Members: Tracy Vitale, DNP, RNC-OB, C-EFM, NE-BC

Jessica Ramos, DNP, RN

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Abstract

The emergency department is often plagued with trauma and suffering. This hectic environment can take a toll on new nurses both mentally and physically. For new nurses who have not been taught proper coping skills, frequent exposure to trauma can have detrimental effects such as memory problems, poor judgment, and loss of concentration and focus. Compassion fatigue is described as emotional, physical and spiritual fatigue from witnessing and taking in the suffering and problems of others (Hunsaker, Hsiu-Chin, Maughan, & Heaston, 2015; Peery, 2010; Sabo, 2011). Compassion fatigue leads to absenteeism, turnover, and increased hospital costs. When nurses are equipped with the proper coping mechanisms, this condition is both manageable and preventable. Compassion fatigue is counterbalanced by compassion satisfaction which is defined as the satisfaction a caregiver gains from their work (Kelly & Lefton, 2017). This pilot study utilized a single group pre/post-test design with a convenience sample of emergency department nurses with 2 years of experience or less. Study interventions such as education, use of a tranquility room, counseling, and meaningful recognition were implemented to prevent and combat compassion fatigue and improve compassion satisfaction. Compassion fatigue and compassion satisfaction were measured pre- and post-intervention utilizing the Professional Quality of Life Scale (ProQOL) version 5. A paired t-test and descriptive statistics were used to analyze the results of the ProQOL and a demographic questionnaire. The findings of this study failed to show any statistical significance that a multifaceted compassion fatigue research project has an effect on compassion fatigue and compassion satisfaction.

Keywords: compassion fatigue, secondary traumatic stress, compassion satisfaction, burnout, vicarious traumatization, meaningful recognition, tranquility room, relaxation room, debriefing

A Multifaceted Approach to Combating Compassion Fatigue in New Emergency Department Nurses

Introduction

The emergency department (ED) is a fast-paced, high-stress area where witnessing suffering and trauma is inevitable. The mental and emotional impact of nursing is not fully understood and for new nurses who have not been taught proper coping skills, working in this fast-paced specialty can have detrimental effects and lead to compassion fatigue (Boyle, 2011). According to the American Psychiatric Association, a traumatic stressor is an event or events that may cause or threaten serious injury death or sexual violence. Therefore, patients with life-threatening illnesses such as stroke, organ failure or sepsis also experience trauma (Sacco, Ciurzynski, Elizabeth, & Ingersoll, 2015). For new nurses who have not been taught proper coping skills, frequent exposure to trauma can have detrimental effects such as memory problems, poor judgment, and loss of concentration and focus. These components are vital to nurses' ability to practice safely (Matey, 2016).

Compassion fatigue is often unrecognized in nursing. It is described as emotional, physical and spiritual fatigue from witnessing and taking in the suffering and problems of others. (Hunsaker et al., 2015; Peery, 2010; Sabo, 2011). This condition affects patient safety and leads to an increase in absenteeism, nurse turnover, and hospital costs. Recent studies suggest that younger and novice nurses are at a higher risk of experiencing compassion fatigue than their seasoned counterparts (Kelly, Baker, & Horton, 2017). To combat compassion fatigue successfully, combined efforts are required from both the hospital's leadership and staff (Emergency Nurse Association, 2014a).

Compassion fatigue is counterbalanced by compassion satisfaction which is defined as

the satisfaction a caregiver gains from their work, including the gratification and pleasure they experience in their position and feelings resulting from helping others through traumatic situations (Kelly & Lefton, 2017). Acknowledging that compassion fatigue not only contributes to self-harm, but also the potential harm of patients may be reason enough to recognize, value, and prioritize compassion fatigue as a safety issue (Matey, 2016). A multifaceted project designed to combat compassion fatigue while improving compassion satisfaction in new emergency department nurses was introduced.

Background and Significance

Compassion fatigue is a significant, often unrecognized issue in nursing. Carla Joinson first introduced the term compassion fatigue in 1992 (Hunsaker et al., 2015). She described compassion fatigue as nurses losing their ability to nurture. According to Dr. Charles Figley, compassion fatigue is a self- protection measure that develops in response to the stress from helping a traumatized or suffering person (Figley, 1995; Hunsaker et al., 2015). Compassion fatigue is comprised of two components known as secondary traumatic stress (STS) and burnout (BO).

STS is the consequence that occurs from witnessing patients' pain, trauma, and suffering (Flarity, Gentry, & Mesnikoff, 2013). A nurse caring for a patient and family who has experienced suffering or trauma begins to feel their own anxiety stress and other emotional responses associated with the traumatic event. Burnout is the consequence of chronic physiologic and emotional stressors experienced by nurses (Kelly et al., 2017). Burnout is associated with work-related, environmental factors. Feelings of exhaustion, frustration, anger, hopelessness, and depression are the result (Flarity et al., 2013). In contrast, compassion satisfaction (CS) balances professional quality of life (Kelly et al., 2017). It is the joy and purpose nurses experience

through caring for others (Flarity et al., 2013). CS can be gained by engaging in activities that assist nurses in reviving and renewing their desire to care for patients (Kelly, Runge, & Spencer, 2015).

There are few systematic supports that aid nurses in dealing with witnessing the pain and trauma experienced by others (Valdez, 2008). Due to lack of knowledge, the warning signs and symptoms of compassion fatigue and burnout often go unrecognized by nurses and their colleagues (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). Compassion fatigue (CF) may be a causative factor in why dissatisfaction and turnover are higher among nurses who recently graduated (Hunsaker et al., 2015). Approximately 20% of new nurses leave the nursing profession within the first year (Kelly et al., 2017). The average cost of turnover for a bedside registered nurse ranges between \$38,000 and \$59,000 resulting in the average hospital losing \$5.1-7.8 million annually (NSI Nursing Solution Inc., 2017). The average cost to replace an ED nurse is \$80,000- \$88,000 (Emergency Nurse Association, 2016).

According to The Bureau of Labor Statistics, it is predicted that there will be a demand for 525,000 replacement nurses in the workforce, which will result in a total of 1,052,000 open registered nurse positions by the year 2022 (United States Department of Labor, 2013). In 2016, the national turnover average for emergency department nurses was 19.1%. Nurses with less than one year of experience had a turnover rate of 25% for all specialties, while nurses with 1-2 years of experience had a turnover rate of 23% for all specialties (NSI Nursing Solution Inc., 2017). The Emergency Nurse Association states turnover for new emergency department nurses has been reported as high as 59% (Emergency Nurse Association, 2016).

Receiving compassionate nursing care is a prime component in whether a patient returns to or recommends a healthcare facility (Emergency Nurse Association, 2014a). Under the

Inpatient Prospective Payment System, hospitals are subject to payment provisions. Hospitals must submit their Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to receive their total annual payment. Medicare and Medicaid report HCAHPS survey results on the official Hospital Compare Website. This website allows patients to objectively compare hospitals. Hospital reimbursement and transparency of HCAHPS scores highlight the significance of sustaining and enhancing nurses' ability to emotionally connect and care for patients (Hooper et al., 2010).

Needs Assessment

In May 2016, the ED at a community hospital in Hudson County, New Jersey began hiring nurses with no prior clinical experience. These nurses were required to sign a two-year contract to aid in retention as well as participate in a six-month nurse residency program. Twenty-six new nurses were hired between May 2016-August 2017 (J. Ramos – ED nurse manager, personal communication, March 26, 2018). Periodic chart reviews conducted by the ED nurse manager revealed 84.6% of these nurses' charts contained patient care errors including 15.3% high-level errors. The percentage of new nurses who resigned, transferred, or were terminated in less than two years was 42.3%.

The institution has incurred increased costs due to turnover and absenteeism. In 2017, the estimated expense for contract labor was \$291,411.78, and the estimated cost of overtime pay was \$260,828.28. The estimated expense for sick pay was \$45,820.40 which exceeded the annual budget for sick pay by \$11,814.40 (J. Ramos – ED nurse manager, personal communication, March 26, 2018). Nurses employed in this ED are neither currently screened for CF nor provided counseling services. These nurses are not allotted time for self-care and self-reflection during their shift, especially after intense situations. These factors can lead to CF. For new nurses to

maintain compassion, creating a healthy work environment is paramount. There is currently no protocol in place for distressed nurses or to assess nurses for CF. This project is the first step in the change process.

Problem Statement

New emergency department nurses have not developed appropriate coping mechanisms to deal with the trauma and suffering they are so frequently exposed to. They often lack confidence and are unable to handle the stressful environment of the emergency department. Institutions often lack programs and resources that will aid in preventing compassion fatigue. Many of these nurses develop compassion fatigue resulting in increased turnover, absenteeism, decreased patient satisfaction, and increased hospital costs.

Clinical Question

The clinical question guiding this project is “In emergency department nurses with two years of clinical experience or less, how does the implementation of a multifaceted compassion fatigue research project affect compassion fatigue and compassion satisfaction?”

Aims and Objectives

The aim of this project was to implement a multifaceted Compassion Fatigue Research Project for emergency department nurses with 2 years of clinical experience or less.

The project objectives were to:

- establish a prevalence of compassion satisfaction and compassion fatigue in new emergency department nurses pre- and post-intervention.
- educate participants on proper coping skills to prevent and combat compassion fatigue

- provide participants with a place to take an uninterrupted break after difficult or stressful situations
- measure if there is a change in the level of compassion fatigue and compassion satisfaction post-intervention.

Review of Literature

A literature search was conducted using the databases CINAHL and Ovid Medline. The keywords *compassion fatigue*, *secondary traumatic stress*, *compassion satisfaction*, *burnout*, *vicarious traumatization*, *meaningful recognition*, *tranquility room*, *relaxation room*, and *debriefing* were used. The search was limited to articles written in English and published between 2011-current. Grey literature was also reviewed to obtain further knowledge of compassion fatigue, compassion satisfaction, and appropriate interventions. Duplicate articles were excluded, and titles and abstracts were reviewed (see Appendix A). Twelve articles were used for the review of the literature (see Appendix B).

Novice Nurses and Professional Quality of Life

While conventional thinking may be the novice nurse is at less risk for CF due to less time spent in the profession, CF early in their careers could be a significant cause for turnover and lack of retention (Kelly et al., 2015). Studies suggest that younger nurses or nurses with less experience have higher levels of compassion fatigue and decreased compassion satisfaction (Hunsaker et al., 2015; Kelly et al. 2015; Sacco et al., 2015). Nurses from the millennial generation are born between 1982 and 2000. These nurses and those with fewer years of experience are at high risk for decreased compassion satisfaction and increased compassion fatigue (Kelly et al., 2017). Kelly et al. (2015) conducted a cross-sectional survey of 491 direct patient care nurses working in a large teaching facility in the southwest United States. Nurses

were categorized into three generational categories: "Millennials" (ages 21-33), "Generation X" (ages 34-49), and "Baby Boomers" (ages 50-65). Study findings showed the "Millennial" generation is more likely to experience greater levels of burnout and secondary traumatic stress while exhibiting less compassion satisfaction than their counterparts who are considered "Generation X" or "Baby Boomers."

Demographics and work-related characteristics can influence the prevalence of CS and CF (Hunsaker et al., 2015). Hunsaker et al. (2015) conducted a cross-sectional descriptive and predictive study with 278 registered nurses who worked in emergency departments throughout the U.S. Sacco et al. (2015) conducted a cross-sectional design study with 221 registered and licensed practical nurses working in critical care at an academic center in western New York. Both study results suggested that younger and less experienced nurses are at higher risk for compassion fatigue than their older and more experienced colleagues. Older nurses exhibited more compassion satisfaction, and younger nurses had higher levels of burnout.

The study conducted by Hunsaker et al. (2015) was limited due to a small sample size and low response rate. The prevalence of CS and CF was measured at a single point in time which was also a limitation. Sacco et al. (2015) stated the generalizability of the study's findings may be limited. The cross-sectional study design may be representative of a bad day, high acuity or other factors. Age and experience can affect professional quality of life; therefore, further study is warranted to examine this relationship thoroughly. Future research concentrating on the finding that older and more experienced nurses have higher levels of compassion satisfaction would be beneficial to the nursing profession. (Hunsaker et al., 2015; Sacco et al., 2015).

Mooney et al. (2017) conducted a quantitative descriptive study with 102 intensive care unit (ICU) and oncology nurses working for a community hospital in the U.S. Participants

completed the Professional Quality of Life Scale and a demographic survey. The purpose of this study was to examine the levels of compassion satisfaction and compassion fatigue in ICU and oncology nurses. Linear regression was used to analyze the effect of years of experience, age and years in current position on CF, CS, and BO. Results showed nurses with more years of experience had lower levels of CF ($F=5.06$; $R^2= 5.7\%$; $p= 0.27$). Compassion fatigue significantly decreased with aging ($F=5.99$; $R^2= 6.7\%$; $p= .016$). The more time a nurse spent in their current position was also correlated to a reduction in compassion fatigue ($F = 4.11$; $R^2= 4.7\%$; $p=.046$). Compassion satisfaction was not impacted by years of nursing experience ($F=0.77$; $R^2= 0.9\%$; $p=.383$) or years in current position ($F= 0.26$; $R^2=0.3\%$; $p=.612$). Years of experience ($F=1.20$; $R^2= 1.4\%$; $p =.276$) and years in current position ($F= 1.25$; $R^2=1.5\%$; $p=.266$) did not have an impact on burnout. The impact age had on compassion satisfaction and burnout was not mentioned in the article (Mooney et al., 2017). The sample size limited this study and was comprised of specialty nurses from one institution which limits generalizability. Nonresponse bias may have impacted results and participants were not required to answer all parts of the survey (Mooney et al., 2017).

Interventions to Improve Compassion Satisfaction and Combat Compassion Fatigue

A vital first step in reducing compassion fatigue is acknowledging the problem exists (Harris & Quinn-Griffin, 2015). A multifaceted approach must be taken to manage compassion fatigue. This approach includes assessment, prevention, and consequence minimization. Interventions such as work/life balance, education, and workplace programs must be utilized to mitigate compassion fatigue in nursing (Boyle, 2011; Figley, 2002). Flarity et al. (2013) conducted a pre- and posttest design study using a convenience sample of 73 self- selected emergency department nurses working at two emergency departments in Colorado. A

multifaceted program was implemented and showed a statistically significant increase in CS ($p=0.004$), a decrease in BO ($p=0.001$ or less), and a decrease in STS symptoms ($P=0.001$) post-intervention. Post-intervention there was a 10% improvement in compassion satisfaction, 34% improvement in burnout and 19% improvement in secondary traumatic stress. The utilization of a convenience sample was a limitation because it affects validity. Recruitment for this study was self-selection, and there was a threat of inaccuracy of self-reported data. The findings may not be reflective of the general emergency department population. There also was a three to four-week timeframe between pre- and posttest which was not reflective of a long-term improvement (Flarity et al., 2013). Most of the current intervention programs impact CS, but CF remains unaffected. An intervention and prevention program specifically designed to target all three components of professional quality of life is essential (Mooney et al., 2017).

Meaningful Recognition

Meaningful recognition has been recognized as a significant component of a healthy work environment, suggesting that the concept of meaningful recognition is systematically correlated with an organization's outcomes (Kelly & Lefton, 2017). A quantitative descriptive online survey was conducted by Kelly & Lefton (2017). Study participants included 761 ICU nurses in 14 hospitals throughout the U.S. that had an established meaningful recognition program, and 410 ICU nurses from 10 hospitals throughout the U.S. that signed up for a meaningful recognition program but had not implemented the program at the time of the study. Study findings indicated that nurses who received meaningful recognition exhibited significantly decreased levels of burnout and higher levels of compassion satisfaction (Kelly & Lefton, 2017).

Meaningful recognition is a powerful and effective tool that can be utilized by administration to acknowledge nurses in a personally valuable way to create ownership and trust.

Nurses who received meaningful recognition exhibited a significant decrease in burnout and increased compassion satisfaction (Kelly & Lefton, 2017). The study limitations included a low response rate and survey responder bias. A convenience sample of hospitals aspiring to participate in a meaningful recognition program was utilized as the control hospital which also limited the study.

Kelly et al. (2015) suggest there is a significant positive relationship between meaningful recognition, compassion fatigue, and compassion satisfaction. Developing a culture of meaningful recognition can directly influence the degree of compassion satisfaction. Organizations must support nurses in attaining job satisfaction and personal growth to achieve improved patient outcomes. To promote a healthy work environment hospital leadership should promote a culture of caring, recognition, professional development, and debriefing (Sacco et al., 2015).

Education

Education is imperative for nurses at risk of experiencing CF (Harris & Quinn-Griffin, 2015). Increasing awareness concerning compassion fatigue may promote an increase in job satisfaction in emergency department nurses and increase quality patient care (Hunsaker et al., 2015). Organizations should provide formal education regarding establishing boundaries, therapeutic communication, conflict resolution, ethical dilemmas, and self-care. Organizations should also ensure that educational sessions are accessible to all shifts. These sessions should be conducted during orientation, and periodically throughout the year (Harris and Quinn-Griffin, 2015).

Self-Care and Self Reflection

Self-care and self-reflection must be incorporated into the daily lives of nurses to maintain the ability to be effective caregivers (Boyle, 2011). Nurses often require a timeout to focus and continue with their day. Timeouts are often necessary after a demise, hectic or critical situation (Harris & Quinn-Griffin, 2015). According to Houck (2014), a timeout is a break that can either be scheduled or requested by a nurse when he or she is incapable of empathizing with a patient and family or when feelings of emptiness are experienced. This break can be as short as five to 10 minutes, or longer if required (Harris & Quinn-Griffin, 2015). Organizations should permit nurses time and opportunity for grieving such as meditation areas. Providing timeouts for nurses by implementing quiet rooms can be facilitated by hospital administrators (Harris et al., 2015). Committing to taking care of oneself involves adequate nutrition, hydration sleep, and exercise. Encouraging nurses to engage in new methods of self-care such as yoga, massage, or meditation is beneficial in combating compassion fatigue (Lombardo & Eyre, 2011).

Tranquility Room

A tranquility room provides nurses with a haven where they can take time out to rejuvenate themselves (Harris & Quinn-Griffin, 2015). Lombardo & Eyre (2011) suggested that an intervention to combat compassion fatigue is to create a comfortable, relaxing environment by transforming a room into a relaxation area. Kelly et al. (2017) described how the utilization the Code Compassion Cart, which was set up in place of a room, demonstrated that raising awareness about compassion fatigue allows nurses to pause, be mindful, reflect, and address their potential burnout.

In a qualitative study conducted by Gonzalez, Pizzi, Thomas, Cooper & Clyne (2015), the utilization of a tranquility room and being afforded with opportunities for self-care and self-reflection enabled nurses to nurture and relate caring in their relationships with patients and

colleagues. Twenty telemetry nurses working in a U.S. hospital utilized a tranquility room for a 15-week period. The time spent in the tranquility room aided caring attitudes that moved beyond task completion while embracing human care. The room afforded nurses a break from the complexity of the work environment and provided an opportunity for uninterrupted reflection (Gonzalez et al., 2015).

Gonzalez et al. (2015) developed a questionnaire consisting of three questions as a guide: How has using the tranquility room impacted caring in your nursing practice? How have you provided caring support today? How have you received caring support today? Group analysis of question one revealed common themes such as: clear and refocus; peace, calm, relax, break; rejuvenated, recharge; and care. These themes revealed abstract meanings that included: spiritual calm, clarity of mind, and physical renewal. Group analysis of question two revealed themes such as: listening, talking and conversation; help, comfort, care, and calm; help and support; and patient time. The abstract meanings found were open communication, a supportive environment, and human support. Question three revealed themes such as support and supportive; help and helpful; tranquility room; relax; and colleague. Abstract themes found were a supportive caring environment and collegial support (Gonzalez et al., 2015).

Utilization of a tranquility room daily during work hours can provide increased clarity, decrease overall stress, increase serenity throughout the day, and increase focus on human care (Gonzalez et al., 2015). This study was limited to the perspectives of a selected group of nurses. There was no participation from nurses in other units or ancillary staff. Face to face interviews and a more diverse nursing population may have provided more insight regarding the impact of the tranquility room.

Counseling

On-site counseling is an essential tool for nurses experiencing compassion fatigue (Harris & Quinn-Griffin 2015). Organizations should provide outlets for sharing emotional expressions such as pastoral care and professional counseling (Houck, 2014). The spiritual needs of nurses affected by suffering and tragedy require special attention since the emotional response to this situation is usually associated with life and death matters. On-site counseling should be provided by a therapist, counselor, psychiatric APN, social worker, or chaplain who is trained to emotionally support health care providers experiencing or at risk of compassion fatigue. Counseling resources must be accessible to the staff and provide practical solutions (Boyle, 2011).

Summary

In summary, the review of the literature provides evidence that is necessary to equip new ED nurses with tools to aid them in coping with the hectic ED environment. New ED nurses must feel appreciated and supported in order to maintain compassion satisfaction. These nurses must be allowed time to cope after difficult situations and provided with a safe space to do so. Providing ED nurses with resources and teaching them coping mechanisms will help them prolong their careers. The importance of implementing a program that focuses on all aspects of professional quality of life is imperative. This review of literature guided the principal investigator (PI) of this study in implementing interventions that targeted preventing and combating CF as well as improving CS.

Theoretical Framework

The theoretical framework for this project is the Professional Quality of Life Model (Stamm, 2010). Professional quality of life is the quality a person experiences in association with their work as a helper. Professional quality of life is comprised of two aspects, the positive

(Compassion Satisfaction) and the negative (Compassion Fatigue). Both the negative and positive aspects of performing one's job influence professional quality of life (Stamm, 2010).

This project focused on both the positive and negative aspects of professional quality of life. A multifaceted project was implemented to improve compassion satisfaction and prevent or manage compassion fatigue.

The prevalence of compassion satisfaction and compassion fatigue was established pre- and post-intervention by administering the Professional Quality of Life Scale Version 5. This project included three education sessions that provided education regarding prevention, self-care, and management of compassion fatigue. A tranquility room was implemented to give nurses the opportunity to take a timeout for self-reflection and to regroup after difficult or stressful situations. Counseling services were available upon request by Pastoral Care. Meaningful recognition was utilized to increase compassion satisfaction (see Appendix C).

Methodology

This pilot study utilized a single group pre/post-test design with a convenience sample. A pilot study was chosen to evaluate the effectiveness of the study interventions in combating compassion fatigue and improving compassion satisfaction. The level of compassion satisfaction and compassion fatigue was measured pre- and post-intervention utilizing the Professional Quality of Life Scale (ProQOL) version 5 (2010). Demographic data was collected. Participants were required to complete a questionnaire after each use of the tranquility room, and a Tranquility Room Evaluation.

Setting

This DNP project was conducted in the emergency department of a 278-bed community hospital in Hudson County, New Jersey. This is a 27-bed emergency department where

approximately 30,000 patients are seen annually. All education sessions took place in the Tranquility Room located within the hospital outside of the ED.

Study Population

There was a total of 28 nurses working in the ED. The target sample size for this study was up to 25 participants. This pilot study aimed to demonstrate the efficacy of multiple interventions in a single group, therefore, a sample in the range of 20-25 was sufficient (Hertzog, 2008). In order to be included in the study, participants were required to be registered nurses with two years of experience or less, work fulltime in the ED at the designated site, and provide direct care to ED patients. Contract or agency nurses and nurses in leadership positions were excluded from participating in the study.

Fourteen nurses met the criteria for participation in the study. Initially, eight nurses agreed to participate in the study. One participant left the institution and another participant went out on Workman's Compensation. Two participants ceased communication. These events took place prior to the first education session. This study included a convenience sample of 4 emergency department nurses.

Study Interventions

The Compassion Fatigue Research Project consisted of three education sessions, the implementation of a tranquility room, meaningful recognition, and counseling services by Pastoral Care upon request. The Tranquility Room and counseling services were available when the first class was completed. The ProQOL 5 was administered by the PI pre- and post-intervention.

Tranquility Room. The Tranquility Room was a hospital room that was no longer in use. This room was transformed into an area of relaxation for study participants. The room was

located outside of the ED on another floor. Study participants who were distressed or that needed to take a time out were required to notify the charge nurse and report off to another nurse in order to use the room. One participant was allowed to use the room at a time. Participants were required to stay in the Tranquility Room for a minimum of 10 minutes, to sign in and out using their assigned number, and complete the Tranquility Room survey after each use. Completed surveys were put in the locked box located inside the Tranquility Room. No eating, drinking, or cellphone was allowed.

The Tranquility Room contained a lavender area rug, lamp, oil diffuser, stress relief lotion, stress balls, a CD player, tranquil CDs, yoga poses on the walls, a back massager that was placed on a reclining chair, an electric water fountain, yoga mats, disinfectant wipes, and gloves. Some of these items were provided by the designated site. The room also contained the cards for Pastoral Care, instructions for use of the room, Tranquility Room questionnaires and a lock box for the completed questionnaires (see Appendix D). The key for the Tranquility Room was left with the ED unit clerk on duty. Participants also had the option of obtaining the key from nursing administration.

Restorative Yoga. Restorative yoga is an intervention developed by B.K.S. Iyengar to induce relaxation, decrease stress, and reduce muscular strain using props and supported poses that are held for extended periods of time (Iyengar & Razazan, 2001; Lasater, 2011; Corey, et al., 2014). Baroreceptor activity is stimulated by supine and inverted positions. This activity stimulates reflexes that produce relaxing effects and causes a shift from sympathetic to predominately parasympathetic nervous system activity (Corey et al., 2014; Gharib, et al., 1988; Shiraishi, Schou, Gybel, Christensen, & Norsk, 2002; Vybiral, Bryg, Maddens, & Boden,

1989). In contrast, upright yoga positions postures reduce baroreceptor activity and produce the opposite effect (Cole, 1989; Corey et al., 2014; Laszlo, Rossler, & Hinghofer-Szalkay, 2001). Restorative yoga poses were hung on the walls of the Tranquility Room. The poses were demonstrated and the rationale for incorporating this form of yoga in the study was explained to the participants.

Music Therapy. Music is one of the most common arts used in healthcare. Music therapy has been found to have substantial effects on psychological and physical health in a number of settings (Ploukou & Panagopoulou, 2018; White, 1992). Although music has been proven to be beneficial on psychological wellbeing, music is seldom used to reduce work-related stress among health professionals (Ploukou & Panagopoulou, 2018). Study participants were encouraged to play tranquil music while in the Tranquility Room to aid with relaxation.

Aromatherapy and Massage. The Tranquility Room contained a heated back massager that was placed on a reclining chair. The room also contained an oil diffuser and a variety of essential oils. Participants were instructed to use the back massager and oil diffuser simultaneously. Studies have shown that massage relieves stress and anxiety (Li, et al., 2018; Jung, Choi, Kang, & Choi, 2017; Saatsaz, Rezaei, Alipour, & Beheshti, 2016). The mechanism of massage is associated with the stimulation of stress receptors, which can increase vagal activity and decrease cortisol levels (Field, 2016; Li et al., 2018; Wu et al., 2014). Aromatherapy and massage are commonly used for stress reduction and relieving physical and mental discomfort (Chamine & Oken, 2015; Chang, Lin, & Chang, 2017; Li et al., 2018;)

Meaningful Recognition

Meaningful recognition acknowledges the contributions of another person with feedback that is relevant to what they accomplished and is equivalent to the person's contribution.

Meaningful recognition is positive feedback that describes the impact a person had on another and how and why their actions and deeds made a difference (Barnes & Lefton, 2013). The nurses participated in meaningful recognition at the end of each session. The participants selected the name of another nurse and wrote three kind or meaningful words to describe them. Participants were instructed to only write positive and kind words to describe their colleagues. At the end of the final session, participants received certificates of recognition stating how they are positively viewed by the other participants of the study (see Appendix E).

During the study, the participants often stated that they did not feel appreciated and their hard work often went unnoticed. Meaningful recognition gave the nurses the opportunity to feel valued. It was also important for them to highlight the good qualities of the other participants. According to Kelly et al. (2015) developing a culture of meaningful recognition can directly influence the degree of compassion satisfaction.

Counseling

Counseling services were optional and available upon request. Pastoral Care agreed to counsel study participants who felt they were in distress or felt the need to speak with a professional. Pastoral Care was provided with a list of the assigned numbers in an attempt to maintain confidentiality. If counseling services were requested, participants were instructed to provide their assigned number to Pastoral Care. Counseling services would be scheduled by the participant and Pastoral Care and the PI would be provided with the assigned numbers of all the participants who sought counseling at the end of the study. The participants could schedule as many counseling sessions as necessary during the duration of the study.

Education Sessions

Class I: Introductory Session/What is Compassion Fatigue?.

During this hour-long session, the expectations and requirements of the study were explained. Participants were de-identified by choosing a number out of a box. The PI maintained a master list that correlated each participant to their number. The ProQOL 5 and the demographic survey were completed at the beginning of the session. A lecture utilizing a PowerPoint presentation was conducted. This lecture educated participants on the signs and symptoms of CF. Meaningful recognition took place after the PowerPoint presentation (see Appendix F). Counseling services were also explained to participants. The participants were provided with the contact information for Pastoral Care and instructed to call if they felt they needed counseling. They were also informed that counseling was confidential. The participants were introduced to the Tranquility Room and given instructions regarding the requirements and regulations associated with the use of the room. The activities in the room were explained and demonstrated. The first \$5 Dunkin Donuts gift card was given to participants and light refreshments were served.

Class II: Taking Care of Self.

This one-hour session took place approximately two weeks after Class I. Participants were educated on self-care/relaxation techniques. A lecture utilizing a PowerPoint presentation on ways to enhance self-care such as proper nutrition, sleep habits, and exercise was conducted (see Appendix G). During this session, the participants were taught the 4-7-8 breathing technique by utilizing a YouTube video. The participants were required to demonstrate the technique after watching the video. Breathing is a process that is both conscious and unconscious and gives cognizant access to the autonomic nervous system. The sympathetic nervous system is stimulated by inhalation while the parasympathetic system is stimulated by exhalation. Inhalation increases the heart rate while exhalation decreases heart rate. The practice of mindful breathing

aids in calming the mind immediately, thus decreasing stress or revitalizing the nervous system if one feels depressed or fatigued (Burg & Michalak, 2011; Mason, et al., 2013; Alexander, Rollins, Walker, Wong, & Pennings, 2015). Awareness of bodily functions such as breathing and awareness of one's thoughts are vital to improving the response to physical and mental stress (Mehling et al., 2011; Vago & Silbersweig, 2012; Alexander et al., 2015).

At the end of the session, meaningful recognition took place and light refreshments were served.

Class III: Now you have the tools...Put them to use!.

This session lasted one hour and provided the participants with the opportunity to share what they learned and express how they will manage difficult work situations going forward. This hour-long session took place approximately two months after Class I. The ProQOL 5 was administered at the beginning of the session. The Tranquility Room evaluation was also completed during this session. There was a discussion about the overall study and whether the participants found the study beneficial. Certificates of recognition and certificates of completion were awarded. Caring for the Caregiver wristbands and the second \$5 Dunkin Donuts gift card was given to participants at the end of the session. Light refreshments were served.

Outcome Measures

CF and CS were measured using the Professional Quality of Life Scale (ProQOL 5) version 5. (see Appendix H) The ProQOL version 5 is the most commonly utilized scale to measure compassion satisfaction and compassion fatigue (Stamm, 2010). The ProQOL 5 is a 30 item Likert scale that is comprised of three subscales to measure professional quality of life. The three scales measure separate constructs. The compassion satisfaction scale has a Cronbach alpha reliability of .88. Compassion fatigue is measured by screening for burnout and secondary traumatic stress individually. The burnout scale has a Cronbach alpha reliability of .75, and the

secondary traumatic stress scale has a Cronbach alpha reliability of .81 (Stamm, 2010).

The ProQOL 5 was selected for this project because all aspects of professional quality of life are measured. The ProQOL 5 was administered pre-and post-intervention to establish the prevalence of compassion satisfaction and compassion fatigue in study participants.

Demographic data such as age, level of education, years of practice, and intention of leaving their current position in the next year was collected during the first education session. The Tranquility Room Questionnaire was developed by the PI. Participants were required to complete the Tranquility Room questionnaire each time the tranquility room was utilized. There was also an evaluation of the Tranquility Room which consisted of two open-ended questions. This evaluation was developed by the PI (see Appendix I).

Benefits/Risks

Participation in this study posed minimal risks. There was a potential risk for emotional impact related to the subject matter of the study. Therefore, counseling services were available by Pastoral Care upon request. There was also a potential risk for loss of confidentiality. The participants were de-identified, and a coding system was used for all data collected. The PI made every attempt to keep participant identity and responses confidential by maintaining all electronic patient data on a password secured laptop and encrypted flash drive. All paper data was maintained in a locked cabinet off-site in the PI's home.

Subject Recruitment

Participant recruitment began after all ethical considerations were met by the IRB at the designated site and Rutgers University's IRB. Recruitment flyers providing information about the study were posted in the ED's nursing lounge. The email addresses of potential participants were obtained from the ED nurse manager. An initial email was sent to all potential study participants explaining the study. The study flyer, consent, and pictures of the Tranquility Room

were attached to the email. The PI's name and contact information was listed on the flyer and included in the email (see Appendix J). Each potential participant also received individual letters that explained the study. These letters contained a consent, pictures of the Tranquility Room and the study flyer. Face to face recruitment took place and potential participants were given letters at that time. Letters were also given to potential participants by the nurse manager. During face to face recruitment, the project was explained to potential participants and they were provided with the opportunity to ask questions. Potential participants interested in the study provided their contact information. The PI's contact was also provided to answer any questions regarding the study. Light refreshments were served.

Consent Procedure

Written consents were distributed to participants by the PI. At the time of distribution, all potential participants were provided with the opportunity to ask questions related to the study. The consent included a detail of the study, estimated timeline of the study, and contained the PI's contact information. The form also included details about the risks, benefits, confidentiality, and compensation for participating in the study. The study posed minimal risks. There was a risk of emotional or psychological impact related to the subject matter. These risks are common.

The benefits included providing new nurses with self-care and relaxation techniques to aid in preventing or managing compassion fatigue to improve the overall well-being of the nurses. Utilization of the Tranquility Room enabled participants to take a time out and regroup especially after intense situations.

The consent clearly stated that participants may withdraw from the study at any time. Participants were informed that they may be removed from the study for inability to honor attendance requirements. They were also informed that if they are terminated or resign from their current position, they were no longer allowed to participate in the study, and they would not

receive compensation. A copy of the signed consent was provided to all participants (see Appendix K).

Subject Costs and Compensation

Participants did not incur any costs by participating in this project. While participants were not be paid for participating in the study, they were compensated by the hospital. Study participants were paid their hourly rate which ranges \$35-\$45 per hour for each education session attended. Participation in the study was not considered as overtime and was not be logged into payroll as such. Participants received a \$5 Dunkin Donuts gift card at the first and last education sessions. certificates of recognition, certificates of completion, and a Caring for the Caregiver bracelet were given to all participants at the last education session. Light refreshments were provided at all education sessions.

Project Timeline

Participant recruitment for this project began in September 2018. The study was conducted for two months and started in November 2018. Data collection began between November 2018-January 2018. Presentation of the final project is anticipated to take place in April 2019. A Gantt chart with the complete project timeline was created (see Appendix L).

Resources Needed/Economic Considerations

Implementation of this project required resources especially regarding the Tranquility Room. The resources and budgetary break down for this project are explained in chart form (see Appendix M).

Evaluation Plan

Data Maintenance/Security

The PI and the project chair will have access to harvested data. All electronic data will be maintained on a password secured laptop and encrypted flash drive. Paper data will be maintained in a locked cabinet off-site. Data will be locked in the chair of this project's office at 65 Bergen Street Newark, New Jersey 07107. Data will be given to chair upon completion of the program and maintained per Rutgers University's Office of Information Technology's policy.

Data Analysis

SPSS version 25 was utilized for statistical analysis of data. A paired t-test was used to analyze data obtained from the ProQOL 5 pre- and post-intervention. Descriptive statistics was used to analyze demographic data.

Results

The findings of this study failed to show any statistical significance that a multifaceted compassion fatigue research project has an effect on compassion satisfaction and compassion fatigue. Due to issues with recruitment and a smaller than expected sample size. This study consisted of 4 female registered nurses working in the ED, with two years of clinical experience or less. The age of the participants ranged from 31 to 40 years of age. Two participants had two years of experience, one participant had one year of experience, and the fourth had more than one, but less than two years of experience. Three of the participants were Bachelor's prepared nurses while one participant had an Associate degree. In regard to leaving their position in the next year, two participants had plans on leaving their current position. Descriptive statistics was used to analyze this data (see Table 1).

The ProQOL 5 was administered pre and post intervention. The ProQOL contains three subscales that measured compassion satisfaction (CS), burnout (BO), and secondary traumatic

stress (STS). The raw scores were calculated into total scores based on Beth Hudnall Stamm's scales. A paired t-test was utilized to analyze the results of the ProQOL pre and post-intervention (see Table 2).

The average score of CS pre-and post-intervention showed the participants had average to high levels which suggest they experience joy in their jobs as caregivers. There was no significant difference in the scores for CS pre-intervention ($M=38.5$, $SD=4.65$) and CS Post-intervention ($M=39.25$, $SD=6.13$); $t(3) = .878$, $p = .444$. Pre-intervention scores for BO were average. Post-intervention scores for BO showed the participants were experiencing low to average levels of BO. There was no significant difference in the scores for BO pre-intervention ($M=28.75$, $SD=.50$) and BO post-intervention ($M=24$, $SD=4.24$); $t(3) = 2.357$, $p = .100$. Pre-and Post-intervention scores for STS showed the participants were experiencing low to average levels of STS. There was no significant difference in the scores for STS pre-intervention ($M=22.5$, $SD=5.44$) and STS post-intervention ($M=20.5$, $SD=2.08$); $t(3) = 1.124$, $p = .343$. These findings suggest that there was no change in the level of CS, BO, and STS post-intervention. Participants completed a Tranquility Room questionnaire after each use of the Tranquility Room. This questionnaire was developed by the PI. The Tranquility Room questionnaire consisted of a Likert scale to assess the participants level of stress prior to use of the Tranquility room and after use. The scale was ranked as follows: **1** = No stress **2** = Some stress **3** = Stressed **4** = Highly stressed.

Based on the results of the Tranquility Room Questionnaire, the level of stress prior to using the room was 4. The level of stress after using the room was 1-2. Some examples of the activities done while using the room were yoga, sleep, using the chair massager and oil diffuser, playing tranquil music, and breathing exercises and meditation. The questionnaire also asked

about the type of activities done and the duration of time spent in the room. According to Harris and Quinn-Griffin (2015), a timeout can be as short as five to 10 minutes, or longer if required (Harris and Quinn-Griffin, 2015). Participants stayed in the room from 10 to 45 minutes. The amount of time spent in the room depended on how soon the participants needed to return to work and their level of stress prior to utilizing the room (see Table 3).

A Tranquility Room evaluation was completed at the end of the last session. The evaluation consisted of two open-ended questions. The first question: What was your overall experience? The overall sentiment was that the Tranquility room was necessary and aided in decreasing stress. The second question stated: What barriers did you experience? The main barriers expressed were short staffing, lack of support and the Tranquility Room key. Although the quantitative data obtained suggests no statistical significance, the statements made by the participants when evaluating the Tranquility Room supports the literature (see Table 4).

Discussion

Emergency department nurses typically encounter patients when they are going through a difficult point in their lives, which increases these nurse's susceptibility to CF. The aim of this project was to implement a multifaceted Compassion Fatigue Research Project for emergency department nurses with 2 years of clinical experience or less. This approach began by establishing if the participants were experiencing CF. As previously stated, the participants of this study were experiencing average levels of BO and low to average levels of STS pre-intervention. Due to these results, the focus was to educate participants on proper coping skills to prevent and combat compassion fatigue.

The participants were educated on the signs and symptoms and techniques to prevent CF. Education is imperative for nurses at risk of experiencing CF (Harris & Quinn-Griffin, 2015).

The participants attended three education sessions. As previously stated, the education sessions focused on the signs and symptoms of CF, techniques to prevent CF, self-care, and self-reflection. Self-care and self-reflection must be incorporated into the daily lives of nurses to maintain the ability to be effective caregivers (Boyle, 2011). Committing to taking care of oneself involves adequate nutrition, hydration sleep, and exercise. Encouraging nurses to engage in new methods of self-care such as yoga, massage, or meditation is beneficial in combating CF (Lombardo & Eyre, 2011). Three of the participants have incorporated exercise into their daily lives as a form of stress relief. The nurses were given a lavender colored wristband with the logo Caring for the Caregiver at the end of the study. They were instructed to wear the wristbands at work and use it as a reminder to care for themselves during their shift. This self-care could be in the form of utilizing the 4-7-8 breathing technique they were taught during the second education session or something as simple as eating or using the restroom during their shift.

The incorporation of a tranquility room in this project was to provide the nurses with a safe haven to decompress and rejuvenate themselves and provide participants with a place to take an uninterrupted break after difficult or stressful situations. The participants found the location of the room to be beneficial because they could take an uninterrupted break. As previously stated, the Tranquility Room was located outside of the ED on another floor. Similar to the findings of Gonzalez et al. (2015), utilizing the tranquility room decreased stress and aided in focusing on human care. This was evident based on the level of stress before and after use of the Tranquility Room and statements made by the participants during the last education session. Each participant used the room at least once. The participants of the study all agreed that the Tranquility Room was necessary and if able, they would have utilized the room.

The level of compassion fatigue and compassion satisfaction was measured pre and post

intervention. Unlike the study conducted by Flarity et al. (2013), where a multifaceted program was implemented, using a pre and posttest design, there was no significant improvement in CS, BO, and STS in this study. Like the Flarity et al. (2013) study, this study was conducted using a convenience sample which may not be reflective of the ED population. Mooney et al. (2017) found that most of the current intervention programs only focused on CS and CF was usually unaffected. This project targeted all three components of professional quality of life, but all three components remained unaffected. Multiple extenuating factors contributed to this result.

Limitations

Recruitment

Recruitment was a challenge and delayed implementation of this project. Fourteen potential participants met the inclusion criteria, and each received individual letters and emails explaining the project. A copy of the consent and pictures of the Tranquility Room were included in emails and personalized letters. Many nurses were reluctant to participate in the project because the study was perceived as additional work and there was also a fear of comments made during the study being reported to administration. Face to face recruitment only took place with the day and evening shift nurses. More of an attempt should have been made by the PI to make in-person contact with the night shift. This may have possibly increased the sample size.

Sample Size

These study findings are limited due to the small sample size and therefore limits generalizability. Also, a convenience sample was used which is not reflective of the ED population (Brown, 2018). There were no participants from the ED nightshift. The participation of nightshift nurses may have provided a different perspective or different results. For example, the evening shift nurse was able to utilize the room more frequently than the dayshift nurses

because she had more downtime.

Staffing

Short staffing played a major role during the implementation of this project. The participants were often unable to find coverage in order to use the Tranquility Room. The nurses would attempt to leave the ED to use the room but were too overwhelmed by their workload to do so. Dayshift nurses had the most difficulty leaving the ED. The participant who utilized the Tranquility Room the most was able to do so because she worked a 12-hour evening shift and was able to use the room when the ED was not busy. In retrospect, an alternative form of coverage while participants used the Tranquility Room should have been implemented.

Study Design

The pre and post-test study design is a weak study design due to difficulty in attributing causation to the intervention if there is no randomization or a control group. The post-test results may be affected by exposure to the pre-test. Utilizing a control group that also has a pre and posttest, using more than one pre and posttest in both groups, and assessing the outcomes of both groups at multiple points in time can strengthen the pre and posttest design (Terry, 2015).

Charge Nurses

The important role the charge nurses played in the implementation of this project was overlooked during the study design. The participants expressed some push back from the charge nurses regarding the study. In retrospect, a meeting with the charge nurses and the PI to explain the project may have been beneficial in implementing the study, as they did not understand the project, and the necessity of the participants utilizing the Tranquility Room during work hours.

Tranquility Room Key

To make utilization of the Tranquility room easier and more accessible, it was discussed

with the nurse manager for the Tranquility Room key to be left with the unit clerk on duty. The Tranquility Room key was only to be given to participants of the study. Initially, locating the key was an issue. There were a few occasions when the key was unable to be located. The study design did not consider communication regarding the Tranquility Room key. During face to face recruitment with the potential participants, a discussion should have been had with the unit secretary explaining the project and the importance of accessibility of the Tranquility Room key.

Self-Reporting

The study participants self-reported the amount of time they spent in the Tranquility Room and the activities they engaged in while utilizing the room and the ProQOL 5 required self-reporting. Although self-reporting is a common approach for obtaining data, self-reported data is considered to be unreliable and threatened by self-reporting bias (Althubaiti, 2016).

Leaving the Organization

The PI leaving the organization prior to the implementation of the project resulted in a loss of control over the project. Navigating meetings and implementation were conducted without the convenience of being at the designated site daily. Being off-site made it difficult to meet with the nightshift nurses face to face which may have affected recruitment.

Summary

The PI should have taken more steps to make in-person contact with all potential participants. A major error was leaving things to chance. The study should have been discussed with everyone who could potentially play a role in the success of the study such as the charge nurses and unit clerks. In the future, more attention will be paid to external factors that can potentially affect a study. These factors will be considered in any future study designs.

Implications/Recommendations

According to the Emergency Nurses Association (ENA), “A healthy work environment is a productive and collaborative setting in which nurses and other health care workers are free from physical and psychosocial harm while maximizing their ability to provide safe, quality care, along with meeting personal needs and with the empowerment to promote a satisfying work experience” (Emergency Nurses Association, 2013, p 1). ED nurses often interact with nurses from other units. Dissatisfied or disgruntled nurses affect the way the ED is perceived by other nurses and often causes conflict with the ED and other units. The ED is the point of entry for most patients entering the hospital. Negative experiences in the ED can shape a patient's perception of the entire hospital. Patients' experiences in the hospital transcend to their home life. Research shows patients who were satisfied with their care while in the hospital are more likely to adhere to treatment regimens (Emergency Nurses Association, 2014b).

Adequate nurse staffing aids in improving outcomes in areas such as patient satisfaction, patient mortality, medication and procedural errors, hospital readmissions, and length of stay (Emergency Nurses Association, 2018). Proper nurse staffing also plays a large role in nurse satisfaction. Nurses comprise the largest clinical subgroup in healthcare systems and are a vital part of healthcare. It is both imperative and beneficial for organizations to begin to invest more in the wellbeing of nurses. Organizations can take the initial step by finding ways to assess job satisfaction among their nurses.

Clinical Practice

The emotional and physical needs of nurses must be nurtured in order to maintain their ability to care for patients compassionately (Flynn Makic, 2015). The focus of healthcare is often patient-centered, but it is imperative that nurses begin to care for themselves and each other. CF not only affects the individual but can affect the entire staff. Nurses have the

responsibility of intervening and assisting co-workers who may be suffering from CF. Nurses must be able to recognize the signs and symptoms of this condition.

According to the ENA Topic Brief on CF, one of the five key elements shown to effectively combat CF is connection or having a strong and positive peer-support system (Emergency Nurse Association, 2014a). The nurses in this study felt as if they were alone and did not have any guidance. They were apprehensive to ask for help when in need because they were fearful of being made to feel inadequate. Nurses have a reputation for eating their young. This culture of nursing needs to shift to a culture of mentorship. It is the responsibility of seasoned nurses to mentor new nurses.

Healthcare Policy

Administration must promote self-care for nurses and attempt to provide a supportive environment. The ENA's position on a healthy work environment states leadership should make resources and education available in the workplace for supporting the psychological and physical needs of the health care worker. This includes safe staffing levels, fatigue-related risks, protected meal times and opportunities to de-brief after a critical event (Emergency Nurses Association, 2013). Administration must also focus on resolving issues with staffing. Proper nurse staffing reduces nurse fatigue and promotes nurse safety, retention, and job satisfaction (Emergency Nurses Association, 2018).

Quality and Safety

Inadequate nurse staffing affects the well-being of nurses and patient safety which further erodes the quality and safety of care (Halm, 2019). The American Association of Critical Care Nurses is heading large-scale initiatives to transform nurse staffing as an investment in patient safety. (Halm, 2019). Healthy work environments are beneficial for

patient safety while providing a valuable support system for nurses (Emergency Nurse Association, 2014a). Working long hours without taking a break is both unsafe and unhealthy. This not only affects nurses but can affect patient safety. Nurses should be allowed to step away from the ED after a stressful situation to regroup.

Education

Nurses should be educated on the signs and symptoms and prevention of CF. It is important that they can recognize the signs and symptoms of CF in their co-workers. Once educated on the signs and symptoms of CF, the participants of this study were all able to point out nurses they felt could benefit from the project. The participants stated they have noticed the signs and symptoms of CF in their co-workers but did not know it had a name.

Educating new nurses on compassion fatigue should be part of the orientation process. Prevention of compassion fatigue can be initiated by teaching ways to deal with patients suffering (Emergency Nurse Association, 2014a). Ongoing education can be in the form of lunch and learn. Posters listing the signs and symptoms of CF can be posted in the nursing lounge or locker room as a reference.

Economic Implications

Receiving compassionate nursing is a principal factor in patient intention to return or recommend a healthcare facility (Emergency Nurse Association, 2014a). Hospital reimbursement and transparency of HCAHPS scores highlight the significance of sustaining and enhancing nurses' ability to emotionally connect and care for patients (Hooper et al., 2010). The more satisfied patients are with their care, the higher the chance that the hospital will receive their total payment under the Inpatient Prospective Payment System. Additionally, nurse turnover will contribute to increased costs for the hospital because they will have to hire new

nurses which as previously stated, can cost up to \$88,000 to train an ED nurse (Emergency Nurse Association, 2016).

Translation

Although the findings of this study are not generalizable, the subject matter is important and can be beneficial in providing nurses with methods to care for themselves and prolong their careers. This information can be translated to a broader group by presenting this topic and by educating new nurses on CF, the detrimental effects, and ways to combat this condition.

Dissemination

The results of this study will be disseminated to the designated site. Leadership at the project site will be provided with a written summary of the study results.

Professional Reporting

The results of this study will be presented to Rutgers University School of Nursing during a Doctor of Nursing Practice project presentation.

References

- Emergency Nurses Association. (2014). *Position statement patient experience/satisfaction in the emergency care setting*. Retrieved March 7, 2019, from Emergency Nurses Association: <https://www.ena.org>
- Alexander, G., Rollins, K., Walker, D., Wong, L., & Pennings, J. (2015). Yoga for self-care and burnout prevention among nurses. *Workplace Health and Safety*, 462-470.
- Althubaiti, A. (2016). Information bias in health research: definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare*, 9, 211-217.
doi:10.2147/JMDH.S104807
- Barnes, B., & Lefton, C. (2013). The power of meaningful recognition in a healthy work environment. *Advanced Critical Care*, 114-116.
- Boyle, D. A. (2011). Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Nursing Issues*, 16, 1-11.
- Brown, S. J. (2018). *Evidence-Based Nursing*. Burlington: Jones & Bartlett Learning.
- Burg, J., & Michalak, J. (2011). The health quality of mindful breathing: Associations with rumination and depression. *Cognitive Therapy and Research*, 35, 179-185.
doi:10.1007/s10608-010-9343-x
- Chamine, I., & Oken, B. (2015). Expectancy of stress-reducing aromatherapy effect and performance on a stress-sensitive cognitive task. *Evidence-Based Complementary and Alternative Medicine: eCam*.
- Chang, Y. Y., Lin, C. L., & Chang, L. (2017). The effects of aromatherapy massage on sleep quality of nurses on monthly rotating night shifts. *Evidence-Based Complementary and Alternative Medicine*.
- Cole, R. (1989). Postural baroreflex stimuli may affect EEG arousal and sleep in humans.

- Applied Physiology*, 67, 2369-2375.
- Corey, S. M., Epel, E., Schembri, M., Pawlowsky, S. B., Cole, R. J., Araneta, M. R., . . . Kanaya, A. M. (2014). Effect of restorative yoga vs. stretching on diurnal cortisol dynamics and psychosocial outcomes in individuals with the metabolic syndrome: the PRYSMS randomized controlled trial. *Psychoneuroendocrinology*, 49, 260-271.
- Emergency Nurse Association. (2014). *ENA topic brief compassion fatigue*. Retrieved April 3, 2018, from Emergency Nurse Association: <https://www.ena.org>
- Emergency Nurse Association. (2016). *Invest in emergency nurse retention*. Retrieved 4 4, 2018, from Nurse Retention Infographic: <https://www.ena.org>
- Emergency Nurses Association. (2013). *Position statement healthy work environment*. Retrieved March 7, 2019, from Emergency Nurses Association: <https://www.ena.org>
- Emergency Nurses Association. (2014). *Position statement patient experience/satisfaction in the emergency care setting*. Retrieved March 7, 2019, from Emergency Nurses Association: <https://www.ena.org>
- Emergency Nurses Association. (2015, April 3). *ENA topic brief the well nurse*. Retrieved from Emergency Nurses Association Institute for Quality , Safety, & Injury Prevention: <https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/the-well-nurse.pdf>
- Emergency Nurses Association. (2018). *Position statement staffing and productivity in the emergency department*. Retrieved March 7, 2019, from Emergency Nurses Association: <https://www.ena.org>
- Field, T. (2016). Message therapy research review. *Complementary Therapies in Clinical Practice*, 34, 19-31.

- Figley, C. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.
- Figley, C. (2002). *Treating compassion fatigue*. New York, NY: Brunner-Routledge.
- Flarity, K., Gentry, J. E., & Mesnikoff, N. (2013). The effectiveness of an educational program on prevention and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal*, 35, 247-258.
- Flynn Makic, M. (2015). Taking care of the caregiver: Compassion satisfaction and compassion fatigue. *Journal of Peri-Anesthesia Nursing*, 30, 546-547.
- Gharib, C., Gauquelin, G., Pequignot, J., Geelen, G., Bizollon, C., & Guell, A. (1988). Early hormonal effects of head-down tilt (-10 degrees) in humans. *Aviation Space Environment Medicine*, 59, 624-629.
- Gonzalez, R., Pizzi, J., Sabratha, T., Cooper, K., & Clyne, M. (2013). Tranquility room study: Caring perspectives. *International Journal of Caring*, 17, 15-19.
- Halm, M. (2019, March). The influence of appropriate staffing and healthy work environment on patient and nurse outcomes. *American Journal of Critical Care*, 28, 152-156.
- Harris, C., & Quinn-Griffin, M. T. (2015). Nursing on empty: Compassion fatigue signs, symptoms, and system interventions. *Journal of Christian Nursing*, 32, 80-87.
- Hertzog, M. A. (2008). Considerations in determining sample size for pilot studies. *Research in Nursing & Health*, 31, 180-191.
- Hooper, C., Craig, J., Janvrin, D. r., Wetsel, M. A., & Reimels, E. (2010, September). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing*, 420-427.

- Houck, D. (2014). Helping nurses cope with grief and compassion fatigue: An educational intervention. *Clinical Journal of Oncology Nursing*, 18, 454-458.
- Hunsaker, S., Hsiu-Chin, C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship*, 47(2), 186-194.
- Iyengar, B., & Razazan, D. (2001). *Yoga: The Path to Holistic Health*. London: Dorling Kindersley.
- Jung, G., Choi, I., Kang, H., & Choi, E. (2017). Effects of meridian acupuncture massage on body composition, edema, stress, and fatigue in postpartum women. *Journal of Alternative and Complementary Medicine*, 787-793.
- Kelly, L. A., & Lefton, C. (2017). Effect of meaningful recognition on critical care nurses' compassion fatigue. *American Journal of Critical Care*, 26, 438-444.
- Kelly, L. A., Baker, B. M., & Horton, K. L. (2017). Code compassion: A caring fatigue reduction intervention. *Nursing Management*, 19-22.
- Kelly, L., Runge, J., & Spencer, C. (2015). Predictors of compassion fatigue and compassion satisfaction in acute care nurses. *Journal of Nursing Scholarship*, 47, 522-528.
- Lasater, J. (2011). *Relax and Renew: Restful Yoga for Stressful Times*. Berkeley: Rodmell Press.
- Laszlo, Z., Rossler, A., & Hinghofer-Szalkay, H. (2001). Cardiovascular and hormonal changes with different angles of head-up tilt in men. *Physiology Research*, 71-82.
- Li, H., Zhao, M., Shi, Y., Xing, Z., Li, Y., Wang, S., . . . Sun, J. (2018). The effectiveness of aromatherapy and massage on stress management in nurses: A systematic review. *Journal of Clinical Nursing*, 28, 372-385. doi:10.1111/jocn.14596
- Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *Online Journal of*

- Issues in Nursing, 16*(1).
doi:<http://dx.doi.org.proxy.libraries.rutgers.edu/10.3912/OJIN.Vol16No01Man03>
- Mason, H., Vandoni, M., DeBarbieri, G., Codrons, E., Ugargol, V., & Bernardi, L. (2013). Cardiovascular and respiratory effect of yogic slow breathin in yoga beginner: What approach? *Evidence Based Complimentary and Alternative Medicine*.
- Matey, L. (2016, May). Compassion fatigue is a safety concern. *ONS Connect, 31*(5), 20-20.
- Mehling, W., Wrubel, J., Daubenmier, J. J., Price, C., Kerr, C., Silow, T., & Stewart, A. (2011). Body Awareness: A phenomenological inquiry into the common ground of mind-body therapies. *Philosophy, Ehtics, and Humanities in Medicine, 6*(1), 6.
- Mooney, C., Fetter, K., Gross, B. W., Rinehart, C., Lynch, C., & Rogers, F. B. (2017). A preliminary analysis of compassion satisfaction and compassion fatigue with considerations for nursing unit specialization and demographic factors. *Journal of Trauma Nursing, 24*, 158-163. doi:10.1097/JTN.0000000000000284
- NSI Nursing Solution Inc. (2017). *2017 National health care retention & rn staffing report*. Retrieved March 24, 2018, from <http://www.nsinursingsolutions.com>
- Peery, A. (2010). Caring and burnout in registered nurses: What's the connection? *International Journal of Human Caring, 14*(2), 53-60.
- Ploukou, S., & Panagopoulou, E. (2018). Playing music improves well-being of oncology nurses. *Applied Nursing Research, 39*, 77-80.
- Saatsaz, S., Rezaei, R., Alipour, A., & Beheshti, Z. (2016). Massage as adjustvant therapy in the management of post-cesarean pain and anxiety: A randomized clinical trial. *Complementary Therapies in Clinical Practice, 24*, 92-98.
- Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online Journal of Issues in*

- Nursing*, 16(1), 1-22.
- Sacco, T. L., Ciurzynski, S. M., Elizabeth, H. M., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse*, 35, 32-43.
- Shiraishi, M., Schou, M., Gybel, M., Christensen, N., & Norsk, P. (2002). Comparison of acute cardiovascular responses to water immersion and head-down tilt in humans. *Applied Physiology*, 264-268.
- Stamm, B. H. (2010). *The Concise ProQOL Manual 2nd Ed.* Pocatello.
- Terry, A. (2015). *Clinical research for the doctor of nursing practice*. Burlington: Jones & Bartlett Learning.
- United States Department of Labor. (2013, December 19). *Bureau of Labor Statistics*. Retrieved January 17, 2018, from Economic Release:
<https://www.bls.gov/news.release.ecopro.t08.htm>
- Vago, D., & Silbersweig, D. (2012). Self-awareness, self-regulation, and self-transcendence (S-ART) A framework for understanding the neurobiological mechanisms of mindfulness. *Frontiers in Human Neuroscience*, 6(296), 1-30.
- Valdez, A. M. (2008, May 15). Transitioning from novice to competent: What can we learn from the literature about graduate nurses in the emergency setting. *Journal of Emergency Nursing*, 435-440.
- Vybiral, T., Bryg, R., Maddens, M., & Boden, W. (1989). Effect of passive tilt on sympathetic and parasympathetic components of heart rate variability in normal subjects. *American Journal of Cardiology*, 63, 1117-1120.
- White, J. M. (1992). Music therapy: An intervention to reduce anxiety in the myocardial.

Clinical Nurse Specialist, 6(2), 58-63.

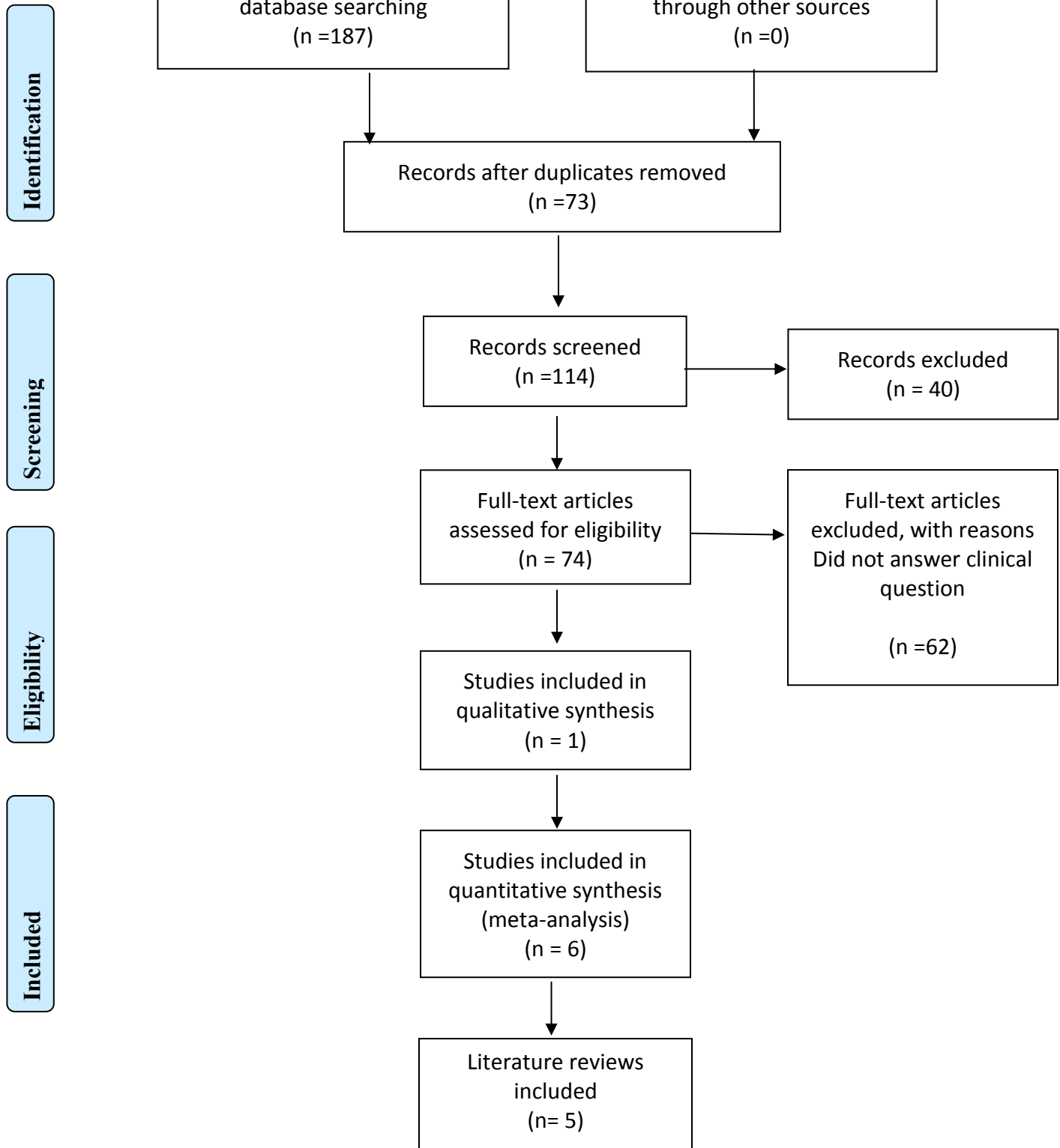
Wu, J., Cui, Y., Yang, Y. S., Kang, M., Jung, S. C., Park, H., & Eun, S. Y. (2014). Modulatory effects of aromatherapy massage intervention on electroencephalogram, psychological assessments, salivary cortisol and plasma brain-derived neurotrophic factor.

Complementary Therapies in Medicine, 456-462.



Appendix A

PRISMA Flow Diagram



Adapted From:

Appendix B

Table of Evidence

Article #	Author & Date	Evidence Type	Sample Size, Setting	Study finding that help answer the EBP Question	Limitations	Evidence Level & Quality
#1	Boyle, D. (2011) Countering Compassion Fatigue: A requisite Nursing Agenda	Literature Review	NA	<p>*The management of compassion fatigue must be multifaceted and include prevention, assessment, and consequence minimization.</p> <p>*Three categories of interventions must be utilized to mitigate compassion fatigue in nursing. They include work/life balance, education, and work- place programs.</p>	*No limitations discussed.	Level V Quality B
#2	Flarity, K. (2013) The Effectiveness of a Program on Preventing and Treating Compassion Fatigue in	Pre/Post Test Design	A convenience sample of n= 73 self-selected emergency department nurses in Colorado.	*The multifaceted program showed a statistically significant increase in CS (p=0.004), decrease in BO	<p>*A convenience sample from the same facility affects validity.</p> <p>*Findings may not reflect the general emergency</p>	Level III Quality B

	Emergency Nurses.			<p>($p=0.001$ or less), and a decrease in STS symptoms ($P=0.001$).</p> <p>*There was a 10% improvement of CS on pre- and posttest, 34% improvement in BO, and 19% improvement of STS.</p>	<p>department population.</p> <p>*The inclusion of new emergency department nurses may have affected the results due to their short tenure in the ED.</p> <p>*The short time frame for returning the posttest may have affected the return rate.</p> <p>*The 3-4-week timeframe between pre- and posttest is not reflective of a long-term improvement.</p> <p>*Recruitment for the study was based on self-selection and there is a risk of inaccuracy of self-reported data.</p>	
#3	Gonzalez, R. (2013) Tranquility Room Study: Caring Perspectives	n=20 Telemetry Nurses working in a hospital in the United States.	Qualitative Study	<p>*Through the utilization of the tranquility room, and being provided with the opportunity self-care and self-reflection, nurses were able to nurture</p>	<p>*The tranquility room study was limited to the perspectives of a selected group of nurses.</p> <p>*Ancillary staff as well as nurses from other units</p>	Level III Quality B

				<p>and relate caring in their relationships with colleagues and patients</p> <p>*The time spent in the tranquility room facilitated a caring outlook that moved beyond task completion while embracing human care.</p>	<p>did not participate in the study.</p> <p>*A more diverse nursing care population, as well as face to face interviews, may have afforded greater insight to the impact of the tranquility room.</p> <p>*Patient perspectives toward their care should also be studied to investigate the impact on caring interactions when a tranquility room is available.</p>	
#4	Harris, C (2015) Nursing on Empty: Compassion Fatigue Signs, symptoms, and interventions.	Literature Review	NA	<p>*A first critical step in reducing compassion fatigue is acknowledging the problem exists.</p> <p>*Acknowledging worker contributions to patients and the organization gives energy to individuals and to nursing unit teams.</p> <p>*Education is important for</p>	*No limitations discussed	Level V Quality B

				<p>nurses at risk or experiencing compassion fatigue.</p> <p>*Timeouts can be used when nurses are working in high acuity areas or caring for patients during intense periods.</p> <p>*Hospital administrators can facilitate timeouts by providing quiet rooms for staff.</p> <p>*Support people available on-site counseling is a useful tool for staff members experiencing compassion fatigue.</p>		
#5	Houck, D. (2014) Helping Nurses Cope with Grief and Compassion Fatigue: An Educational Intervention	Literature Review	NA	<p>*Access to institutional pastoral care services is an important aspect of spiritual care and should be available to nurses.</p> <p>*Organizations should allow time and opportunities for grieving such as</p>	*No limitations discussed.	Level V Quality B

				<p>meditation areas.</p> <p>*Outlets for sharing emotional expressions such as professional counseling and pastoral care should be provided by the organization.</p>		
#6	<p>Hunsaker, S. (2015)</p> <p>Factors that Influence the Development of Compassion Fatigue, Burnout, and Compassion Satisfaction in Emergency Department Nurses</p>	<p>Cross-sectional descriptive, and predictive study</p>	<p>n=278</p> <p>Registered nurses who work in EDs throughout the United States.</p>	<p>*Increased awareness about burnout and CF may aid in improved ED nurse job satisfaction and increase quality patient care.</p> <p>*Demographics and work-related characteristics influence the prevalence of CS, CF and burnout.</p> <p>*Older nurses had more compassion satisfaction and younger nurses had higher levels of burnout.</p>	<p>*Small sample size with a low response rate.</p> <p>*The prevalence of CS, CF, and burnout was measured at a single point in time.</p>	<p>Level III</p> <p>Quality B</p>

#7	Kelly, L. (2017) Effect of Meaningful Recognition on Critical Care Nurses' Compassion Fatigue	Quantitative , descriptive online survey	n=761 ICU nurses in 14 hospitals throughout the United States that had an established meaningful recognition program. n=410 ICU nurses from 10 hospitals throughout the United States that signed up for a meaningful recognition program but had not implemented the program.	<p>*Nurses in the study who had received meaningful recognition showed significantly decreased burnout and higher compassion satisfaction.</p> <p>*Nurse leaders can use meaningful recognition as a powerful tool to acknowledge team members in a personally valuable way to create ownership and trust.</p> <p>*Meaningful recognition has been acknowledged as a component of a healthy work environment, suggesting that the concept of meaningful recognition is systematically intertwined with the organization's outcomes.</p>	<p>*Low response rate Survey responder bias</p> <p>*Convenience sampling of the hospitals aspiring to participate in the meaningful recognition program as control hospitals.</p>	Level III Quality B
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#8	Kelly, L. (2017) Code Compassion: A Caring Fatigue Reduction Intervention	Literature Review	NA	*Utilizing the Code Compassion Cart demonstrated how raising awareness about compassion fatigue allows nurses to pause, be mindful, reflect, and address their potential burnout.	*Measuring outcomes	Level V Quality C
#9	Kelly, L (2015) Predictors of Compassion Fatigue and Compassion Satisfaction in Acute Care Nurses	Cross-sectional survey	n=491 direct care registered nurses working in a large quaternary care teaching facility in the south- west U.S.	*Significant positive associations between meaningful recognition, compassion fatigue, and compassion satisfaction was found. *“Millennial” generation (ages 21-33 years) were more likely to be experiencing higher levels of burnout and secondary traumatic stress and lower level of compassion satisfaction than their counter parts in the “Baby Boomer” (ages 50-65 years) or “Generation X”	*No limitations discussed.	Level III Quality B

				<p>(ages 34-49 years).</p> <p>*Nurses are experiencing higher levels of compassion fatigue that are going unresolved.</p>		
#10	Lombardo, B (2011) Compassion Fatigue: A Nurse's Primer	Literature Review	NA	<p>*Developing positive self-care strategies and healthy rituals are very important for a caregiver's recovery from compassion fatigue.</p> <p>*An idea to combat compassion fatigue is to create a comfortable, relaxing environment in a designated place on the nursing unit. This can be done by transforming an available room into a relaxation area.</p> <p>*Nurses can select a soothing color for the walls and assist in purchasing a</p>	No Limitations Discussed.	Level III Quality B

				small waterfall, comfortable chairs, a CD player, and/or a collection of relaxation CDs that can provide comforting stress relief.		
#11	Mooney, C. (2017) A Preliminary Analysis of Compassion Satisfaction and Compassion Fatigue with Considerations for Nursing Unit Specialization and Demographic Factors	Quantitative descriptive Study	n=102 ICU and oncology nurses working for a community hospital that is part of Lancaster General Health in Pennsylvania	<p>*Although current intervention programs impact compassion satisfaction, burnout and compassion fatigue remain unaffected.</p> <p>*There is a need for an intervention prevention program specifically designed to combat all three components of professional quality of life.</p>	<p>* The study was limited by its sample size.</p> <p>*Generalizability is limited because the sample was comprised of specialty nurses from a single institution.</p> <p>*Nonresponse bias could have impacted results.</p> <p>*Participants were not required to answer all components of the survey.</p>	Level III Quality B
#12	Sacco, T. (2015) Compassion Satisfaction and Compassion Fatigue Among Critical Care Nurses	Cross-sectional design	n=221 registered nurses and licensed practical nurses working in critical care at an academic center in Western New York State	<p>*Younger and/or less experienced nurses are at higher risk for compassion fatigue than their older colleagues.</p> <p>*Differences in age and experience can affect</p>	<p>*The generalizability of findings may be limited.</p> <p>*The cross-sectional study design may be reflective of a bad day, high acuity, or any number of factors.</p>	Level III Quality B

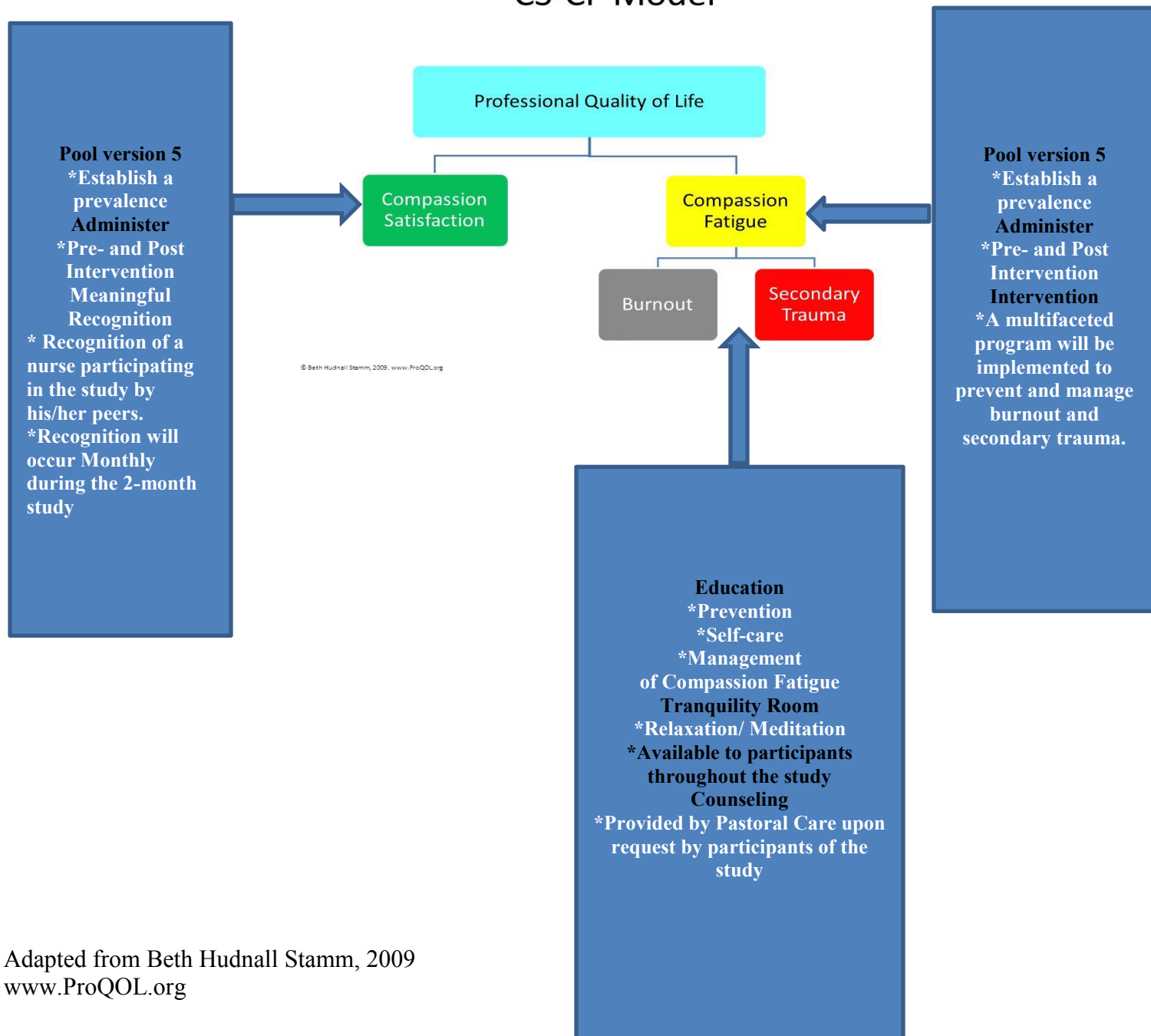
				<p>professional quality of life and therefore further study is warranted to fully examine this relationship.</p> <p>* Developing a culture of meaningful recognition can directly influence the degree of compassion satisfaction.</p> <p>*To improve the work environment, leaders should promote a culture of caring, recognition, professional development, and debriefing.</p>		
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Appendix C

Conceptual Framework

Professional Quality of Life Model

CS-CF Model



Adapted from Beth Hudnall Stamm, 2009
www.ProQOL.org

Appendix D
Tranquility Room





Appendix E

Certificates

Certificate of Recognition



Certificate of Completion

NAME

Presented By: Josephine A. Smith, MSN, APN-C
Compassion Fatigue Research Project Principal Investigator



Appendix F

PowerPoint Presentation-Class 1

Professional Quality of Life



JOSEPHINE A. SMITH, MSN, APN-C

For more information see www.proqol.org
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Professional Quality of Life

- Professional quality of life is the quality a person experiences in association with their work as a caregiver.
- Professional quality of life is comprised of two aspects, the positive Compassion Satisfaction and Compassion Fatigue (Stamm, 2010).

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Effects of Compassion Fatigue

- ▶ Compassion fatigue can precipitate:
 - Memory problems
 - Poor judgment
 - Loss of concentration and focus.
- ▶ These components are vital to nurses' ability to practice safely (Matey, 2016).

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Compassion Fatigue

- Negative aspects of working as a caregiver
- Losing the ability to nurture
- Self-Protection measure

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Compassion Fatigue

- ▶ Compassion fatigue is comprised of two components:
 - Secondary Traumatic Stress
 - Burnout

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Effects of Compassion Fatigue

- ▶ Compassion fatigue leads affects patient safety and leads to:
 - Absenteeism
 - Nurse turnover
 - Increased Hospital costs

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Burnout

▶ Burnout

- Work-related hopelessness and feelings of inefficacy
- associated with work related environmental factors.

Symptoms of Burnout

- Exhaustion
- Frustration
- Anger
- Hopelessness
- Depression

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Secondary Traumatic Stress (STS)

- ▶ The consequence that occurs from witnessing patients pain, trauma, and suffering
 - Work-related secondary exposure to extremely or traumatic
 - Stressful events

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Compassion Satisfaction

- Positive aspects of working as a caregiver
- The joy and purpose experienced from caring for others
- Balances professional quality of life

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Professional Quality of Life

Compassion Satisfaction

- ▶ The positive aspects of being a caregiver

Compassion Fatigue

- ▶ The negative aspects of being a caregiver

Both the negative and positive aspects of performing one's job influence professional quality of life (Stamm, 2010).

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CS-CF Model



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Signs and Symptoms of Compassion Fatigue

- ▶ Gastrointestinal upset
- ▶ Headaches
- ▶ Cardiac symptoms
- ▶ Insomnia

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Signs and Symptoms of Compassion Fatigue

- Anxiety
- Difficulty with memory
- Poor judgement
- Mood swings
- Depression

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Prevention and Treatment

- ▶ Recognition
- ▶ Stress Reduction Measures
- ▶ Seek professional counseling

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Questions????

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References

Emergency Nurses Association. (2015, April). *ENA topic brief the well nurse*. Retrieved from Emergency Nurses Association Institute for Quality, Safety, & Injury Prevention: <https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/the-well-nurse.pdf>

Figley, C. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

Hunsaker, S., Hsiu-Chin, C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship*, 47(2), 186-194.

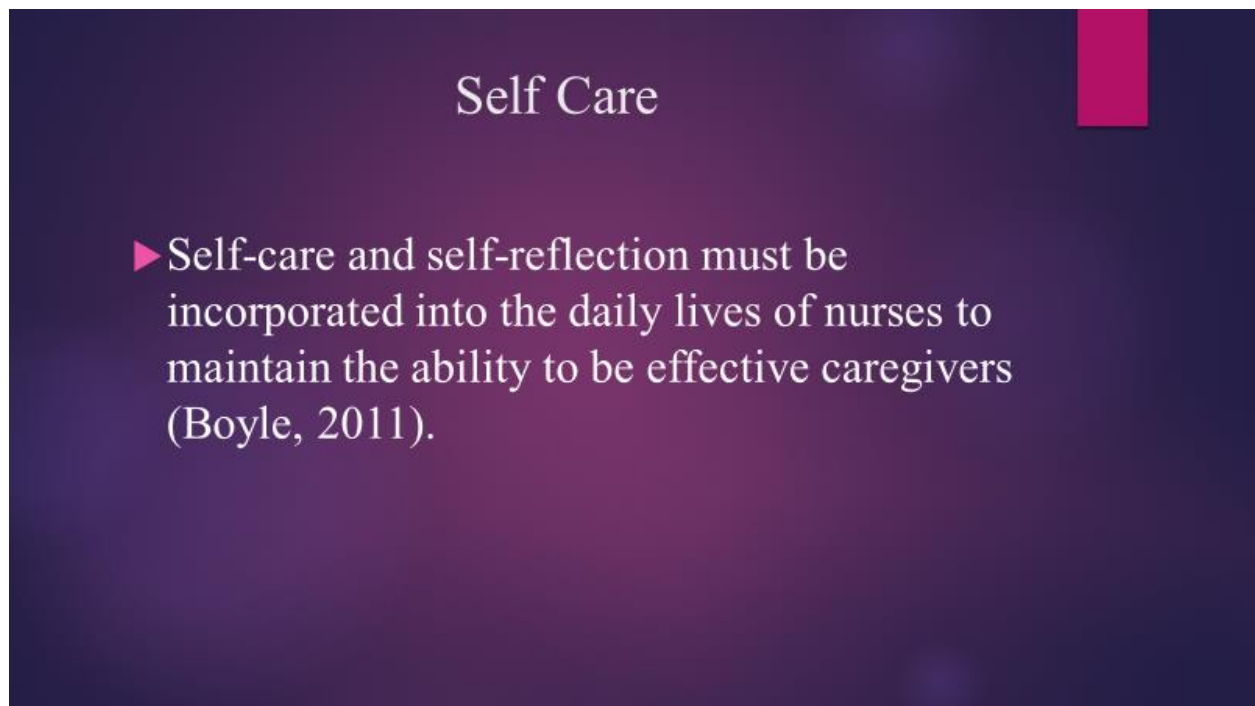
Matey, L. (2016, May). Compassion fatigue is a safety concern. *ONS Connect*, 31(5), 20-20.

Stamm, B. H. (2010). *The Concise ProQOL Manual 2nd Ed*. Pocatello.

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Appendix G

Class II PowerPoint Presentation



Self-Care

- ▶ Nurses have difficulty caring for themselves.
- ▶ Nurses often wait until they are in crisis to seek help

Work /Life Balance

- ▶ Enables nurses to invest time and energy into caring for themselves
- ▶ Involves creating a self-care plan or responsible selfishness
- ▶ Rendering compassionate self-care

Work/Life Balance

- ▶ Requires both introspection and action that is ongoing and perceived as necessary to ensure professional longevity (Boyle, 2011).

Personal Stress

- ▶ Identification of personal stressors
- ▶ Recognition of the demands of caregiving
- ▶ Awareness of danger –signal responses

Positive Self-Care Strategies/ Healthy Rituals

- Activities that one participates in on a regular basis and that replenish personal energy levels and enhance feelings of well being (Lombardo & Eyre, 2011).

Positive Self-Care Strategies/ Healthy Rituals

- ▶ Commitment to caring for oneself includes:
 - Adequate Nutrition
 - Exercise
 - Adequate Sleep
 - Stress Reduction Measures

Adequate Nutrition/Exercise

- ▶ Central to work/life balance
- ▶ Improves overall health
- ▶ Improves function, mood, and quality of life
- ▶ Imperative for patient care activities

Adequate Sleep

- ▶ Adequate sleep is necessary for overall well being
- Fights infection
- Enhances cognitive performance
- Reduces unsafe behaviors
- ▶ Minimum of seven to eight hours each night

Adequate Sleep

- ▶ Sleep deprivation is associated with:
 - Reduced attention and alertness
 - Memory impairment
 - Depression
 - Fatigue

Stress Reduction Measures

- ▶ Journaling
- ▶ Yoga
- ▶ Meditation
- ▶ Timeout during work hours
- ▶ Breathing exercises

The 4-7-8 Breathing Exercise

https://youtu.be/YRPh_GaiL8s

The 4-7-8 Breathing Exercise

- ▶ 1) Exhale completely through your mouth, making a whoosh sound.
- ▶ 2) Close your mouth and inhale quietly through your nose to a mental count of four.
- ▶ 3) Hold your breath for a count of seven.

The 4-7-8 Breathing Exercise

- ▶ 4) Exhale completely through your mouth, making a whoosh sound to a count of eight.
- ▶ 5) This is one breath. Now inhale again and repeat the cycle three more times for a total of four breaths.

Questions????

References

- ▶ Boyle, D. A. (2011). Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Nursing Issues*, 16, 1-11.
- ▶ Emergency Nurses Association. (2015, April). *ENA topic brief the well nurse*. Retrieved from Emergency Nurses Association Institute for Quality, Safety, & Injury Prevention: <https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/the-well-nurse.pdf>
- ▶ Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010, September). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing*, 420-427.
- ▶ Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *Online Journal of Issues in Nursing*, 16(1). doi:<http://dx.doi.org.proxy.libraries.rutgers.edu/10.3912/OJIN.Vol16No01Man03>
- ▶ Weil, A. (2011, May 23). How to perform the 4-7-8 breathing exercise [Video File]. Retrieved from https://youtu.be/YRPh_GaiL8s

Tool

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

(PROQOL) VERSION 5 (2009)

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.

Appendix I

Questionnaires

**Compassion Fatigue Research Project
Demographic Questionnaire**

Assigned Number: _____

Age: _____

Gender: _____

Please check one:**Years of Practice:**

< 1 year _____

1 year _____

< 2 years _____

2 years _____

Level of Education:

Associates _____

Bachelors _____

Masters _____

Doctorate _____

Do you plan on leaving your current position in the next year: Yes _____ No _____?



Compassion Fatigue Research Project Tranquility Room Questionnaire

Assigned Number: _____

1 = No stress **2** = Some stress **3** = Stressed **4** = Highly stressed

Please circle one:

1. Level of stress prior to using the Tranquility Room?

1 2 3 4

2. Level of stress after using the Tranquility Room?

1 2 3 4

3. What activity did you do?

4. How long did you stay in the Tranquility Room? _____



Compassion Fatigue Research Project

Tranquility Room Evaluation

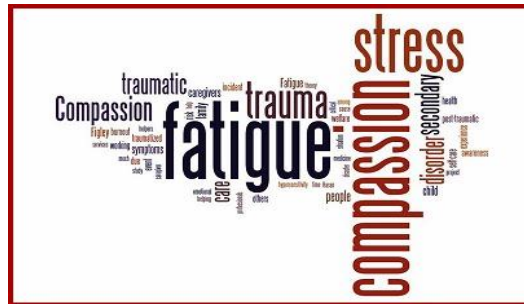
Assigned Number: _____

1. What was your overall experience utilizing the tranquility room?

2. What barriers did you experience?

Recruitment Flyer

Seeking New ED Nurses Compassion Fatigue Research Project



Appendix K

Consent

CONSENT TO TAKE PART IN A COMPASSION FATIGUE RESEARCH PROJECT

TITLE OF STUDY: A Multifaceted Approach to Combating Compassion Fatigue in New Emergency Department Nurses

Principal Investigator: Josephine A. Smith, MSN, APN-C

Purpose of the Study:

The purpose of this pilot study is to examine if the implementation of a multifaceted Compassion Fatigue Research Project will influence compassion satisfaction and compassion fatigue in emergency department nurses with two years of clinical experience or less.

Who may take part in this study:

Registered nurses working a minimum of 20 hours in the Emergency Department with two years of clinical experience or less may take part in this study. Nurses must provide direct patient care to emergency department patients. Contract or agency nurses and nurses in a leadership role are excluded from participating in this study.

Expectations:

Participants of the study will be required to participate in one hour long introductory session and three hour long educational sessions. The education sessions will be conducted monthly. Participants will also be required to utilize a Tranquility Room during the study. Completion of a demographic questionnaire and the Professional Quality of Life Scale Version 5 (Pool) is required pre- and post-intervention. Participants will also be required to complete a tranquility room questionnaire after each use. The principal investigator is recruiting up to 25 new emergency department nurses to take part in this study for three months

Risks:

The study poses minimal risks. There is a risk of emotional impact related to the subject matter.

Benefits

Providing new nurses with self-care and relaxation techniques to aid in preventing or managing compassion fatigue improves the overall well-being of nurses. Utilization of the Tranquility Room will enable participants to take a time out and regroup especially after intense situations.

Cost:

There is no cost to take part in the study

Compensation:

Participants will be paid their individual hourly rate by the hospital for each session attended. Participation in the study will not be considered or documented in payroll as overtime for any reason. Participants will receive a \$5.00 Dunkin Donuts gift card at the introductory session and the final education session provided all requirements of the study have been met. Caring for the Caregiver wristbands, certificates of recognition and certificates of completion will be awarded at the last education session. Light refreshments will be provided at each session.

Confidentiality:

All efforts will be made to keep your personal information and responses to surveys confidential.

Withdrawal:

Participation in the study is voluntary. You may change your mind and withdraw from the study at any time. Withdrawal from the study will affect compensation.

Contact Information:

If you have questions about taking part in this study you can contact the principal investigator: Josephine A. Smith at [REDACTED]@sn.rutgers.edu

If you have questions about your rights as a research subject, you can call the IRB Director at: Newark Health Science (973)-972-3608.

You will be provided with a copy of this consent for your records.

AGREEMENT TO PARTICIPATE**Participant Consent:**

I have read this entire consent form, or it has been read to me, and I believe that I understand what has been discussed. All my questions about this form and this study have been answered. I agree to take part in this study.

Subject Name: _____

Subject Signature: _____ Date: _____

2. Signature of Principal Investigator:

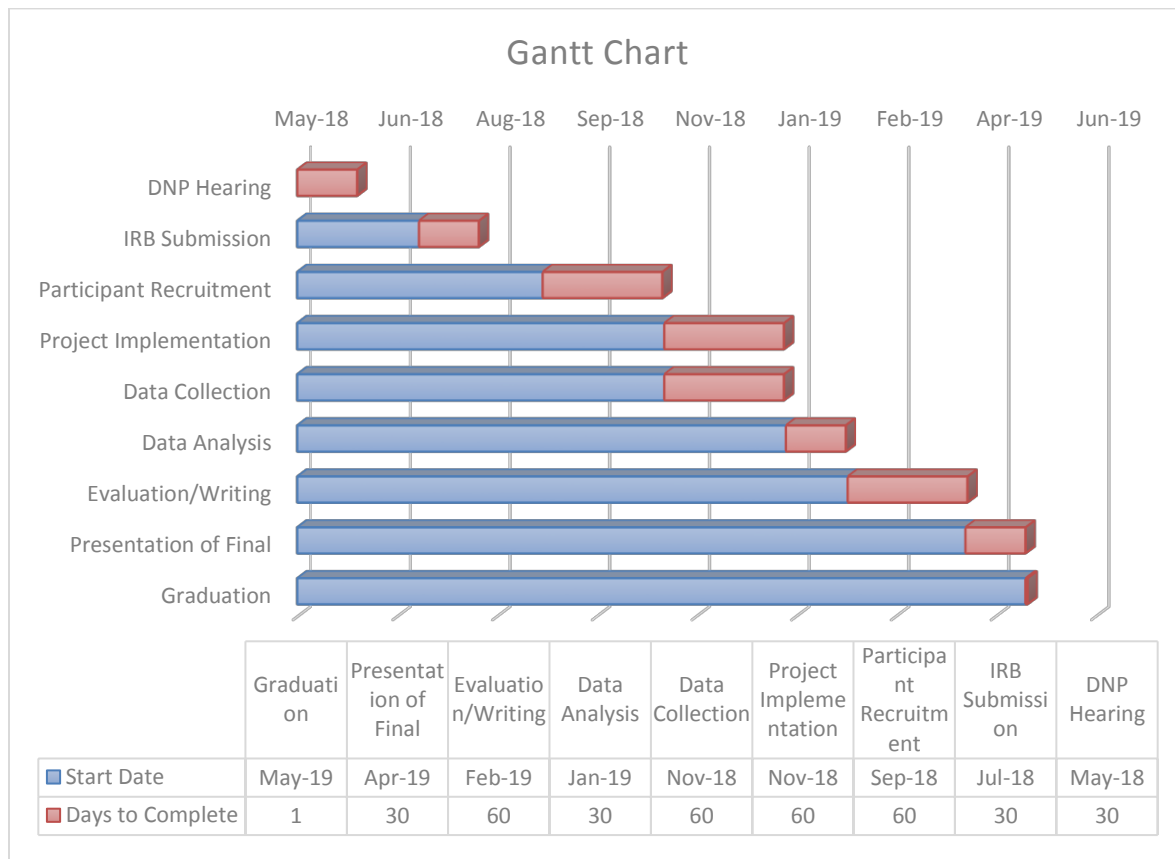
To the best of my ability, I have explained and discussed all the important details about the study including all the information contained in this consent form.

Principal Investigator (printed name): _____

Signature: _____ Date: _____

Appendix L

GANTT Chart



Appendix M**Budget**

Expense	Cost
Recruitment Fliers/Certificates	\$25
Dunkin Donuts Gift Card	\$40
Caring for the Caregiver wristbands	\$63.74
Lavender Diffuser	\$35
Lock Box	\$15
Back Massager	\$69
Electric Water Fountain	\$35
Yoga Mats	\$10
Survey Box	\$30
Light Refreshments	\$60
Total Budget	\$382.74

Table 1***Descriptive Statistics***

		Age	Gender	Years of Practice	Level of Education	Plans on leaving position in the next year
N	Valid	4	4	4	4	4
	Missing	0	0	0	0	0
Mean		35.5000	1.0000	3.2500	1.7500	1.5000
Median		35.5000	1.0000	3.5000	2.0000	1.5000
Mode		31.00 ^a	1.00	4.00	2.00	1.00 ^a
Std. Deviation		3.87298	.00000	.95743	.50000	.57735
Skewness		.000		-.855	-2.000	.000
Std. Error of Skewness		1.014	1.014	1.014	1.014	1.014
Kurtosis		-1.200		-1.289	4.000	-6.000
Std. Error of Kurtosis		2.619	2.619	2.619	2.619	2.619

a. Multiple modes exist. The smallest value is shown

Table 2***Paired t-test***

		Paired Differences							
		95% Confidence							
		Interval of the							
			Std.	Std. Error	Difference				Sig. (2-
		Mean	Deviation	Mean	Lower	Upper	t	df	tailed)
Pair 1	CSPreTest - CSPostTest	- .75000	1.70783	.85391	-3.46753	1.96753	-.878	3	.444
Pair 2	BOPreTest - BOPostTest	4.75000	4.03113	2.01556	-1.66443	11.16443	2.357	3	.100
Pair 3	STSPreTest - STSPostTest	2.00000	3.55903	1.77951	-3.66320	7.66320	1.124	3	.343

Table 3

Tranquility Room Evaluation		
Participant	Overall Experience	Barriers
Participant 001	“Overall the Tranquility Room was great when I was able to use it. Though I was not able to use it as much as I wish and needed to, it was a place that helped relieve some stress and tension.”	“Due to short staffing, I was not able to go to the Tranquility Room as much as I needed. No one was able to take over my section. Also lack of support and at one point no key to access the room made it difficult.”
Participant 002	“I was not able to use the room as much as I would have liked to, but I do feel it is necessary for nurses.”	“I couldn’t leave the ED. We were short every day. I asked the charge nurse and she refused and stated a study shouldn’t be done during work hours.”
Participant 003	“Life changing! The Tranquility Room would be a great asset to the hospital setting for nurses and other medical providers. The hospital setting is very stressful, and the Tranquility Room allowed a few moments of peace to re-center my purpose as a nurse.”	“The only barrier I experienced was the room not being accessible to my convenience. There were a few times I could not find the Tranquility Room key to enter.”
Participant 005	“It was a rewarding experience. In truth, the room is a necessity for all nurses. It provided a safe place and one that promotes relieving stress.”	“I found it difficult to get away due to lack of staffing. There wasn’t much support from other staff.”

Table 4*Tranquility Room Questionnaire*

# of times room used	3	2	6	3
Amount of time spent each session	Session 1 15 mins Session 2 30 mins Session 3 20 mins	Session 1 20 mins Session 2 20 mins	Session 1 45 min Session 2 10 mins Session 3 23 mins Session 4 23 mins Session 5 15 mins Session 6 40 mins	Session 1 45mins Session 2 20 mins Session 3 30 mins
Activities	Session 1 Massage chair and oil diffuser Tranquil music Session 2 Massage chair and oil diffuser Tranquil music Session 3 Massage Chair and oil diffuser Tranquil music	Session 1 Massage chair and oil diffuser Tranquil music Session 2 Massage Chair and oil diffuser Tranquil music	Session 1 Massage chair and oil diffuser Tranquil Music Session 2 Yoga Session 3 Sleep Session 4 Breathing exercises/meditate Session 5 Yoga Session 6 Massage chair and oil diffuser Tranquil Music	Session 1 Massage chair and oil diffuser Tranquil music Session 2 Massage chair and oil diffuser Tranquil music Session 3 Massage chair and oil diffuser Tranquil music
Level of stress Pre use of room	Session 1 4 Session 2 4 Session 3 4	Session 1 4 Session 2 4	Session 1 4 Session 2 4 Session 3 4 Session 4 4 Session 5 4 Session 6 4	Session 1 4 Session 2 4 Session 3 4
Level of Stress Post use of room	Session 1 1 Session 2 1 Session 3 1	Session 1 1 Session 2 2	Session 1 2 Session 2 2 Session 3 2 Session 4 1 Session 5 1 Session 6 1	Session 1 1 Session 2 1 Session 3 1