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The Effect of Education on Compassion Fatigue as Experienced by Staff Nurses

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THE EFFECT OF EDUCATION ON COMPASSION FATIGUE AS EXPERIENCED BY STAFF NURSES

by

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DEDICATION

This project is dedicated to my amazing husband, Bryan, who has been a constant support, confidant, and comedian at all the right moments during this exciting journey. Bryan, thank you for encouraging me through some very tough situations and helping me keep perspective, *one step at a time*. I appreciate all your hard work to provide for us and keep our home functional and organized these past three years. Also, this project is dedicated to my parents, for their continued support throughout my entire educational venture from childhood. Thank you dad for instilling a hard work ethic in all your children; and thank you mom for inspiring my passion for nursing through your great example.

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ABSTRACT

Historically, nursing has been perceived as a highly rewarding profession. Yet, due to the increasing complexity of today's healthcare, nurses are faced with greater challenges in their work environments. Registered nurses who work in tertiary care settings are exposed to disturbing patient situations including trauma, death, abuse, or chronic disease. Joinson (1992) described this experience as compassion fatigue and symptoms include headaches, short attention span, or fatigue. A review of literature has identified that nurses should be educated about risk factors and coping strategies to combat compassion fatigue. Guided by the Model for Evidence-Based Practice Change and Jean Watson's Theory of Transpersonal Caring, the purpose of this EBP project was to increase awareness about compassion fatigue risks, symptoms, and coping mechanisms through educational training for registered nurses in an effort to decrease levels of compassion fatigue. Educational training was designed to take place face-to-face with participants and incorporated a PowerPoint presentation developed by the project manager, which was presented to medical-surgical staff nurses at a 526-bed level II trauma center in Northern Indiana. Project evaluation included the use of the Professional Quality of Life Scale (ProQOL-V), which measured secondary traumatic stress (i.e., compassion fatigue), burnout, and compassion satisfaction. Results were analyzed utilizing one-way repeated measures ANOVA, which demonstrated no statistical significance in reduction of compassion fatigue. However, a reduction in compassion fatigue scores was noted overtime: pre-intervention M = 20.7, immediate post-intervention M = 20.6, 1-month post-intervention M = 18.8, and 3-month post-intervention M = 17.9. The small sample size of this EBP project potentially impacted the ability to achieve statistical significance. It is recommended that future research and EBP projects focus on CF education within larger, more diverse nursing populations.

CHAPTER 1

INTRODUCTION

Advanced practice nurses (APNs) have become leaders in today's dynamic healthcare environment. Thoroughly prepared through graduate education, APNs are well versed in evidence-based practice (EBP) and, as such, have the knowledge and skills to positively impact patient care. A wealth of scientific evidence is currently available to APNs; however, this evidence is not meaningful unless it is analyzed and put into practice to enhance patient outcomes. The first step in this process requires APNs to have a spirit of inquiry. Cultivating a spirit of inquiry requires APNs to question current practices in healthcare and then investigate evidenced-based interventions that may be used to improve practice (Melnyk & Fineout-Overholt, 2011). APNs incorporate EBP within their own practices, but also champion change within the larger community of nursing.

Background

Historically, nursing has been perceived as a highly rewarding profession. Yet, due to the increasing complexity of today's healthcare, nurses are faced with greater challenges in their work environments. Patient care is becoming more demanding, because (a) patients' healthcare needs are more complex and (b) many environmental influences prohibit patients from acquiring the care that is required for successful outcomes. Today's healthcare environment is intensely dynamic, requiring nurses to become more flexible and creative as they are required to do more with fewer resources. Greater responsibilities include higher acuity of patients and higher nurse to patient ratios. These changes are accompanied by greater demands from administration requiring nurses to perform at higher levels to appeal to patient satisfaction, which can affect reimbursement for services.

Nurses, who have difficulty adapting to the oftentimes tumultuous environment, may experience greater levels of stress or helplessness (Neville & Cole, 2013). Joinson (1992) described this experience as compassion fatigue. Different from burnout, compassion fatigue is experienced only by those who provide care to others. Joinson explained that those who experience compassion fatigue may have symptoms such as headaches, depression, anger, short attention span, chronic tiredness, or helplessness; while, Boyle (2011) later identified other signs of compassion fatigue: tardiness, absenteeism, desire to quit, and diminished performance ability.

Slatten, Carson, and Carson (2011) described compassion fatigue as "an occupational hazard for those in the helping professions and is a natural consequence of working with people who have experienced extremely stressful events" (p. 327). Slatten et al. (2011) correlated compassion fatigue with the nurse's ability to perform roles and responsibilities and ultimately patient care. Yoder (2010) surmised that nurses should be cognizant of triggering factors and coping strategies to prevent the negative aspects of compassion fatigue from affecting personal and professional abilities.

Statement of the Problem

Registered nurses who work in tertiary care settings are exposed to disturbing patient situations that can be detrimental on psychological health. These situations can be related to trauma, death, abuse, or chronic disease, but may also be related to the home environment of the patient. With each exposure, the nurse can experience a "debilitating weariness" (Perry, Toffner, Merrick, & Dalton, 2011, p. 91), which has become more commonly described using the term *compassion fatigue*. The term *secondary traumatic stress* has also been used within the literature to describe nurses' exposure to the traumatic situations of patients and is often used interchangeably with compassion fatigue (Beck, 2011; Flarity, Gentry, & Mesinkoff, 2013; Perry et al., 2011; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013b; Slatten et

al., 2011), but is contrasted by compassion satisfaction: the pleasure that nurses derive from the ability to perform their work well (Stamm, 2009). Slatten et al., (2011) described compassion fatigue as a natural consequence of nursing; therefore, prevention of exposure should not be the focus of any intervention. Rather, a review of literature has identified that nurses should be educated about risk factors and coping strategies to combat compassion fatigue.

Data from the literature supporting the need for the project

Throughout literature, evidence has demonstrated that staff nurses experience compassion fatigue (Flarity et al., 2013; Perry et al., 2011; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013; Yoder, 2010). Flarity et al. (2013) identified that 44% of emergency department nurses experienced moderate to high levels of secondary traumatic stress. Yoder (2010), who conducted her study in the same region as the target facility for this EBP project, found that 15.8% of nurses fell into the category of high risk for secondary traumatic stress. Potter, Deshields, Berger, et al. (2013) identified high risk secondary traumatic stress in 19.76% of nurses within their study. Additionally, Potter, Deshields, and Rodriguez (2013) identified that 37.5% of nurses experienced high levels of secondary traumatic stress.

Neville and Cole (2013) opined that “addressing compassion fatigue is a strategic imperative in the future to ensure the nursing workforce is resilient as changes and the resulting increasing levels of stress continue to occur” (p. 354). By providing measures to combat compassion fatigue, nurses can assist one another in personal and professional development. This innovative process is essential to cultivating a community of empowered individuals that perform excellent patient care, yet are able to later disconnect from the situation to prevent detrimental effects on their own personal health. Health institutions would be remiss to ignore the risks of compassion fatigue that face nurses on a daily basis. Risks for compassion fatigue include exposure to life-

threatening situations, urgent situations, abuse, chronic disease, pain, suffering, and death (Boyle, 2011; Hodge & Lockwood, 2013; Slatten et al., 2011).

Neville and Cole (2013) highlighted an additional incentive for health institutions to become proactive in preventing compassion fatigue; they explained

> The care patients receive from nurses is one of the most significant predictors of patient satisfaction and is a quality indicator of overall healthcare performance. Research demonstrates that nurses' perception of work environment and patient satisfaction are highly correlated; thus, measures to enhance nurses' ability to deliver excellent care and to thrive in their work environments are of paramount importance to healthcare institutions. (p. 349)

Data from clinical agency supporting the need for the project

Through personal communication with the chief nursing officer of the target facility, the topic of compassion fatigue was an appropriate focus for this EBP project. The target facility (Hospital X) was a 526-bed level II trauma center in northern Indiana: the facility's designation as a trauma center may have placed nurses at higher exposure to secondary traumatic stress from patients. Many changes within the facility and workflow processes were also being implemented at the time of EBP project planning, which were potentially contributing to an already existing weariness from stressful patient care (Medical/Surgical Unit Director, personal communication, May 21, 2014). The medical-surgical unit of focus for this EBP project consisted of 33 registered nurses. Hospital X had 1,209 patients registered as trauma admissions, and 33,282 adult and pediatric admissions in the year 2012 (Medical/Surgical Unit Director, personal communication, March 4, 2015).

In 2014, the RN population within Hospital X had experienced an overall turnover rate of 10.24%. A healthy turnover rate is ideally below 15% (Director of Associate Relations, personal communication, March 5, 2015). The medical-surgical floor of focus

for this EBP project experienced a RN turnover rate of 12.5%; although this rate was still considered healthy, it was higher than the overall hospital rate and a concern for the unit director. Hospital X had conducted annual engagement surveys for employees; these surveys have provided information about morale and communication processes. Isolated for nurse responses only on the 2013 Annual Engagement Survey, 38.5% disagreed with the following statement, “My organization helps me deal with stress and burnout.” In reference to the manageability of workload, 23.6% of nurses disagreed that their workload was manageable. In reference to leadership assisting employees to balance job and personal life, 21.9% of nurses disagreed. While there was not an engagement survey in 2012 for comparison (Medical/Surgical Unit Director, personal communication, July 23, 2014), with consideration to literary evidence and of the preceding data of Hospital X, nursing leadership confirmed the need of this EBP project.

Purpose of the EBP Project

The purpose of this EBP project was to increase awareness about compassion fatigue risks factors, symptoms, and coping mechanisms through educational training for registered staff nurses in an effort to ultimately decrease levels of compassion fatigue. Additionally, it was anticipated that by increasing educational training about compassion fatigue that compassion satisfaction would also be increased. Demographic variables were also analyzed in conjunction with compassion fatigue to identify any existing trends among participants.

Identify the compelling clinical question

The compelling clinical question to be answered by this EBP project was: For registered nurses working on the medical-surgical unit at Hospital X, will providing educational measures about compassion fatigue by identifying risk factors, symptoms, and coping strategies, as compared to current practice, decrease the level of compassion fatigue that is experienced by staff nurses over a three-month period?

PICOT format

The compelling clinical question was developed using a PICOT question format to identify the key components of this EBP project. Fineout-Overholt and Stillwell (2011) defined each component of a PICOT question: (P) the population of interest, (I) the intervention of interest, (C) intervention of comparison, (O) outcome of interest, and (T) time involved to reach the outcome. For this EBP project, each component was outlined in the following:

P- The population of interest for this EBP project was registered nurses who worked as staff nurses on a medical-surgical unit.

I- The intervention that was identified as best practice from a literature review was educational training about compassion fatigue. Educational training was designed to take place face-to-face with participants and incorporated a PowerPoint presentation developed by the project manager. The contents therein were adapted from information found within the literature. The PowerPoint presentation was approximately 30 minutes in length.

C- The comparison of interest was baseline data collected prior to nurses completing the educational training about compassion fatigue.

O- The outcome of interest was the reduction of compassion fatigue post-intervention (via self-report) and the ability to sustain the reduction one-month and three-month post intervention.

T- The time frame for this EBP project was a three-month period from late fall of 2014 and to early spring of 2015.

Significance of the Project

According to Boyle (2011) nurses are not only ‘first responders’ when witnessing changes in patients’ conditions but also ‘sustained responders’ who provide ongoing care thereafter and due to the increasing complexity of patient care and increased

demands on nurses throughout the work day, nurses are susceptible to experience compassion fatigue. Compassion fatigue is a subjective experience that can have negative physical manifestations for the nurse. Should the effects of compassion fatigue be ignored, nurses are at risk for decreased morale and work performance. “These conditions not only impact retention of staff but also may influence patient satisfaction and patient safety” (Boyle, 2011, p. 7).

Within previously published literature, educational interventions have proven to be successful for reducing the effect of compassion fatigue by informing nurses about signs and symptoms, contributing factors, and coping strategies. It was anticipated that this project would show a reduction in the levels of compassion fatigue as experienced by staff nurses upon completion of educational training. The reduction of compassion fatigue was essentially anticipated to improve job satisfaction and provide nurses personal enrichment. By addressing compassion fatigue, institutions may ultimately see a reduction in nurse turnover (Boyle, 2011; Slatten et al., 2011). This EBP project provides additional depth to the current body of knowledge about compassion fatigue. Additionally, the results may be used by APNs within other tertiary care centers to institute staff education interventions that may be used to further increase staff morale, enhance retention, and improve patient satisfaction and safety.

CHAPTER 2

THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE

This EBP project addressed the clinical question: For registered nurses working on the medical-surgical unit at Hospital X, will providing educational measures about compassion fatigue by identifying risk factors, symptoms, and coping strategies, as compared to current practice, decrease the level of compassion fatigue that is experienced by staff nurses over a three-month period? A guiding nursing theory and EBP framework were chosen to provide a solid foundation for the educational component of this project.

Theoretical Framework: Theory of Transpersonal Caring

The Theory of Transpersonal Caring is a revision of the original work, Theory of Human Caring, developed by Jean Watson in 1979. Watson's model has explained the unique work that nurses have within healthcare. Watson has highlighted subjective experiences such as love and caring as opposed to disease and illness focus (Watson & Woodward, 2010). According to Watson, "It is when we include caring and love in our work and in our life that we discover and affirm that nursing, like teaching, is more than just a job; it is also a life-giving and life-receiving career for a lifetime of growth and learning" (Watson & Woodward, 2010, p. 354).

As healthcare has evolved, Watson adapted her model to include concepts that indicate a continuum of caring versus a destination. The Theory of Transpersonal Caring "seeks to connect with and embrace the spirit or soul of the other through the processes of caring and healing and being in authentic relation…" (Watson & Woodward, 2010, p. 356). Watson defined three core concepts within her theory: (a) transpersonal caring relationship, (b) caring moment/caring occasion, and (c) caring consciousness or healing (Watson & Woodward, 2010).

The transpersonal caring relationship between nurse and patient should go beyond the external interaction and reach deep connections with the spirit and soul of the other. Watson described the ultimate goal of the nurse as consciously viewing the patient behind the disease or illness. The disease or illness has been referred to as an illusion that masks the soul of the patient. A transpersonal caring relationship requires authenticity. Authenticity requires commitment, sincerity, and intentionality for a common purpose (Watson & Woodward, 2010).

Watson defined a caring moment or occasion as anytime in which both nurse and patient come together in a "human-to-human transaction" (Watson & Woodward, 2010, p. 358). These caring moments have the potential to transcend into a deeper interaction based upon the uniqueness of each individual. If a transpersonal interaction is achieved, the connection enhances the ability of caring consciousness or healing to occur and new opportunities for the nurse are presented to reach the patient on a deeper level (Watson & Woodward, 2010).

In Watson's original model, she defined 10 carative factors that served as the core of nursing to facilitate transpersonal experiences. In subsequent works, Watson renamed these carative factors as clinical caritas processes. The clinical caritas processes more thoroughly define the work of nurses and are more consistent with the teachings of Florence Nightingale (Watson & Woodward, 2010). These caritas processes are as follows:

1. Formation of a humanistic-altruistic system of values becomes the practice of loving kindness and equanimity within the context of caring consciousness.
2. Instillation of faith-hope becomes being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one in which care is being provided.

3. Cultivation of sensitivity to one's self and to others becomes cultivation of one's own spiritual practices and transpersonal self, going beyond ego self, opening to others with sensitivity and compassion.

4. Development of a helping-trusting, human caring relationship becomes developing and sustaining a helping-trusting, authentic caring relationship.

5. Promotion and acceptance of the expression of positive and negative feelings becomes being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one in which care is being provided.

6. Systematic use of a creative problem-solving caring process becomes creative use of self and all ways of knowing as part of the caring process; to engage in artistry of caring-healing practices.

7. Promotion of transpersonal teaching-learning becomes engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others' frames of reference.

8. Provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment becomes creating a healing environment at all levels (a physical and nonphysical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated).

9. Assistance with gratification of human needs becomes assisting with basic needs, with an intentional caring consciousness, administering "human care essentials," which potentiate alignment of mind-body-spirit, wholeness, and unity of being in all aspects of care, tending to both embodied spirit and evolving spiritual emergence.

> 10. Allowance for existential-phenomenological-spiritual forces becomes opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one in which care is being provided (Watson & Woodward, 2010, p. 355).

Watson has invited all nurses to experiment with transpersonal caring and to recognize those caring moments when healing can occur. Watson's theories have been used to guide educational programs, clinical practice models, and research in nursing (Watson & Woodward, 2010).

Theory summary for EBP project

Watson's Theory of Transpersonal Caring appropriately correlated with this EBP project because repetitive exposure to transpersonal experiences with traumatic patient situations may begin the cascade of events leading to compassion fatigue. While Watson's theory has described a transcending experience for both nurse and patient (when a piece of one another is shared), modern conditions in healthcare limit the time available to develop this relationship. Often nurses are exposed to trauma, death, and the abusive experiences in which patients have endured. These situations can be detrimental for nurses in the absence of coping mechanisms or adequate education. The caritas processes within Watson's theory can assist the nurses to view the patient beyond the external mask of disease, trauma, or abuse. The caritas processes can also assist nurses to consciously seek transpersonal caring opportunities in conjunction with proper education about compassion fatigue, which can elevate the nurse-patient relationship to one that is beneficial for both parties.

Evidenced-Based Framework: The Model for Evidence-Based Practice Change

To successfully implement a practice change in healthcare, it has been recommended to utilize a guiding evidence-based framework. In preparation for this EBP project, seven models were reviewed for appropriateness. Each model differed slightly;

however, the core steps were similar. The main core features of each model assimilated the following steps: (a) problem identification, (b) selection of change agents, (c) search and analyze high-quality research to support a practice change, (d) identify potential barriers, (e) design practice change, (f) implement practice change, (g) evaluate change processes and outcome measures, and (h) develop strategies to maintain practice change (Ciliska et al., 2011).

The Model for Evidence-Based Practice Change provided the best fit and was thus chosen as the framework for this EBP project. The original model was named by thought leaders, Rosswurm and Larrabee, *Model for Change to Evidence-Based Practice* in 1999, but was renamed in 2009, by the original authors, to foster a spirit of continual pursuit of practice change as opposed to a “one-stop destination”. Also, the steps within the model were revised to be more user-friendly. The revised model incorporates strategies to enhance successful practice change through quality improvement and teamwork. The Model for Evidence-Based Practice Change uses six steps to guide clinicians in the pursuit of practice change: (a) assess the need for change in practice, (b) locate the best evidence, (c) critically analyze the evidence, (d) design practice change, (e) implement and evaluate change in practice, and (f) integrate and maintain change in practice (Ciliska et al., 2011).

Assess the need for change in practice

The first step within the Model for Evidence-Based Practice Change is to assess the need for change by identification of a clinical or practice problem. The need for practice change can be influenced by patient satisfaction, cost burden, or institutional quality improvement data (Ciliska et al., 2011). New research data can bring about change in practice from provider inquiry. Practice change inquiry should include data collection about the problem (Rosswurm & Larrabee, 1999). Both internal data from staff and patients as well as external data from benchmark comparisons should be included

as part of the assessment for practice change. During the practice change assessment, formulating a team to organize the change process is helpful. The team can begin to link possible intervention alternatives to resolve the problem. Also, team members should work to organize the problem into a PICOT question (Ciliska et al., 2011).

Locate the best evidence

The second stage within the Model of Evidence-Based Practice Change includes planning evidence searches and locating critical appraisal tools to analyze the search results (Ciliska et al., 2011). Best evidence can include systematic reviews, randomized control trials (RCTs), quantitative studies, or qualitative studies to name a few. The principal investigator should select inclusion and exclusion criteria for evidence articles (Rosswurm & Larrabee, 1999). Once the search planning is complete, the project manager should perform evidence searches within several databases using various types of search strategies (Ciliska et al., 2011).

Critically analyze the evidence

The third stage within the Model of Evidenced-Based Practice Change is to utilize the critical appraisal tools that were gathered during stage two and critically appraise the evidence, which includes determining the strength of evidence. After appropriate articles are gathered, synthesis of the evidence is essential to determine best practice interventions. The project manager should assess the feasibility of implementation of the best practice intervention found within the literature, as well as risks, benefits, and costs (Ciliska et al., 2011).

Design practice change

The fourth stage within the Model of Evidence-Based Practice Change includes defining the practice change which can involve the development of protocols, policies, or guidelines. Part of the practice change definition should include identification of required resources such as personnel, materials, and equipment (Ciliska et al., 2011). The project

manager should determine both process and outcome measurements to be collected at baseline and post-intervention to evaluate the effects of the process change. These measurement tools are often found within the literature from evidence articles that were summarized within step three (Rosswurm & Larrabee, 1999). Other tasks within this step include designing the implementation plan, identifying change champions, and developing educational materials (Ciliska et al., 2011).

Implement and evaluate change in practice

The fifth step is to implement the best practice intervention in a pilot project. The EBP team members should seek out feedback from front line staff to make minor alterations to the implementation plan. After feedback has been incorporated into the process, project outcomes should be evaluated. The project manager evaluates the intervention by comparing pre-pilot data with post-pilot data to analyze the effectiveness of practice change (Rosswurm & Larrabee, 1999). Using both feedback and data results, team members decide to adapt, adopt, or reject the new practice change. If the decision is made to adapt or adopt the new practice, EBP team members develop conclusions and recommendations for a more seamless transition to the implementation organization wide (Ciliska et al., 2011).

Integrate and maintain change in practice

The final step within the Model for Evidence-Based Practice Change is to share the recommendations that were developed during Step 5 with key stakeholders to gain approval to implement the new practice as the new standard of care. Widespread education about the new practice change is essential for staff to understand the importance of best practice for positive patient outcomes (Rosswurm & Larrabee, 1999). The EBP team members, along with organization leadership, must then develop mechanisms for ongoing monitoring of the practice change as well as evaluating outcome indicators that were developed during the pilot. Lastly, EBP team members

should celebrate the results and disseminate the information organization wide. Disseminating information outside the organization would also be beneficial for other healthcare institutions (Ciliska et al., 2011).

Model summary for EBP project

The Model for Evidenced-Based Practice Change was an appropriate model for this EBP project; the appropriateness of fit was apparent within the name of the model, but the goals and tasks of this EBP were reflected within each step of the model. The authors clearly and concisely described the tasks to be completed in each step. The revised model equally divided the tasks among the six steps; therefore, no one step was too monumental to complete. This benefit was determined to be especially useful for the novice clinician. Facility contacts were essential during the design of the intervention. While the literature identified the educational material for compassion fatigue, key stakeholders assisted the project manager in determining the dates, times, and length of teaching that would best fit the flow of the target unit. During the implementation and evaluation stage, the project manager utilized feedback from participants to re-evaluate the inclusion of a YouTube video. Based on this feedback, the video was omitted during later presentations, which allowed more time for project manager and nursing interaction during the deep breathing exercises. This model also highlighted the use of a team throughout the process. While the project manager performed the bulk of the background investigation, facility contacts, project advisor, and course instructors were instrumental in creating a realistic and relevant proposal to address compassion fatigue in staff nurses.

Literature Search

With the PICOT question in mind, a thorough search of the literature was performed. This literature search was guided by step two: locate the best evidence, as presented in The Model for Evidence-Based Practice Change.

Search engines and key words

To acquire relevant supporting evidence for the best practice intervention to address compassion fatigue, a computer-based search of databases was conducted. A hand search of reference lists was also performed. Searched databases included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, ProQuest, Cochrane Collaboration and Library, Joanna Briggs Institute, and National Guideline Clearinghouse. Searched key words included “compassion fatigue” OR “secondary traumatic stress” AND nurs* in CINAHL which yielded 53 articles and Medline which yielded 23 articles. Searched key words included “compassion fatigue” OR “secondary traumatic stress” AND nurs* AND intervention in ProQuest which yielded 37 articles. Searched key words included “compassion fatigue” in Joanna Briggs Institute which yielded three articles and National Guideline Clearinghouse which yielded one article. A hand search of reference lists resulted in one additional article (see Table 2.1).

Inclusion and exclusion criteria

The large number of articles that were found in the literature search required narrowing in order to obtain articles with likeness to Hospital X. Therefore, inclusion and exclusion criteria were developed. The inclusion criteria were determined to be articles that were (a) written in the English language (b) peer reviewed, (c) scholarly, and (d) included nurses in the acute care setting. No date specifications were used as inclusion or exclusion criteria. Adults ages 18-65 years were only included as well. All specialties of nursing were eligible for inclusion. Research articles were focused upon; however, expert opinions were also eligible for inclusion.

Articles pertaining to professions other than nursing (i.e., social work), family caregivers, and nursing students were excluded because staff nurses were the focus of this EBP project. Research conducted in military hospitals and settings other than acute care hospitals were also excluded because the patient population would differ

significantly than that of the target facility for this EBP project. Studies that included nurses who were working during natural disasters or war and terror were also excluded because these situations are not typical within the region of the target facility. Articles were excluded if coping strategies or interventions were not addressed within the research.

Search results from each database were reviewed and after duplicates were eliminated, each article was initially screened by title. Then, abstracts of potential articles were reviewed. Seventeen articles were determined to be potentially included and the full text of these articles was reviewed. Of these 17 articles, eight were determined to be relevant to this EBP project: three quasi-experimental studies, one systematic review, one clinical practice guideline, and three expert opinions. These articles were determined to fulfill inclusion criteria as well as identify best practice for combating compassion fatigue.

Levels of evidence

Melnyk & Fineout-Overholt's (2011) rating system for hierarchy of evidence was used to determine the level of evidence of each of the articles providing supportive evidence for this EBP project. In the hierarchy, level I evidence is from a systematic review or meta-analysis of randomized control trials (RCT). Level II evidence is from single RCTs that are well-designed. Level III evidence is from non-randomized control trials. Level IV evidence is from single case-control and cohort studies. Level V evidence is from systematic reviews of descriptive or qualitative studies. Level VI evidence is from single descriptive or qualitative studies. Level VII evidence is from expert opinions (see Table 2.2).

Appraisal of relevant evidence

According to The Model of Evidence-Based Practice Change, step three describes the task of critically appraising supporting articles. As such, each of the eight articles

was appraised to determine the quality of evidence provided therein. Melnyk & Finout-Overholt's (2011) rapid critical appraisal for quantitative studies and Powers (2011) appraisal for qualitative studies were utilized in the evaluation of evidence. Critical Appraisal Skills Programme (CASP) for systematic reviews was used to evaluate the systematic review. Finally, Broughton and Rathbone's (n.d.) evaluation criteria were used to evaluate the clinical practice guideline that was included within the literature support of this EBP project. All of the eight articles were rated of at least "fair" quality and thus were included in the body of evidence supporting the change in practice.

Level III evidence

Potter, Deshields, Berger, Clarke, Olsen, and Chen (2013) conducted a quasi-experimental pilot study to evaluate a compassion fatigue resiliency training program to reduce compassion fatigue among oncology nurses in a cancer center in the Midwestern United States. The training consisted of five 90-minute sessions. The sample size consisted of 13 oncology nurses. Data was collected and analyzed pre-intervention, immediately post-intervention, 3-month post-intervention, and 6-month post-intervention. The authors used four instruments to measure the level of compassion fatigue among nurses which included (a) Maslach Burnout Inventory (MBI)-Human Services Survey, (b) Professional Quality of Life version IV (ProQOL-IV), (c) Impact of Event Scale-Revised (IES-R), and (d) Nursing Job Satisfaction Scale. The results supported a strong correlation of compassion fatigue and burnout among nurses. The level of compassion fatigue improved on each of the data collection tools post-intervention, but statistical significance was only achieved on one tool, the ProQOL-IV. On this scale, nurses scored at high-risk levels of burnout and secondary traumatic stress with a mean score of 19.76 pre-intervention; scores higher than 17 are indicative of secondary traumatic stress. Statistically significant results demonstrated decreased secondary traumatization at 6-months post educational training with a mean score of 16.23, $p = 0.044$ (Potter,

Deshields, Burger, et al., 2013). A mixed model repeated-measures analysis was utilized to determine the efficacy of education across the four data collection points in time. Untoward events during this pilot study were minimal: loss of subjects and small sample size. Due to the voluntary nature of the study, nurses suffering from severe compassion fatigue may not have been included (Potter, Deshields, Berger, et al., 2013). Although the sample size was small, the findings of this study support the proposed practice change. The ProQOL-IV data collection tool within this study influenced the use of Stamm's (2009) updated version, ProQOL-V, which was used within this EBP project. The study was rated of good quality and the findings support using educational training to combat compassion fatigue.

Potter, Deshields, and Rodriguez (2013) published a follow-up quasi-experimental study expounding on their earlier work. Within this follow-up study, the educational intervention was implemented to all other nursing units within the target hospital. The educational intervention in this study was adapted from the previous 5-week (7 ½ hour) program to a single 8-hour educational session. The sample included 389 staff members from various specialties. Nurses accounted for 73% (n = 284) of responses. The ProQOL-IV data collection was utilized within the study. Pre-intervention, 38.3% of participants were determined to be at high risk for secondary traumatic stress and 48.1% were determined to be at high risk for burnout. Of the participants that completed the follow-up assessment tool (n = 85), 78.9% (n = 67) were nurses. Statistically significant improvements were noted for burnout (23.5%, $p < 0.01$) and secondary traumatic stress (21.2%, $p < 0.01$) post-education intervention. The authors completed data collection pre-intervention and 3-month post-intervention. Data was reported by percentage before and percentage after as well as t-test analysis (Potter, Deshields, & Rodriguez, 2013). The study further supported the use of the Pro-QOL-V data collection tool. The researchers did report that 3-month post-intervention data analyses were limited by a

22% response rate; but, overall, the study was rated as “fair” and provided additional support for the development of this EBP project.

Flarity et al. (2013) sought to determine the effectiveness of an educational training program on preventing and treating compassion fatigue. Flarity et al. implemented a 4-hour compassion fatigue seminar, which was adapted from Eric Gentry’s Compassion Fatigue Prevention & Resiliency, Fitness for the Frontline. This seminar was offered to emergency department nurses at two emergency departments from the same multi-hospital organization. The intervention included a video documentary and an interactive group discussion. The convenience sample consisted of 73 emergency department nurses. The efficacy of the compassion fatigue training/education was measured using a pre-/post-test design with the Professional Quality of Life Scale version V (ProQOL-V). The level of significance was $p = 0.05$. The educational program in this study was determined to have statistical significance by improving compassion satisfaction, decreasing burnout, and decreasing compassion fatigue. Pre-intervention, 59.3% (n = 35) of participants scored at moderate to high risk levels for secondary traumatic stress and 57.6% (n = 34) scored at moderate to high levels of burnout. Post-intervention, only 40.7% (n = 24) scored at moderate to high levels of secondary traumatic stress and only 23.7% (n = 14) scored at moderate to high levels of burnout, improvement of 18.6 and 33.9 percentage points, respectively (Flarity et al., 2013). Subjective comments about the program were positive from all participants as well. No untoward events were identified by the authors. The results of this study correlated with previous research in this area. Although the researchers targeted emergency department nurses, there was no reason to question the generalizability and applicability of findings to a broader range of nurses. Thus, it was determined that the educational program within this study would potentially impact clinical practice by benefitting all nurses within the target organization and not solely emergency department nurses. The data collection tool utilized by these

authors supports the use within this EBP project. Overall, the study was rated as “good” and provided additional support for the development of this EBP project.

Level V evidence

Beck (2011) conducted a systematic review of qualitative and quantitative research focusing on secondary traumatic stress in nurses. Secondary traumatic stress has been identified as a synonym for compassion fatigue. Beck (2011) clearly identified the clinical question being investigated as, “Is there a cost of caring for healthcare providers of traumatized patients?” (p. 2). The focus population consisted of nurses in various specialties including oncology, pediatrics, intensive care, sexual assault nurse examiners, hospice, and emergency room.

Beck (2011) included seven studies in this systematic review. The studies consisted of both quantitative and qualitative research. Six of the seven studies utilized at least one measurement tool from literature. The remaining study was qualitative in nature and consisted of open-ended questions for participants to answer. The author included relevant studies in this review by searching for common synonyms for compassion fatigue (i.e., secondary traumatic stress). Three databases were searched for potential articles. Unpublished and non-English studies were not included in the review. Beck identified limitations in the quality of various studies included in the review. For instance, small sample sizes and various measurement instruments among the studies presented difficulty for making comparisons. Also, the author of this review suggested more qualitative research should be conducted to enhance the findings of quantitative research. Beck presented a discussion of the results from each study. Common themes were identified from the qualitative studies included in the review: education about risk factors and coping behaviors, peer support, and more professional education. These findings were presented as the overall result of this systematic review.

The generalization of these results cannot be determined based on the various instruments used among the studies to measure outcomes.

These results can be applied to local populations as each of the various specialties included in this review are present in the target area for this EBP project. Beck included each important outcome among the included studies. The benefits of the outcome of this review are worth consideration to enhance the overall health of nurses and potentially improving patient care. The risk of implementing an educational intervention is minimal. The overall quality of this systematic review was determined to be “fair” and was thus included as support for this EBP project.

Level VII evidence

Hodge and Lockwood (2013) authored a proposal for a systematic review in regard to compassion fatigue. The authors clearly identified the focused question of the review at the beginning of the article. The clinical question was: Can structured interventions implemented by nurse leaders decrease compassion fatigue among healthcare providers? The question included an identified population, intervention, and outcome. The authors identified the types of studies to include in the review as both quantitative and qualitative. The databases that were utilized are clearly identified. Databases such as CINAHL, Medline, ProQuest Nursing, Allied Health Source, and EMBASE were listed within this article review. The authors searched for published and unpublished studies. The articles that were included in this review were thoroughly assessed for quality by utilizing two independent reviewers and then a third reviewer if disagreements occurred. The critical appraisal tools used to evaluate the articles were included in the appendices of the systematic review.

The authors synthesized the interventions for compassion fatigue that were identified within the literature; however, the results were not differentiated between quantitative or qualitative studies. The authors provided the expert opinion that the most

appropriate intervention to reduce compassion fatigue was to implement “focused education to increase the awareness of compassion fatigue, specifically the risks, causes, signs for early detection and available resources to combat the detrimental effects of compassion fatigue should be considered with caregiver population” (Hodge & Lockwood, 2013, p. 83). The identified intervention, focused education to increase awareness of compassion fatigue, can be applied to local nurses. The cost of the proposed intervention appears to be worth the benefits. By reducing compassion fatigue, standards for patient satisfaction and employee productivity are more achievable. Important outcomes were identified by the systematic review. However, it would have been beneficial for the reader if statistical information were incorporated throughout the review. A final count of total articles and differentiation between quantitative and qualitative studies could not be determined; however, upon completion of the review, this information would help create a more detailed picture in support of the conclusion of the review.

The authors of the systematic review proposal were both doctorally prepared and considered clinical experts. Lori Hodge, a member of the Oncology Nurses Society, was noted to currently be the director of medical and oncology services at University of Texas Southwestern Medical Center in Dallas. Previously, she served as the clinical manager of oncology services at Baylor All Saints Medical Center and was the director of oncology services at Plaza Medical Center Fort Worth. Suzy Lockwood was noted to be a professor and director for oncology nursing and research for 18 years at Texas Christian University. This systematic review proposal was determined to be of “fair” quality and was included as supporting evidence for compassion fatigue education.

Additional support for this EBP project was obtained via expert opinion from nurses working at the Cincinnati Children’s Hospital Medical Center. Cincinnati Children’s Hospital Medical Center (2013) developed a clinical practice guideline, which was clearly

stated at the beginning of the guideline. No external funding was used in the development of the practice guideline; therefore, no external bias is present. The objective of the guideline was to identify functional knowledge of compassion fatigue in conjunction with self-care skills and the reduction compassion fatigue experienced among pediatric intensive care nurses. The guideline was authored by two registered nurses with advanced education, who were certified in pediatric care. This peer-reviewed guideline stated that no financial or intellectual conflicts of interest were identified.

The databases used to search for supporting evidence were CINAHL and MEDLINE. Detailed statements of search terms and search limiters were clearly available within the guideline description of methods. The formulation of recommendations was based upon expert consensus. The guideline stated that compassion fatigue training, including functional knowledge of compassion fatigue and the practice of self-care skills would reduce compassion fatigue. The rating scheme was provided in a table format for each article used within the practice guideline. Potential benefits of the recommendation were stated as decreased incidence of compassion fatigue among pediatric intensive care nurses. No potential harms were stated. The future update and review of this guideline was not described. There was no mention of other practice guidelines about compassion fatigue. The guideline has been made available electronically as well as a printed document. It was recommended that nurses working in pediatric intensive care settings receive training that includes compassion fatigue awareness, coping strategies, stress management, relaxation techniques and self-care interventions to decrease the level of compassion fatigue experienced in the work environment (Cincinnati Children's Hospital Medical Center, 2013). This clinical practice guideline was determined to be of "good" quality for use in this EBP project.

Slatten et al. (2011) provided insightful descriptions about compassion fatigue, associated symptoms, and potential interventions gleaned from current literature. The target audience for this review was nurse managers. The authors adequately introduced managers to compassion fatigue and potentially recognizing it in staff nurses. Slatten et al. provided a comprehensive description of possible compassion fatigue symptoms. Compassion fatigue assessment tools, including the ProQOL scale, were introduced and each tool was thoroughly described and a location from which they could be obtained was provided. Interventions were grouped within four categories: (a) diversifying patient assignments, (b) offering compassion fatigue training/education along with self-care activities for staff nurses, (c) maintaining professional distance, and (d) supporting employee development. Slatten et al. opined that educational measures should include symptom recognition and development of coping strategies. Supporting employee development was noted to include shared responsibility with decision-making and allowing autonomy among nurses. Nurse managers were encouraged to empower nurses and provide a safe environment for voicing concerns. The opinions of the authors were clearly stated, realistic, and were congruent with other sources within the literature and no conflict of interest existed. Dr. Lise Slatten was noted to be an assistant professor from the Department of Management at the University of Louisiana at Lafayette. She has served on various committees within her academic facility. She was noted to be the founder of Right Place Management Consulting, which has provided consultation for organizational challenges. From July 1997 to December 2007, Lise Slatten was the executive director of Woman's Foundation Inc. Kerry Carson has been a professor from the Department of Management at University of Louisiana. Paula Carson has been Assistant Vice President of Institutional Planning and Effectiveness at the University of Louisiana. Kerry Carson and Paula Carson were both doctorally prepared

and considered clinical experts. This expert opinion was determined to be of “good” quality and was included as supporting evidence for compassion fatigue education.

Boyle (2011) provided a detailed contemporary description of compassion fatigue in her article, “Countering Compassion Fatigue: A Requisite Nursing Agenda”. Deborah Boyle was noted to be an advanced practice nurse who has authored over 200 publications including journal articles and books. She has been a lecturer nationally and internationally and has received several awards from Oncology Nursing Society. In 1999, Deborah Boyle was inducted as a fellow into the American Academy of Nursing.

In this article, Boyle (2011) clearly stated her views which were congruent with current literature. No potential biases were identified. A thorough history of compassion fatigue was presented, beginning with the first appearance of the term by Joinson in 1992. The common compassion fatigue measurement tools discussed by Boyle had been used in other studies within the literature. Boyle differentiated compassion fatigue and burnout. The definitions of each were weaved throughout the majority of the literature to provide a better understanding of compassion fatigue. Symptoms of compassion fatigue identified within this article included depression, anger, detachment, feeling tired, headaches, and insomnia. Boyle presented three groups of interventions as ways to diminish the intensity of compassion fatigue. First, Boyle noted that work and life balance is essential for nurses to tend to self. Second, Boyle opined that education about compassion fatigue is seldom utilized; however, education can assist nurses in developing necessary skills to prevent and reduce compassion fatigue. Furthermore, proper education should incorporate coping strategies, communication strategies, and self-care strategies. Finally, Boyle noted that work-setting interventions can be very effective in relieving the emotional strain of compassion fatigue as well. On-site counseling, support groups, de-briefing, massage, or bereavement counseling were identified as some additional interventions. This expert opinion was determined to be of

"good" quality and was included as supporting evidence for compassion fatigue education.

Construct Evidence-Based Practice

The appraisal of evidence provided a solid base for developing a best practice intervention to implement for this EBP project. The process of critically appraising articles allowed the project manager to develop an appropriate intervention, as well as identify an appropriate measurement tool to evaluate the effectiveness of the proposed intervention. Other useful findings gleaned from the literature were common definitions, signs and symptoms, and synonymous terms for compassion fatigue (see Appendix A).

Synthesis of Critically Appraised Literature

Compassion fatigue and burnout. The literature reviewed demonstrated evidence of evolution since Joinson (1992) coined the term compassion fatigue. Authors have transitioned from describing nursing burnout to describing nursing compassion fatigue. All eight articles that were critically appraised included differentiation between the two terms and incorporated synonymous definitions of each term. Burnout has been defined as the "inability to achieve one's goals resulting in frustration, a sense of loss of control, and diminished morale" (Yoder, 2010, p. 191). It has been further noted that burnout is gradual and requires a longer period of time to recover. Compassion fatigue, however, has been reported to occur suddenly and resolve more quickly. Compassion fatigue has been described as "an emotional effect of being indirectly traumatized by helping those who experience primary traumatic stress" (Yoder, 2010, p. 191). Boyle (2011) identified triggers for burnout, with workplace conflicts being at the core of the problem. Such conflicts could include inadequate working conditions or disagreements with coworkers. Compassion fatigue, however, was noted to stem from emotional connections that nurses have with patients (Boyle, 2011). All authors defined these concepts in a similar manner. Boyle (2011) uniquely described potential causes for

nurses' susceptibility for compassion fatigue. She opined that nurses are not only "first responders" but also "sustained responders" that continually absorb the secondary traumatic stress of patients. This sustained exposure can cause nurses to feel helpless over the situation or even guilty that more assistance is not available.

Signs and symptoms. Another similarity between the chosen articles rose from the description of the signs and symptoms of compassion fatigue. These symptoms were defined as avoidance, headaches, depression, anger, short attention span, chronic tiredness, or helplessness (Boyle, 2011; Flarity et al., 2013; Hodge & Lockwood, 2013; Potter, Deshields, Berger, et al., 2013; Slatten et al., 2011). Hodge and Lockwood (2013) identified other symptoms as negativity toward nursing leadership, resistance to change, and loss of regard for policies and meeting deadlines.

Assessment tools. Due to the likeness of signs and symptoms, several authors utilized the same assessment tool (Boyle, 2011; Flarity et al., 2013; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013; Slatten et al., 2011). The assessment tool was titled the Professional Quality of Life Scale (ProQOL) developed by Stamm (2009). Other tools that were used within the reviewed literature included the Compassion Fatigue Self-Test, Compassion Fatigue Scale- Revised, Secondary Traumatic Stress Scale, Impact of Event Scale, and Nursing Job Satisfaction Scale (Beck, 2011; Boyle, 2011; Potter, Deshields, Berger, et al., 2013; Slatten et al., 2011). Potter, Deshields, Berger, et al. (2013) used a combination of measurement tools to evaluate intervention efficacy.

A notable difference between the chosen articles was reflected in sample population. All authors chose nursing participants (Aycock & Boyle, 2009; Flarity et al., 2013; Perry et al., 2011; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013; Yoder, 2010). However, Aycock and Boyle (2009), Hodge and Lockwood (2013), and Perry et al. (2011) were the only authors to solely incorporate

oncology nurses. Other nursing specialties that were studied included emergency departments, intensive care units, and medical-surgical units (Flarity et al., 2013; Potter, Deshields, & Rodriguez, 2013; Yoder, 2010).

Coping strategies. Coping strategies that were presented within the chosen articles had a common theme: self-care (Hodge & Lockwood, 2013). Self-care is a concept that existed in Florence Nightingale's era. Nightingale believed that nurses' self-care practices were an important aspect of holistic nursing (Neville & Cole, 2013). Each study, included within the evidence for this EBP project, incorporated various aspects of self-care based on the responses of study participants. Adequate sleep was mentioned as a method of restoring a healthy balance of life. Good nutrition and aerobic exercise were identified as ways to combat compassion fatigue. Additionally, humor was identified as having a positive effect on compassion fatigue (Slatten et al., 2011). Interestingly, none of the chosen articles cited membership to professional organizations as a measure to reduce the effects of compassion fatigue, although the sample population was often recruited from professional organizations.

Best practice recommendation. Despite all the previously discussed aspects of self-care, one aspect was constant between articles— nurses need educational training about compassion fatigue. Three studies implemented an educational training program about compassion fatigue that proved successful upon evaluation (Flarity et al., 2013; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013). Cincinnati Children's Hospital Medical Center (2013) developed a clinical practice guideline supporting compassion fatigue training, including functional knowledge and self-care skills. One systematic review identified the need for compassion fatigue training and education (Beck, 2011). Finally, two expert reports presented arguments in support of implementing more education for those at risk for developing compassion fatigue (Boyle, 2011; Hodge & Lockwood, 2013; Slatten et al., 2011).

Answering the clinical question

The appraisal of current literature suggests the best practice recommendation would indeed answer the clinical question of the EBP project: Will compassion fatigue education/training, compared to current practice, decrease the level of compassion fatigue experienced among staff nurses in an acute care setting over a three-month period? Also gleaned from the literature was the measurement tool to assess the degree of compassion fatigue that is experienced among nurses (i.e., ProQOL-V).

Table 2.1

Database Search Results

Database	Results	Included Article(s)
CINAHL	53	4
Cochrane	1	0
JBI	3	1
Medline	23	0
NGC	1	1
ProQuest	37	1
Citation Chasing	1	1

Table 2.2

Levels of Evidence

Author (s)	Level of Evidence
Beck (2011)	V
Boyle (2011)	VII
Cincinnati Children's Hospital Medical Center (2013)	VII
Flarity et al. (2013)	III
Hodge & Lockwood (2013)	VII
Potter…Chen (2013)	III
Potter…Rodriguez (2013)	III
Slatten et al. (2011)	VII

CHAPTER 3

IMPLEMENTATION OF PRACTICE CHANGE

The steps outlined within the Model of Evidence-Based Practice Change have been adhered to throughout the planning stages of this EBP project. The fifth step within the process is to implement and evaluate the practice change. Within this chapter, the implementation plan for compassion fatigue education has been described in detail.

METHOD

Participants and setting

Participants for this EBP project were registered nurses who worked on a medical-surgical unit at Hospital X, a level II trauma center in northern Indiana. This unit had a total of 33 nurses, all of which were female. The majority of the eligible participants varied in age from mid-twenties to late fifties. Additionally, the majority was noted to have an Associate's degree as their educational background and most worked as full-time employees. Participants were anticipated to have varying number of years in practice. Generally, the night shift nurses were younger and less experienced and the day shift nurses were older and more experienced. These variables were assessed via a demographic form that was administered prior to educational training (see Appendix B).

Hospital X was a community-owned, non-profit tertiary care hospital located in Northern Indiana: a 526 bed facility and was a part of a larger corporation that was established in 2012. The larger corporation consisted of three local hospitals (including Hospital X) and physician medical group. As a community hospital and level II trauma center, the target facility was accessible to the general public of the regional Michiana area. Patients with all types of payer sources have been accepted for in-patient and out-patient medical services. Patients have had private insurance, Medicare, Medicaid, and self-pay (Medical/Surgical Unit Director, personal communication, April 5, 2014). Nurses

within the organization have been encouraged to earn a Bachelor's degree; many scholarship opportunities, as well as tuition reimbursement, have been available for those who are interested. Also, all nurses have been required to complete 10 continuing education hours annually, as part of their employment within the organization.

Outcomes

The primary outcome of this EBP project was to decrease staff nurses' levels of compassion fatigue by educating participants about signs and symptoms of compassion fatigue and discussing coping strategies. A secondary outcome focused on increasing compassion satisfaction by raising awareness about compassion fatigue through an education presentation. Other outcomes of interest pertained to population attributes in relation to the level of compassion fatigue. For example, were older nurses more likely to experience compassion fatigue as compared to younger nurses? Were nurses with greater years' of experience more likely to suffer from compassion fatigue? Did educational background affect the level of compassion fatigue? And finally, did employment status (i.e., full-time, part-time, or prn) affect the level of compassion fatigue?

Intervention

A literature review identified educational training as best practice to decrease levels of compassion fatigue among staff nurses. Educational training was designed to take place face-to-face with participants and incorporated a PowerPoint presentation developed by the project manager (see Appendix C). The contents therein were adapted from information found within the literature. The PowerPoint presentation was approximately 30 minutes in length. The intervention was of no cost to participants and no risk was imposed. The intended benefits were personal enrichment and decrease levels of compassion fatigue, which was measured via the ProQOL-V scale. There were several goals of this EBP project: (a) at least 50% participation from nurses on the target

unit, (b) immediately post-intervention, 100% of ProQOL-V scales returned, (c) one-month post-intervention, at least 80% of ProQOL-V scales returned, (d) three-month post-intervention, at least 75% of ProQOL-V scales returned, and (e) data analysis would identify improvement of compassion fatigue level of affect by one category by the end of the three month period (i.e., high risk reduced to moderate risk or moderate risk reduced to low risk).

Planning

Initial planning for this EBP project consisted of a literature review to determine the best practice intervention for the topic of CF. After critically appraising all relevant evidence and determining educational training about CF as best practice, a search was conducted to find available teaching modules related to the subject. In three studies found within the literature, educational modules had been used that were developed by Dr. Eric Gentry and Dr. Anna Baranowsky (Flarity et al., 2013; Gentry, Baranowsky, & Dunning, 2002; Potter, Deshields, Berger, et al., 2013; Potter, Deshields, & Rodriguez, 2013). An internet search revealed several educational modules from these authors. The cost and feasibility of each module was taken into consideration. It was determined that a PowerPoint presentation incorporating Dr. Gentry's and Dr. Baranowsky's key points, but developed by the project manager was the best option for this project. Email communication (A. Baranowsky, personal communication, September 2014) took place with Dr. Anna Baranowsky, who granted permission for use of her *Breath Training: 3-6 Breathing: The Window into the Nervous System* from YouTube. Dr. Baranowsky offered other materials that provided additional background topic information (i.e., videos and articles) to the project manager. The project manager also completed Traumatology Institute's Compassion Fatigue Resiliency- Educator Course. Several meetings with key stakeholders (i.e., the unit director and CNO of Hospital X) were carried out to gain support for the proposed EBP project.

Protection of human subjects

The protection of human rights was maintained throughout the implementation of this EBP project. In the planning stage, the project manager completed training through the National Institutes of Health (NIH). Additionally, the unit director who served as this project manager's facility contact completed training through the NIH. The project manager and unit director were in agreement with the ethical principles regarding all research involving humans as subjects as set forth in the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research titled, "The Belmont report: Ethical principles and guidelines for the protection of human subjects of research" (1979). A copy of this training was provided to the Internal Review Board (IRB) of Valparaiso University as well as the IRB of Hospital X. IRB approval was obtained from both Valparaiso University as well as Hospital X. An informed consent (see Appendix D) was also obtained from participants prior to completing the educational training per Hospital X's IRB request. Lastly, confidentiality was maintained by instructing participants to omit names from the demographic information sheet as well as each ProQOL-V scale. Each participant's forms were numerically identified to allow the project manager to assess for trends and confounding factors without using the names of participants. All data collection forms were collected weekly and kept secured in the residence of the project manager, which was not accessible to any study participant.

Recruiting participants

After receiving IRB approval, recruitment of participants was undertaken using the dry erase board in the unit break room, email notifications, and the daily assignment sheets that were provided to all staff members at the beginning of the shift. Participants self-selected to participate as they were part of a pre-established cohort: all nurses working on the medical-surgical unit at Hospital X. Notification of compassion fatigue

training was written on the dry erase board in the employee break room two weeks prior to the pre-determined training dates, which were approved by the unit director. The break room dry erase board was utilized because it was visible to nurses upon entering and exiting each shift. Also, this board has been utilized in the past for other unit specific communications (i.e., scheduling due dates). One week prior, a unit-wide email was sent to all nurses. The email message was drafted by the project manager and forwarded to the unit's Administrative Service Representative (ASR), who electronically distributed the email to all 33 nurses on the unit. Email notifications were chosen as a means of communication because staff members are expected to check their emails each shift. The pre-determined dates of compassion fatigue training were identified on the daily assignment sheets that were given to nurses at the beginning of each shift. These sheets provided the patient assignments, essential phone numbers, and on-call physicians, etc. The daily assignment sheets were utilized to inform the charge nurse and both the oncoming and off going shifts of compassion fatigue education to better prepare for change of shift.

Practice Change Implementation

A total of five educational sessions occurred at change of shift on pre-determined dates in the month of October, which were agreed upon with the unit director. Five educational sessions were completed on five different dates to capture both day shift and night shift nurses. Nurses who wished to attend the compassion fatigue educational training simply remained in the break room at change of shift. The break room was located on the unit and seated approximately 12 staff members, however, a maximum of only five nurses attended at one time. This allowed for anonymity when filling out the demographic form as well as the ProQOL-V scales because the additional space allowed participants to spread out when completing their demographic forms and ProQOL-V scales. The roominess facilitated the ability to provide honest answers as

their colleagues were not able to view each other's answers. This supported the integrity of the data. Compassion fatigue education was scheduled during regular work hours. Nurses were allowed to stay over their shift, but doing so was voluntary, as no overtime was offered for participation. The project manager provided nurse participants with snacks before and after the presentation.

The Power Point presentation consisted of 16 slides pertaining to compassion fatigue and the contents included the definition, background information, risk factors, signs and symptoms, six resiliency strategies, and interactive deep breathing techniques to calm the nervous system. The presentation was presented by the project manager, utilizing a computer with projector and a projector screen provided by Hospital X.

DATA

The data for this EBP project was evaluated by pre-test/post-test measures. The data was evaluated to determine the effectiveness of the educational intervention to the entire nursing population. Compassion fatigue scores and compassion satisfaction scores were evaluated at each of the three measurement intervals. Additionally, secondary analyses were undertaken to compare compassion fatigue within subgroups: varying ages, years of practice, educational background, and employment status (i.e., full-time, part-time, or PRN).

Reliability and validity

The tool that was used to evaluate the effectiveness of the educational session, the Professional Quality of Life scale, was developed by Stamm (2010). Several versions have been used by researchers and results of their findings have been widely published within the literature; however, for this EBP project the most recent version (i.e., version five, ProQOL-V) was utilized (Appendix E). According to Stamm (2010), the α reliability of each subscale within the ProQOL-V has ranged from 0.84 to 0.90 and the tool has had a structural reliability coefficient of 0.91. The tool was established to

measure secondary traumatic stress (i.e., CF), burnout, and compassion satisfaction. The validity of each construct has been previously established: inter-scale correlations of 2% shared variance (r = -0.23; co-σ = 5%; N = 1,187) with secondary traumatic stress and 5% variance (r = -0.14; co-σ = 2%; N = 1,187) with burnout. The 30-item ProQOL-V has used a Likert-type scale to evaluate whether participants have experienced each situation in the last 30 days.

Collection

Data collection took place pre-intervention, immediately post-intervention, 1-month post-intervention, and 3-months post-intervention. All data collection tools were provided for participants at the time of the educational intervention. Prior to the start of the presentation, each nurse completed a demographic information sheet (Appendix B) and a ProQOL-V scale (Appendix E). After the training was complete, each nurse completed a second ProQOL-V scale, and all data sheets were collected by the project manager at that time. Each nurse was distributed two envelopes, each containing a 1-month and 3-months post-intervention ProQOL-V scale, and verbal instructions were given. Each participant received forms that were numerically identified (omitting the names of participants) ensuring anonymity while providing an opportunity for data comparison.

The due dates for submitting each follow-up ProQOL-V scale was printed on the outside of the envelope as a reminder. Follow-up ProQOL-V scales were numerically coded and participants were instructed to turn sealed forms into a black envelope that was hung in the charge nurse’s office. Participants freely had access to this envelope and could return them without identifying themselves. Email reminders were sent unit-wide 1 week in advance to remind participants of the due dates for both the 1-month and 3-months ProQOL-V scale. A reminder was also written on the break room dry erase board 2 weeks in advance.

Summary of Implementation

After completing the initial planning stages as described by Rosswurm and Larrabee (1999) in their *Model for Evidence-Based Practice Change*, implementation strategies for this EBP project were developed. Within the model, stage four, design the practice change, required key stakeholder involvement. Time consuming efforts were put forth in determining dates, copying materials for participants, and securing electronic equipment for presentation purposes. Compassion fatigue education took place on October 12, 17, and 19, 2014. On the dates of October 12 and 19, two educational sessions took place, one for day shift and then again for night shift. Data collection was completed on October 12, 17, and 19, 2014 for pre-intervention and immediate post-intervention data. Data collection for 1-month post-intervention occurred the week of November 15, 2014. Data collection for 3-month post-intervention occurred the week of January 15, 2015. Findings from the data analysis are detailed in Chapter 4.

CHAPTER 4

FINDINGS

The purpose of this EBP project was to increase awareness about CF symptoms and coping mechanisms through educational training for registered staff nurses in an effort to decrease levels of compassion fatigue. Additionally, it was the hope that educational training about compassion fatigue would also increase compassion satisfaction, a subscale incorporated in the ProQOL-V. The compelling clinical question to be answered by this EBP project was: For registered nurses working on the medical-surgical unit at Hospital X, will providing educational measures about compassion fatigue by identifying risk factors, symptoms, and coping strategies, as compared to current practice, decrease the level of compassion fatigue that is experienced by staff nurses over a three-month period?

Participant Characteristics

The following section provides a description of participants included within this EBP project sample. Participant characteristics include sample size, demographics, and attrition details. The characteristic data points were collected via a demographic tool, which was administered prior to compassion fatigue education and can be found in Appendix B. The demographic tool contained six items that were evaluated: age, gender, highest level of education, number of years in nursing practice, employment status, and area of specialty (see Table 4.1).

Size

Of the 23 nurses who were eligible to participate in the five educational sessions, 18 (78%) staff nurses attended the compassion fatigue educational intervention and completed, in its entirety, the demographic form. The 78% attendance rate was appropriate considering that nurses had potential of being released on call for unit staffing and/or attended educational training on another day they worked during the

week, which would duplicate nurses in attendance. Seventeen participants completed the pre- and immediate post-intervention ProQOL-V assessment tool equating to 94% participation; one participant turned in both scales but did not answer every question on the assessment tool. Therefore, the data from this participant was eliminated from further analysis. Fourteen of the seventeen participants (82.3%) returned fully completed 1-month post-intervention ProQOL-V assessment tools. Ten of these fourteen participants returned fully completed 3-month post-intervention ProQOL-V assessment tool and the information provided from these ten participants was included in the final data analysis to determine the effectiveness of the intervention.

Nurse Characteristics

Upon analysis of the demographic form, all 18 original participants were found to be specialized in the area of general medical nursing. Additionally, all 18 participants were female. The age distribution of nurses was as follows: 22.22% were between the age range of 21-30 years, 27.78% were between the age range of 31-40 years, 22.22% were between the age range of 41-50 years, and 27.78% were 51 years or older. Relevant to educational background, 72.22% of nurse participants had an associate's degree and 27.78% had a bachelor's degree. The number of years in nursing practice was as follows: 38.89% had 1-5 years' experience, 22.22% had 6-10 years' experience, 11.11% had 11-20 years' experience, 11.11% had 21-25 years' experience, and 16.67% had 26 or more years' experience. Employment status within the initial 18 participating nurses was 83.33% full-time and 16.67% part-time. These characteristics for nurses who participated in compassion fatigue education can be found within Table 4.1.

Additionally, the 10 participants who completed all four ProQOL-V scales were also analyzed. The age distribution was as follows: 20% were between the age range of 21-30 years, 30% between the age range of 31-40 years, 20% between the age range of 41-50%, and 30% were 51 or older. The educational background consisted of 90% with

an associate's degree and 10% with a bachelor's degree. The number of years in nursing experience was as follows: 40% had 1-5 years' experience, 20% had 6-10 years' experience, 20% had 11-20 years' experience, and 20% had 21-25 years' experience. The employment status consisted of 90% full-time and 10% part-time. The characteristics of the final 10 participants are shown in Table 4.1. Upon analysis of the nurse characteristics, it was determined that the 10 final participants were representative of the 18 educated participants, who were representative of the entire unit population.

Statistical analysis was conducted to determine if the group that participated in the educational session, but did not complete all four of the ProQOL-V tools differed from those that completed all of the assessment tools. The groups were remarkably similar in regards to age, gender, years in practice, employment status, and area of specialty. The level of education did vary between the two groups, 72.22% associate's degree to 90% associate's degree. Chi square analysis was undertaken to determine if this difference was statistically significant ($X^2 = 1.11$, $p = .292$). Based on these findings, it was determined that additional analysis of the remaining demographic variables was not warranted.

Changes in Outcomes

The primary outcome of this EBP project was to decrease staff nurses' levels of compassion fatigue by educating participants about signs and symptoms of compassion fatigue and discussing coping strategies. A secondary outcome focused on increasing compassion satisfaction by raising awareness about compassion fatigue through an education presentation. Other outcomes of interest pertained to population attributes in relation to the level of compassion fatigue. For example, were older nurses more likely to experience compassion fatigue as compared to younger nurses? Were nurses with greater years' of experience more likely to suffer from compassion fatigue? Did educational background affect the level of compassion fatigue? And finally, did

employment status (i.e., full-time, part-time, or prn) affect the level of compassion fatigue?

Statistical Testing and Significance

Repeated measures ANOVA was used to compare differences in compassion fatigue pre-intervention, immediate post-intervention, as well as 1-month and 3-months post intervention. All statistical analyses were completed with SPSS 18.0 software and Microsoft Excel. The data from the ProQOL-V assessment tool was analyzed utilizing cumulative totals as well as subclasses via individual items within the tool itself. Statistical significance for all analyses was established as $p < .05$.

Participant responses were evaluated by a mean total ProQOL-V score of each subscale (i.e., compassion satisfaction, burnout, and secondary traumatic stress [compassion fatigue]). Within the ProQOL-V, the cumulative score for *compassion satisfaction* is computed by the sum of items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30. The cumulative secondary traumatic stress score is computed by the sum of items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28.

For this EBP project, the repeated measures ANOVA for compassion satisfaction was determined *not* to be statistically significant between any of the measured four testing intervals ($p = 0.617$). The mean cumulative scores for compassion satisfaction were as follows: pre-intervention $M = 39.1$(SD 5.1); immediate post-intervention $M = 39.7$ (SD 5.4); 1-month post-intervention $M = 39.1$ (SD 4.2); and 3-month post-intervention $M = 38.4$ (SD 3.7). Each of the four testing intervals were determined to have mean cumulative scores within the average level of compassion satisfaction, which was defined as a mean score between 23 and 41.

For this EBP project, the repeated measures ANOVA score for secondary traumatic stress was determined *not* to be statistically significant ($p = 0.118$). There was, however, a pattern found related to the means of each measurement: the means tended

to decrease over time. The mean cumulative scores for compassion satisfaction were as follows: pre-intervention *M* = 20.7 (*SD* 2.0); immediate post-intervention *M* = 20.6 (*SD* 3.6); 1-month post-intervention *M* = 18.8 (*SD* 2.7); 3-month post-intervention *M* = 17.9 (*SD* 3.1). Each of the four testing intervals were determined to have mean cumulative scores within the low level of compassion fatigue, which has been defined as a mean score of 22 or less. These scores are patterned within Figure 4.1.

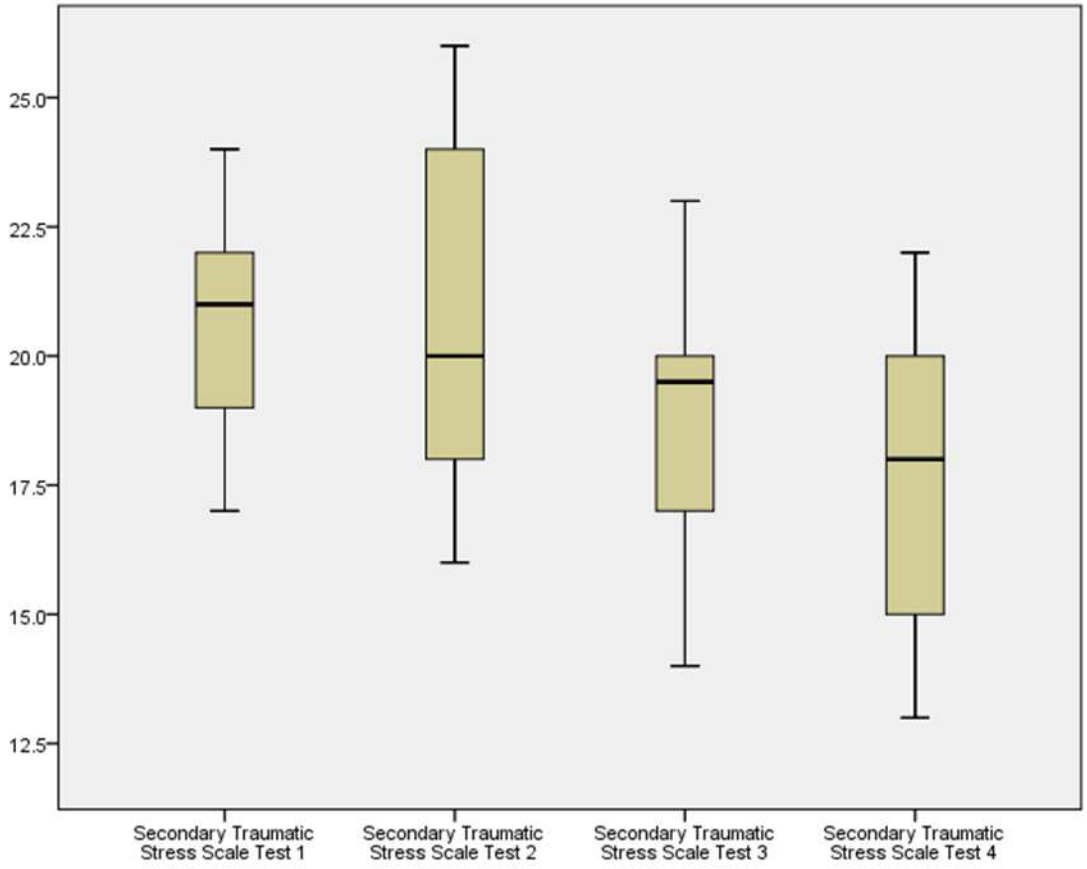
Table 4.1

Nurse Characteristics: Initial Participants vs. Final Participants

Characteristic	Frequency (*N* = *18*) Results	Frequency (*n* = 10) Results
Age		
21-30 years	4 = 22.22%	2 = 20%
31-40 years	5 = 27.78%	3 = 30%
41-50 years	4 = 22.22%	2 = 20%
51years or older	5 = 27.78%	3 = 30%
Gender		
Female	18 = 100%	10 = 100%
Education		
Associate's degree	13 = 72.22%	9 = 90%
Bachelor's degree	5 = 27.78%	1 = 10%
Practice		
1-5 years	7 = 38.89%	4 = 40%
6-10 years	4 = 22.22%	2 = 20%
11-20 years	2 = 11.11%	2 = 20%
21-25 years	2 = 11.11%	2 = 20%
26 or more years	3 = 16.67%	0 = 0%
Employment Status		
Full-time	15 = 83.33	9 = 90%
Part-time	3 = 16.67%	1 = 10%
Area of Specialty		
Medical	18 = 100%	10 = 100%

Figure 4.1

Compassion Fatigue Scores



CHAPTER 5

DISCUSSION

The purpose of this EBP project was to increase awareness about compassion fatigue symptoms and coping mechanisms through educational training for registered staff nurses in an effort to ultimately decrease levels of compassion fatigue. Additionally, it was anticipated that by increasing educational training about compassion fatigue that compassion satisfaction would also be increased. The compelling clinical question to be answered by this EBP project was: For registered nurses working on the medical-surgical unit at Hospital X, will providing educational measures about compassion fatigue by identifying risk factors, symptoms, and coping strategies, as compared to current practice, decrease the level of compassion fatigue that is experienced by staff nurses over a three-month period?

Explanation of Findings

For this EBP project, data collection took place at four intervals including pre-intervention, immediate post-intervention, 1-month post intervention, and 3-months post intervention. Data analysis was conducted utilizing SPSS 18.0 software and Microsoft Excel. Extracted data included overall level of significance for each ProQOL-V subscale (i.e., compassion satisfaction, burnout, and secondary traumatic stress), standard deviation, and mean score for each subscale at each measurement interval.

The primary outcome was related to the overall level of compassion fatigue. Stamm (2010) identified the average score for secondary traumatic stress as 50. For this EBP project, the average baseline score was 20.7. These results are well below the norm. It was anticipated that by providing the educational training, the participants would demonstrate decreased levels of compassion fatigue overtime. While the data did not achieve statistical significance ($p = 0.118$), mean scores showed a patterned decrease

at each measurement interval. As such, the primary outcome for this EBP project was successfully achieved. Factors that may have potentially impacted the inability to achieve statistical significance include a small sample size (n = 10), the variability in developing the education training PowerPoint, and the length of the training (i.e., 30 minutes). Therefore, it is recommended that future projects incorporate larger sample sizes that would incorporate various specialties and work shifts. Additionally, a more variable population group would be beneficial (i.e., inclusion of males and more diverse educational preparation).

Further goals for the primary outcome included a categorical improvement of compassion fatigue by one level as determined by the ProQOL-V rating system. The mean scores of participants were determined to be within the low risk category. As such, a categorical improvement could not be achieved because mean scores were already in the lowest possible category. These results were not anticipated due to that fact that engagement survey data demonstrated a moderate level of disagreement in receiving assistance for stress and burnout. This could possibly be attributed to the fact that engagement survey data was filtered for nurses within the entire hospital and not solely the target unit. These results may be different within other patient care units.

Secondary outcomes included analyses for compassion satisfaction and demographic variables. Stamm (2010) identified the average score for compassion satisfaction as 50. For this EBP project, the average score for compassion satisfaction at baseline was 39.1. This may be attributed to participants deriving satisfaction from other areas of their life and not necessarily from their job. Compassion satisfaction scores improved immediately post-intervention but then decreased to baseline by 1-month post-intervention and dipped below the baseline by 3-months post-intervention. As such, compassion satisfaction did not improve with the educational training. These results indicated that there was not an inverse relationship between compassion fatigue and

compassion satisfaction among this population. The compassion satisfaction trends in this EBP project do not follow the same patterns found within the literature. The baseline scores, however, were in the average category at each measurement interval and did not drop into the low category.

Secondary analyses for statistical significance of demographic variables in relation to compassion fatigue could not be calculated due to the small sample size (n = 10). However, based on the descriptive statistics of nurse characteristics, it was determined that the 10 final participants were representative of the 18 educated participants, who were representative of the entire unit population. The majority (90%) of participants had an associate's degree and were employed full-time. Results were equally distributed among age ranges; so, no conclusions could be drawn about a younger or older nurse population. As far as years of experience, a slight majority (40%) was found in the 1-5 years range. Despite equal age distribution, it appears that these participants were novice nurses in regard to years of experience.

One of the goals for the EBP project was that 50% of the 23 potential nurses would participate in the educational training about compassion fatigue. Five educational sessions were offered on different days and times to capture both day shift and night shift nurses. Eighteen nurses participated in the training, which was an initial participation rate of 78.2%. Other goals consisted of the ProQOL-V return rated from participants. Immediate post-intervention, I was the hope that 100% of participants would return the ProQOL-V, since these were collected before participants left the break room. The project manager did collect 100% of ProQOL-V scales; however, only 17 were fully completed. This particular goal would be reworded in the future to have 100% immediate post-interventions scales fully completed. For 1-month post-intervention ProQOL-V scales, it was the hope that 80% would be returned. After eliminating the partially completed scale, 14 out of 17 participants returned the ProQOL-V scale, a return rate of

82.3%. For 3-month post-intervention ProQOL-V scales, it was the hope that 75% would be returned. After adjusting for 3 unreturned scales, 10 out of 14 participants returned the ProQOL-V scale, a return rate of 71.4%. The overall attrition rate was calculated as 10 out of 18 participants, which resulted in 44.5%. Data collection efforts could have incorporated a reward for the return of completed ProQOL-V scales, such as a snack for coupon for the hospital cafeteria. This may have motivated more participants to return the completed data collection forms.

Applicability of the Theoretical Framework

Jean Watson's Theory of Transpersonal Caring was chosen as the theoretical framework for this EBP project. Watson's model has explained the unique work that nurses have within healthcare. According to Watson, "It is when we include caring and love in our work and in our life that we discover and affirm that nursing, like teaching, is more than just a job; it is also a life-giving and life-receiving career for a lifetime of growth and learning" (Watson & Woodward, 2010, p. 354).

Fit to the theoretical framework. Watson's Theory of Transpersonal Caring appropriately correlated with this EBP project, because repetitive exposure to transpersonal experiences with traumatic patient situations may begin the cascade of events leading to compassion fatigue. While Watson's theory has described a transcending experience for both nurse and patient (when a piece of one another is shared), modern conditions in healthcare limit the time available to develop this relationship. The greater acuity of patients and the higher nurse to patient ratios potentially affect the ability to apply the caritas processes of Watson's theory.

Often nurses are exposed to trauma, death, and the abusive experiences in which patients have endured. These situations can be detrimental for nurses in the absence of coping mechanisms or adequate education. The caritas processes within Watson's theory can assist the nurses to view the patient beyond the external mask of

disease, trauma, or abuse. The caritas processes can also assist nurses to consciously seek transpersonal caring opportunities in conjunction with proper education about compassion fatigue, which can elevate the nurse-patient relationship to one that is beneficial for both parties.

Resiliency strategies that were incorporated into the educational training captured themes from Watson's caritas processes. The focus of cultivating a positive nurse-patient relationship by recognizing and accepting both the nurse's and the patient's positives and negatives whereby using problem-solving to deepen the understanding of the caring relationship. This creates a supportive environment that each can learn and grow from, eliminating dominance. The themes of resiliency strategies included self-care and revitalization, connection and support, perceptual maturation and self-validation, intentionality, and self-regulation (Flarity et al., 2013; Gentry, Baranowsky, & Dunning, 2002; Watson & Woodward, 2010).

Strengths and limitations of theoretical framework. The incorporation of the Theory of Transpersonal Caring included both strengths and limitations. The inclusion of caritas processes guided the resiliency strategies proposed in the educational training. Additionally, the target facility utilized the Theory of Transpersonal Caring as the guiding theory for their hospital mission. As such, nurses were familiar with theory constructs of the caritas processes. But, the complexity of language within the theory was a limitation for this EBP project. Newer nurses had difficulty envisioning the transcending nurse-patient interaction, which could have been expected as most novice nurses begin as task-oriented.

Applicability of the EBP Model

The Model for Evidence-Based Practice Change was chosen as the EBP model to guide this project. The model uses six steps to guide clinicians in the pursuit of practice change: (a) assess the need for change in practice, (b) locate the best

evidence, (c) critically analyze the evidence, (d) design practice change, (e) implement and evaluate change in practice, and (f) integrate and maintain change in practice (Ciliska et al., 2011). By incorporating this model, clinicians can methodically complete evidence based practice change within practice.

Strengths and Limitations of the EBP model. The revised model equally divided the tasks among the six steps; therefore, no one step was too monumental to complete. This benefit was determined to be especially useful for the novice clinician. Additionally, the team based approach was essential in the development stages. The final step in the model, integration and maintenance of practice change, had a limitation for the project manager. The project manager presented best practice data and outcome data to key stakeholders of the target facility. However, the decision to adopt or reject the practice change was determined by the target facility, which was not in the control of the project manager.

Strengths, Limitations, and Modifications of the EBP Project

Upon evaluation, it was determined that the overall project had both strengths and limitations. It is essential that future project incorporate changes to enhance the overall body of knowledge about compassion fatigue for staff nurses. As Neville and Cole (2013) opined, “addressing compassion fatigue is a strategic imperative in the future to ensure the nursing workforce is resilient as changes and the resulting increasing levels of stress continue to occur” (p. 354)

During the location of best evidence phase, an identified limitation was that articles were determined to be lower levels of evidence. Randomized control trials were not available for review. Much of the supporting evidence for this EBP project was derived from expert opinions. Additionally, the educational designs in the various studies were quite different. One study incorporated a keynote speaker for one 8-hour session while another incorporated 5 weeks of educational training (Potter, Deshields, Berger, et

al., 2013; Potter, Deshields, & Rodriguez, 2013). The shortest intervention was one 4-hour session (Flarity et al., 2013). Therefore, the design of the practice change was developed based on the input of target facility stakeholders because the literature was not very prescriptive. The content of the educational intervention was thoroughly described in only one of the studies (Flarity et al., 2013). The two other studies incorporated compassion fatigue education as developed by Dr. Eric Gentry and Dr. Anna Baranowsky. Drs. Gentry and Baranowky's content, as well as content from other experts, was incorporated into the educational PowerPoint developed by the project manager. A protocol developed by the project manager introduced a degree of variability to the successfulness of outcomes. The educational session was only 30 minutes at change of shift. This was determined to be the best option in order to have more participants. Nurses were not willing to attend education without pay. The facility IRB did not support paying nurses any overtime for a longer educational session. Modifications were made to the PowerPoint due to time constraints. The viewing of a YouTube video by Dr. Anna Baranowsky was omitted, but summarized for participants, to allow more interactive time for deep breathing exercises. A longer educational intervention may have potentially resulted in a greater impact on compassion fatigue and impacted compassion satisfaction, findings which were noted in the literature.

If this EBP project were repeated, modifications would include a longer education session and repeated sessions with a greater number of participants. If financial support from the institution was available, the educational intervention would be offered on days when nurses were not scheduled to work on the patient care unit. The demographic tool would also be modified to include the participant's designated shift (i.e., day shift or night shift).

Unforeseen circumstances that may have impacted results included (a) the facility implementation of new discharge processes and (b) an increased number of

cardiac arrest codes on the target unit in the months of December and January. The discharge process changes were discussed with the nurses from various units of the hospital during the months of the planning stages of this EBP project; however, these changes were actually implemented during the same months of this EBP project implementation. The new discharge processes created greater time constraints on nurses for documentation and some instances required extra phone calls to physicians. Physicians had expressed frustration with the increased pages and oftentimes were not as helpful as needed toward the nursing staff. Therefore, tension on the unit increased. The other factor potentially impacting project results was an unavoidable change in patient acuity. The flu season in December and January brought an increased number of cardiac arrest codes on the medical-surgical unit at Hospital X. These situations exposed nurses to trauma, and the greater number of respiratory isolations of the unit caused delays while performing patient care.

Implications for the Future

Practice. APNs assimilate the following roles within practice: educator, leader, consultant, clinician, and researcher. This EBP project assisted the project manager in the further development of each of these roles and can offer similar experiences for future projects about compassion fatigue. As leader, APNs can prioritize organizational needs within institutions as well as patient care needs. These activities allow for leadership opportunities and ensure the time is best spent in areas of need for the betterment of an institution. As consultant, APNs have educational background regarding EBP and oftentimes have implemented the steps for practice change. APNs can share these experiences with others as well as provide recommendations for future modification that will enhance the outcomes of the practice change. As clinician, APNs understand the importance of utilizing EBP standards for patient care. For this EBP

project, the focus was providing compassion fatigue education for nurses with a goal of decreasing compassion fatigue, which can impact the nursing care provided to patients.

Theory. Theory expansion in regard to compassion fatigue is essential in developing specific educational interventions that will impact the nurse in each area of the ProQOL-V tool: compassion satisfaction, burnout, and compassion fatigue. Educational strategies should be developed based on the needs of the target nurse population. Theoretically, specific events on patient care units should be recognized as impacting one of the categorized areas. This will identify if all nurses should receive the same education or should education be individualized to the type of patient care unit.

Research. As researcher, APNs can locate and identify reputable evidence to use as the basis for practice change. Additionally, APNs understand the importance of creating a strong base for research by incorporating a theoretical and evidence-based model to guide the planning and implementation of practice change. This EBP project contributed to the body of knowledge for current compassion fatigue education strategies for nurses. Future work should include larger samples and longer, or even repeated, education sessions. Additionally, future research should focus on the contents of the educational session to provide continuity among various studies. For the project, lower levels of evidence, mainly expert opinions, were utilized in the development of the intervention. The limited availability of higher level evidence supports the need for additional research.

Education. Nursing programs are focused on preparing nurses to care for the complex needs of patients, but nursing students learn strategies for leadership as well. Still, little is known about the incorporation of compassion fatigue in nursing program curricula. It is essential that new nurses have the resources and knowledge to adequately cope with disturbing patient situations. By doing so, nurses are able to continually provide effective patient care without experiencing detrimental psychological

effects. As educator, APNs are experienced with providing organized education to groups or individuals (e.g., patients and colleagues) and can be instrumental in providing coping strategies for bedside nursing. After all, the goal of healthcare is to provide high quality care for patients, and healthcare workers must establish a healthy team-based approach to ensure this goal is achieved.

Conclusion

The purpose of this EBP project was to answer the following question: for registered nurses working on the medical-surgical unit at Hospital X, will providing educational measures about compassion fatigue by identifying risk factors, symptoms, and coping strategies, as compared to current practice, decrease the level of compassion fatigue that is experienced by staff nurses over a three-month period? Data analysis demonstrated a patterned decrease in compassion fatigue among participating nurses, even if this change was not to a statistically significant level. Although this EBP project contributed to the current body of knowledge about compassion fatigue, future research is warranted. Higher levels of evidence are needed to gain better insight to the contents of educational measures and the length of the teaching intervention.

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BIOGRAPHICAL MATERIAL

Kathryn L. Zehr

Katie graduated from Saint Joseph's College with a Bachelor of Science in Nursing in December 2009. She began her nursing career by working on a rehabilitation unit at an extended care facility for two years after graduation. Upon acceptance into Valparaiso's DNP program, she sought for acute care nursing experience. She then began working on a busy medical/surgical unit at a level II trauma center in Northcentral Indiana. She has served as a mentor, clinical coach, and was most recently promoted to the role of charge nurse. She has received a peer nominated R.I.C.E. award. Katie's fellow nursing staff nominated her for this unit-based award that recognizes individual nurses who demonstrate the attributes of respect, integrity, compassion, and excellence. Katie demonstrates these traits in her role as charge nurse where she has been exposed to fellow nurses who experience emotional difficulties, frustrations, and burnout. These experiences sparked her interest in the topic of nursing compassion fatigue, which she has chosen as her evidence based practice project. Katie is a member of AANP and a recipient of the Gerke Scholar Award. As part of her coursework at VU, Katie participated in international studies during a CONHP trip to Chile. After receiving her Doctorate of Nursing Practice, Katie desires to focus her career on the care of the acutely ill adult within an inpatient setting. She recently accepted a position within the Hospitalist program at her current place of employment.

ACRONYM LIST

APN: Advanced Practice Nurse

ASR: Administrative Services Representative

CF: Compassion Fatigue

CNO: Chief Nursing Officer

EBP: Evidence-Based Practice

NIH: National Institutes of Health

IRB: Institutional Review Board

PICOT: Population, Intervention, Comparison, Outcome, Time

ProQOL-V: Professional Quality of Life Scale version V

SR: Systematic Review

Appendix A

Summary of Appraised Literature

Author (s) & Level of Evidence	**Design & Sample**	**Purpose, Intervention, & Outcomes**
Beck (2011) Level V	SR 7 studies- (1) Qualitative & (6) Quantitative	· Clinical question: Is there a cost of caring for healthcare providers of traumatized patients? · Study populations included the following nurse specialties: oncology, pediatric, intensive care, sexual assault nurse examiners, hospice, and emergency department. · Instruments included Secondary Traumatic Stress Scale (STSS), Compassion Fatigue Self-Test for Helpers (CFST), and Compassion Fatigue Scale-Revised (CFS-R). · Secondary traumatic stress is prevalent among various nurse specialties and ranged from 25% in forensic nurses to 78% in hospice nurses. · Nurses need education about vulnerability to compassion fatigue, risk factors, signs & symptoms, and coping strategies. · Continuing education should be instituted.
Boyle (2011) Level VII	Expert Opinion Based on 19 articles within the literature.	· Instruments included CFS-R, STSS, ProQOL. · Contemporary description of compassion fatigue is introduced. Risk factors are identified. · Interventions include 3 categories- work/life balance (7 articles), education (2 articles), and work setting interventions (10 articles).

Cincinnati Children's Hospital Medical Center (2013) Level VII	Clinical Practice Guideline Based on 4 expert opinions	· The purpose of the guideline was to evaluate, among pediatric intensive care nurses, if functional knowledge of compassion fatigue and the practice of self-care skills, compared to not, demonstrates less compassion fatigue. · The experts recommended compassion fatigue training, including the functional knowledge and the practice of self-care skills. · Peer reviewed guideline authored by two registered nurses with advanced education and certified in pediatric care.
Flarity et al. (2013) Level III	Quasi-Experimental Study Convenience sample; 73 emergency room nurses	· ProQOL-V scale utilized · 4 hour group seminar provided compassion fatigue origin, signs and symptoms, prevention and treatment utilizing multimedia resources. · Pre-intervention, 59.3% (n = 35) of participants scored at moderate to high risk levels for secondary traumatic stress and 57.6% (n = 34) scored at moderate to high levels of burnout. · Post-intervention, only 40.7% (n = 24) scored at moderate to high levels of secondary traumatic stress and only 23.7% (n = 14) scored at moderate to high levels of burnout, improvements of 18.6 and 33.9 percentage points. · Increase in compassion satisfaction (p = .004), decrease in burnout (p = .001), and decrease in secondary traumatic stress (p = 0.001).

Hodge & Lockwood (2013) Level VII	Expert Opinion SR proposal to include both quantitative & qualitative studies.	· Clinical question: Can structured interventions implemented by nurse leaders decrease compassion fatigue among healthcare providers? · Background and symptoms of compassion fatigue were discussed. · The experts identified the most effective intervention as focused education to increase the awareness of compassion fatigue, specifically the risks, causes, signs for early detection and available resources to combat the detrimental effects of compassion fatigue should be considered with caregiver population.
Potter…Chen, (2013) Level III	Quasi-Experimental Study 13 oncology nurses	· Instruments utilized included ProQOL-IV, Maslach Burnout Inventory, Impact Event Scale-Revised, Nursing Job Satisfaction scale. · Nurses attended five 90-minute education sessions about compassion fatigue. · Data collection took place pre-intervention, immediate post-intervention, 3-month post-intervention, and 6-month post-intervention. · Results demonstrated a reduction of secondary traumatic stress with a mean score pre-intervention of 19.76 and mean score of 16.23 6-month post-intervention (p = .044).

Potter, Deshields, & Rodriguez, (2013) Level III	Quasi-Experimental Study 389 staff members from various nursing specialties	· The instrument utilized was the ProQOL R-IV. · One 8-hour educational session about compassion fatigue was implemented. · Data collection took place pre-intervention and 3-month post-intervention. · Pre-intervention, 38.3% of participants were determined to be at high risk for secondary traumatic stress and 48.1% were determined to be at high risk for burnout. Improvements were noted for burnout (23.5%, $p < 0.01$) and secondary traumatic stress (21.2%, $p < 0.01$) 3-month post-intervention.
Slatten et al. (2011) Level VII	Expert Opinion Target audience was nurse managers for recognizing CF in nursing staff.	· Instruments included ProQOL & CFST · Experts differentiated between CF and burnout; signs and symptoms identified. · Coping strategies included diversifying caseload mix, offering compassion fatigue education/training, maintaining professional distance, and supporting employee development.

Appendix B

Demographic Form for Compassion Fatigue Training

Instructions:
1. Please answer all demographic questions.
2. All data obtained from this demographic questionnaire will remain confidential and will be used solely for the purpose of this EBP project.

1. Age (please choose only one)
a. 21-30
b. 31-40
c. 41-50
d. 50-over

2. Gender (please chose only one)
a. Female
b. Male

3. Highest level of education (please chose only one)
a. Nursing Diploma
b. Associate's degree
c. Bachelor's degree
d. Master's degree
e. Doctorate degree

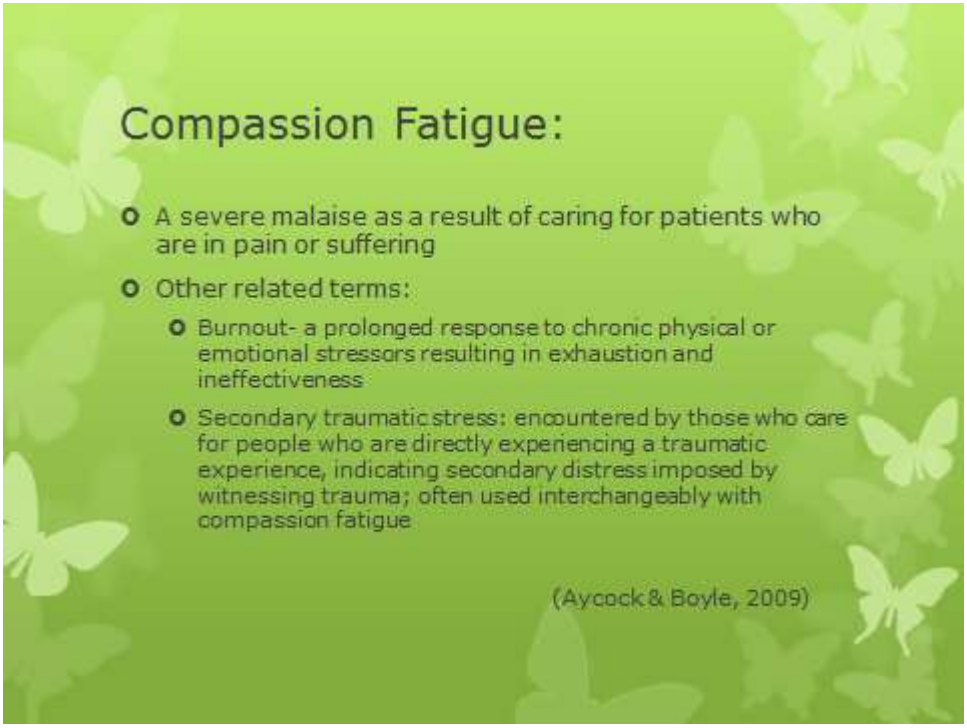
4. Number of years in practice (please chose only one)
a. 1-5 years
b. 6-10 years
c. 11-20 years
d. 21-25 years
e. 26 or more years

5. Current employment status (please chose only one)
a. Full-time
b. Part-time
c. PRN (as needed)

6. Area of specialty (optional)
a. Medical
b. Surgical
c. Oncology
d. Resource

Appendix C

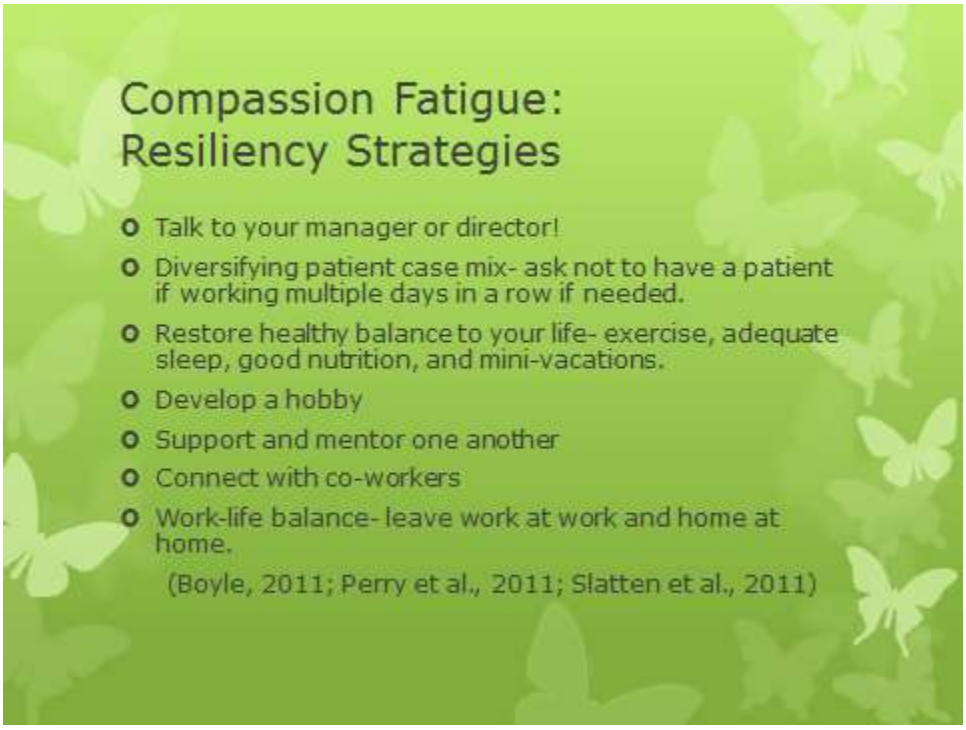
Compassion Fatigue Education Power Point

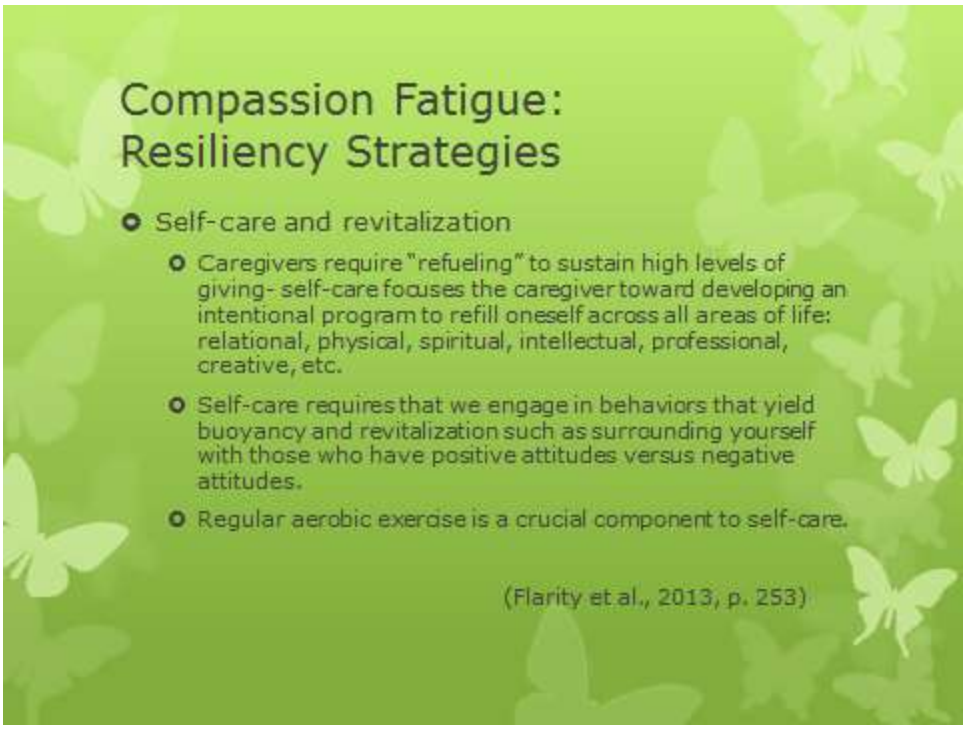


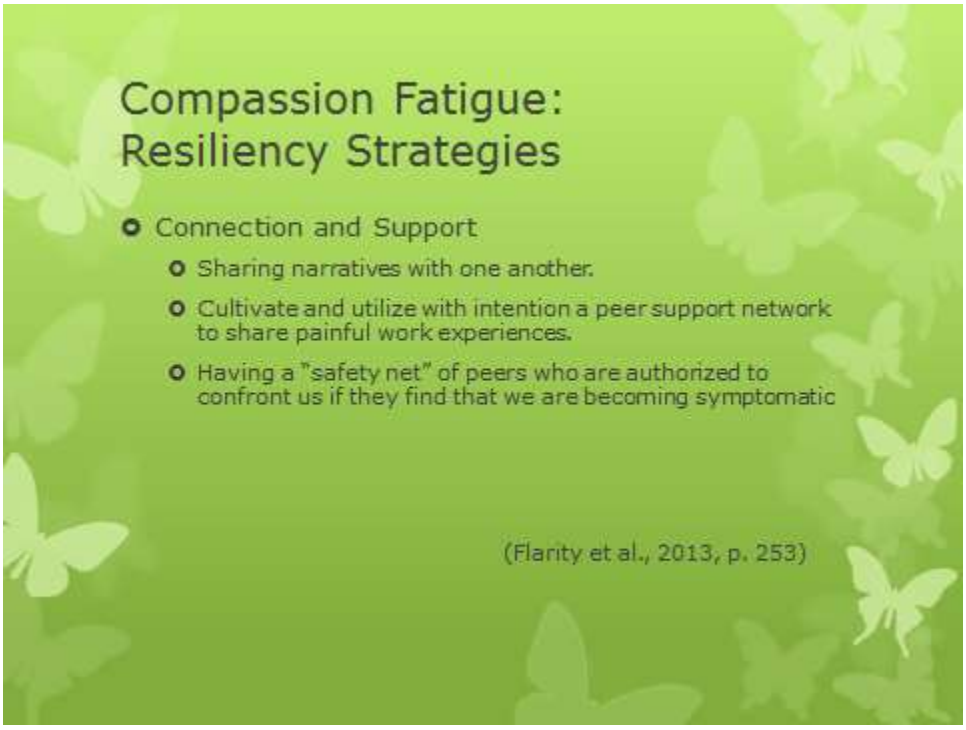

Compassion Fatigue: Background
Compassion fatigue has been discussed in literature for 20 years!
Dynamic healthcare environment.
Complex patient care.
Natural consequence of caring.
Fine line between not enough compassion and too much compassion?
"Nurses are expected to be compassionate in their work. It is part of the role requirement for which they are being paid. If they perform poorly in their compassionate role, they receive patient complaints. On the other hand, those who are overly responsive in their compassionate role may experience negative consequences if they are spending too much time with traumatized patients" (Slatten et al., 2011, p. 326).

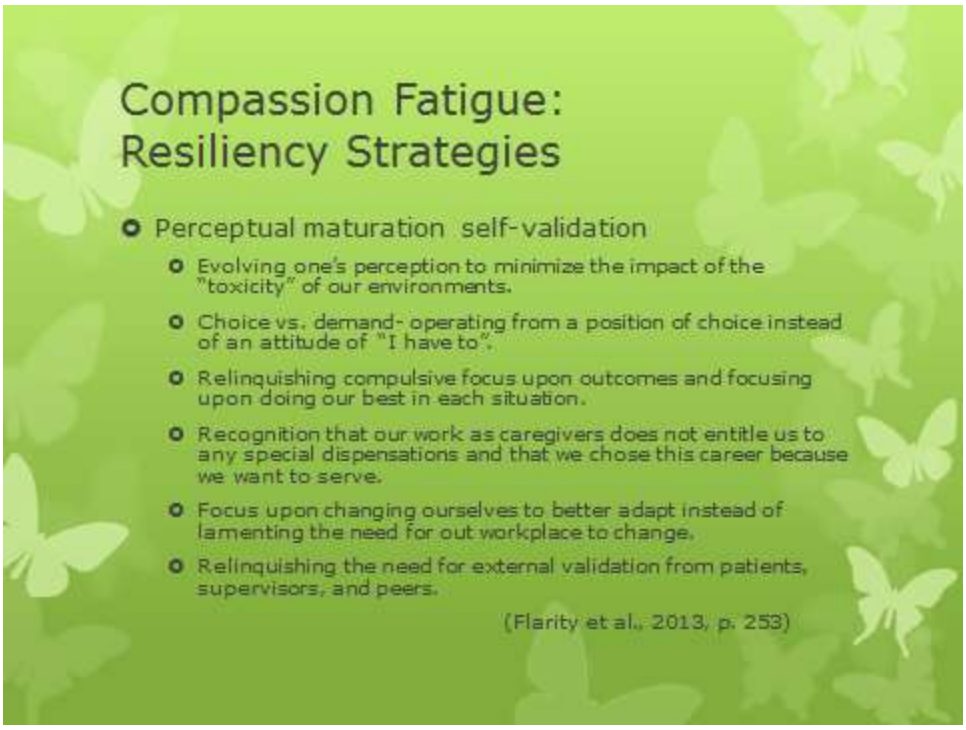

Compassion Fatigue: Risk Factors
Exposure to patient situations that include:
Trauma (life-threatening situations or urgent situations)
Abuse
Chronic disease
Pain
Suffering
Home environment of the patient
Death
(Boyle, 2011; Hodge & Lockwood, 2013; Slatten et al., 2011)

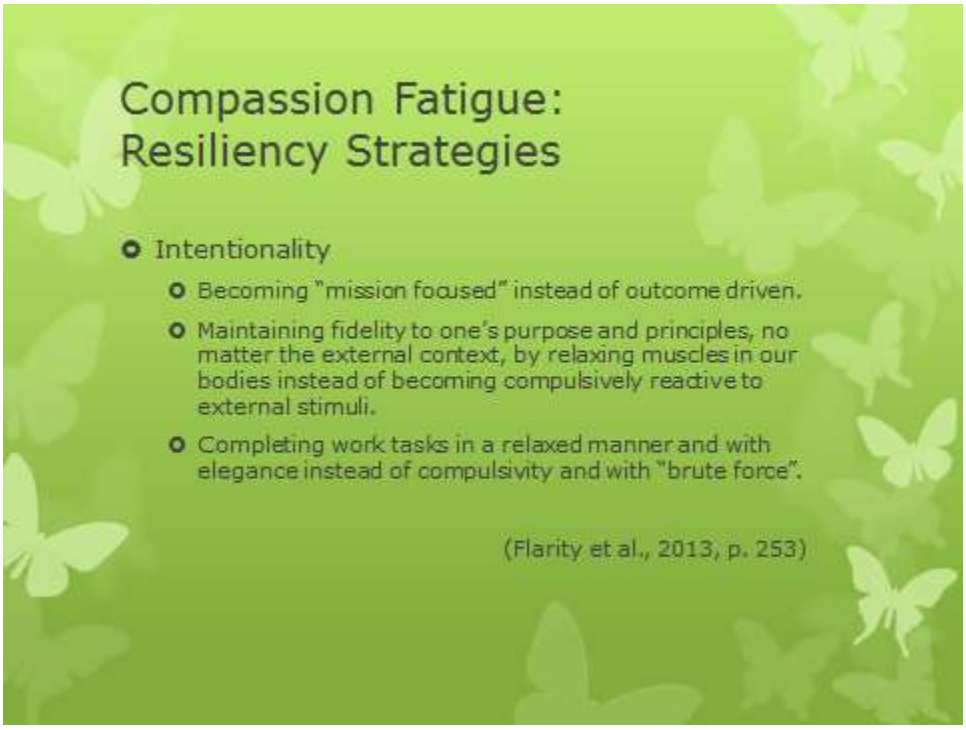

Compassion Fatigue:
Signs & Symptoms
Emotional: anger, apathy, cynicism, desensitization, feeling overwhelmed, irritability, decreased enthusiasm, and sarcasm.
Intellectual: boredom, inability to concentrate, decreased attention to detail.
Physical: increased somatic complaints, lack of energy, fatigue, loss of strength, and prone to accidents.
Social: isolation, loss of interest in hobbies, withdrawal from family.
Spiritual: lack of spiritual awareness.
Work: tardiness, absenteeism, desire to quit, diminished performance (i.e. increase in medication errors, decrease in accuracy)
(Boyle, 2011)

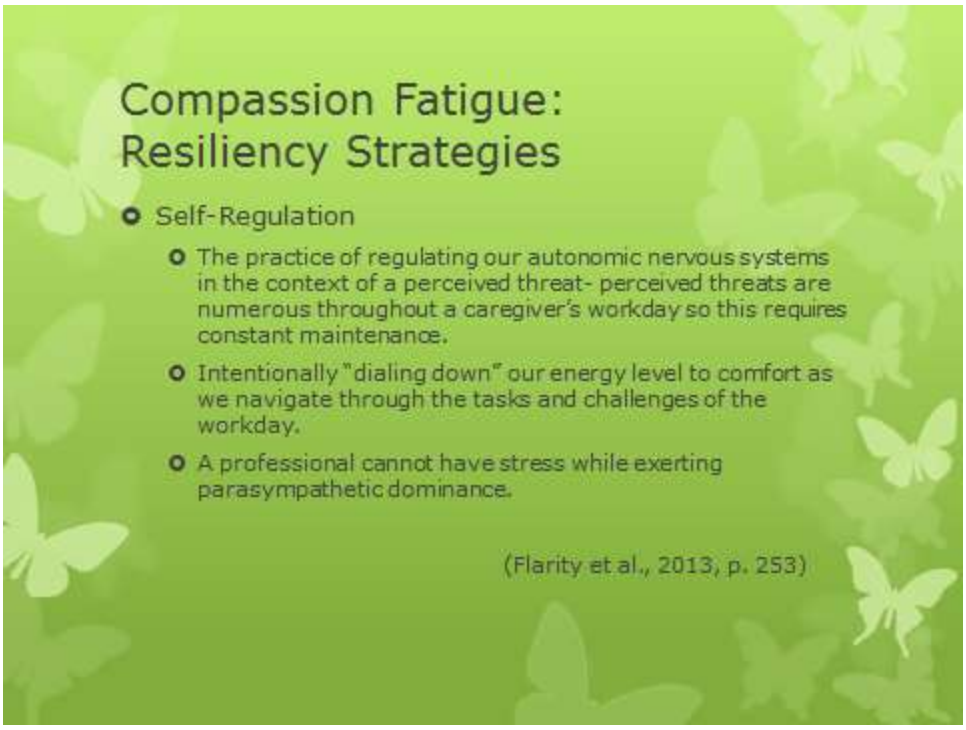

Compassion Fatigue:
Resiliency Strategies
Talk to your manager or director!
Diversifying patient case mix- ask not to have a patient if working multiple days in a row if needed.
Restore healthy balance to your life- exercise, adequate sleep, good nutrition, and mini-vacations.
Develop a hobby
Support and mentor one another
Connect with co-workers
Work-life balance- leave work at work and home at home.
(Boyle, 2011; Perry et al., 2011; Slatten et al., 2011)


Compassion Fatigue:
Resiliency Strategies
Self-care and revitalization
Caregivers require "refueling" to sustain high levels of giving- self-care focuses the caregiver toward developing an intentional program to refill oneself across all areas of life: relational, physical, spiritual, intellectual, professional, creative, etc.
Self-care requires that we engage in behaviors that yield buoyancy and revitalization such as surrounding yourself with those who have positive attitudes versus negative attitudes.
Regular aerobic exercise is a crucial component to self-care.
(Flarity et al., 2013, p. 253)


Compassion Fatigue:
Resiliency Strategies
Connection and Support
Sharing narratives with one another.
Cultivate and utilize with intention a peer support network to share painful work experiences.
Having a "safety net" of peers who are authorized to confront us if they find that we are becoming symptomatic
(Flarity et al., 2013, p. 253)


Compassion Fatigue:
Resiliency Strategies
Perceptual maturation self-validation
Evolving one's perception to minimize the impact of the "toxicity" of our environments.
Choice vs. demand- operating from a position of choice instead of an attitude of "I have to".
Relinquishing compulsive focus upon outcomes and focusing upon doing our best in each situation.
Recognition that our work as caregivers does not entitle us to any special dispensations and that we chose this career because we want to serve.
Focus upon changing ourselves to better adapt instead of lamenting the need for out workplace to change.
Relinquishing the need for external validation from patients, supervisors, and peers.
(Flarity et al., 2013, p. 253)


Compassion Fatigue:
Resiliency Strategies
Intentionality
Becoming "mission focused" instead of outcome driven.
Maintaining fidelity to one's purpose and principles, no matter the external context, by relaxing muscles in our bodies instead of becoming compulsively reactive to external stimuli.
Completing work tasks in a relaxed manner and with elegance instead of compulsivity and with "brute force".
(Flarity et al., 2013, p. 253)


Compassion Fatigue:
Resiliency Strategies
Self-Regulation
The practice of regulating our autonomic nervous systems in the context of a perceived threat- perceived threats are numerous throughout a caregiver's workday so this requires constant maintenance.
Intentionally "dialing down" our energy level to comfort as we navigate through the tasks and challenges of the workday.
A professional cannot have stress while exerting parasympathetic dominance.
(Flarity et al., 2013, p. 253)


Compassion Fatigue:
Resiliency Strategies
https://www.youtube.com/watch?v=lR0cV9vOIRM
3-6 Breathing: The Window into the Nervous System
by Anna Baranowsky, CEO, Traumatology Institute

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Appendix D

Compassion Fatigue Education Informed Consent Form

Study Title: The Effect of Education on Compassion Fatigue as Experienced by Staff Nurses.

Researcher: Kathryn (Katie) Zehr BSN, RN, DNP student, Valparaiso University

Purpose: I, _____, understand that I am being asked to take part in an educational intervention project to measure the effect of education on compassion fatigue as experienced by staff nurses.

Procedure: The participants of this evidence-based practice project will complete a pre-test questionnaire measuring the baseline compassion fatigue (i.e. secondary traumatic stress), burnout, and compassion satisfaction of participants and a demographic form; a Power Point presentation about compassion fatigue will be presented by the principal investigator; the PowerPoint will address the phenomena of compassion fatigue including definitions, risk factors, and resiliency strategies; a post-test questionnaire will then be completed immediately, one month, and three months after the educational intervention. The educational intervention will take approximately 45 minutes to complete.

Risks & Benefits: There are no physical or other known risks to participating in the project. There are no invasive techniques used. Participants in the project will be engaging in educational teaching about compassion fatigue and thus are expected to increase their knowledge about compassion fatigue. This may result in a sense of greater job satisfaction and personal enrichment, and in turn promote better patient care.

Costs: Participants will not be compensated in overtime pay for their participation.

Voluntary participation & Confidentiality: I understand that participating in this project is my choice, and I am free to stop at any time. Although the information and answers I give may be used and reported by the principal investigator, my name and other facts that would identify me will be kept strictly confidential. Participation in this study will not affect my employment or my relationship with my employer.

Questions: If I have any questions about being in the project/study now or in the future, Katie Zehr may be contacted at 574-344-3741 or kathryn.zehr@valpo.edu. If I have any questions about my rights as a project participant, Alicia Dombkowski, Chairman of the Institutional Review Board at Memorial Hospital of South Bend, may be contacted at 647-7390.

Consent to participate in the research study: I have read all of the above information about this project and I understand the information therein. All of my questions have been answered and I have received a copy of this consent form. I give my consent freely, and offer to participate in this project.

_____	_____	_____
Participant's signature	Participant (printed)	Date

_____

Principal Investigator's signature

Appendix E

Professional Quality of Life Scale

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

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

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.