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## Staff Education to Reduce Compassion Fatigue in Acute Care Staff Nurses

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# Walden University

College of Nursing

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Kamala C. McGee

has been found to be complete and satisfactory in all respects,  
and that any and all revisions required by  
the review committee have been made.

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2026

Executive Summary: Staff Education Project  
Staff Education to Reduce Compassion Fatigue in Acute Care Staff Nurses

by

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Executive Summary Submitted in Partial Fulfillment  
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## Summary

Compassion fatigue (CF), burnout, and moral distress are common in high-acuity nursing environments, yet nurses are rarely taught how to recognize or manage these challenges. The guiding question for this staff education project was about whether education focused on CF and mindfulness-based coping strategies would improve nurses' knowledge and attitudes in an acute care VA medical center.

Posteducation results ( $n = 20$ ) showed meaningful, statistically significant improvements. Familiarity with CF increased from baseline ( $M = 2.35$ ;  $SD = 1.04$ ) to postimplementation ( $M = 3.75$ ;  $SD = .91$ ),  $t(19) = -5.085$ ,  $p < .001$ . Confidence in recognizing CF in oneself improved from baseline ( $M = 2.6$ ;  $SD = .875$ ) to postimplementation ( $M = 3.60$ ;  $SD = .821$ ),  $p = .004$ . Confidence in recognizing CF in colleagues increased from baseline ( $M = 2.40$ ;  $SD = .821$ ) to postimplementation ( $M = 3.15$ ;  $SD = .671$ ),  $p = .012$ . Agreement that seeking help is a sign of weakness decreased from baseline ( $M = 2.00$ ;  $SD = .503$ ) to postimplementation ( $M = 1.40$ ;  $SD = .951$ ),  $p = .024$ . Although perceptions of organizational support did not change, nurses reported greater use of mindfulness, peer support, and boundary setting, supporting nurse well-being and psychological safety.

Several recommendations emerge from this project. CF education should be integrated into routine staff development, annual competencies, and onboarding for new nurses. By reducing stigma around seeking help and promoting peer awareness, this work supports fostering a workplace culture where all nurses feel safe, supported, and valued, a positive social change.

## **Background**

CF, burnout, and moral distress are increasingly recognized as significant occupational hazards for nurses practicing in acute and high-acuity care environments, particularly within Veterans Affairs (VA) healthcare settings where exposure to trauma, complex moral situations, and emotionally demanding patient care is routine (Cocker & Joss, 2016; El-Ashry et al., 2023; Pan et al., 2025). Nurses frequently encounter cumulative psychological stressors that erode empathy, professional engagement, and emotional resilience over time (Abou Hashish & Ghanem-Atalla, 2023; Wei et al., 2025). Qualitative evidence describes CF as a form of “emotional bruising of the soul,” where nurses experience a gradual diminishment of their capacity to connect therapeutically with patients (Gustafsson & Hemberg, 2022). Quantitative studies further demonstrate that CF is strongly associated with emotional exhaustion, decreased compassion satisfaction, increased burnout, and diminished quality of care delivery (Yu & Gui, 2022; Yin et al., 2024).

A gap remains in routine practice at the project site because nurses receive little to no formal preparation on recognizing and managing CF. This gap in practice was the reason for the development of a staff education project designed to equip VA nurses with the knowledge, skills, and attitudes necessary to recognize CF early and apply practical strategies to mitigate its effects. The practice focused question that I used to guide this project was: Will a staff education program on CF and strategies to reduce CF like the use of mindfulness improve knowledge, skills, and attitudes in VA staff nurses, ultimately reducing CF?

I conducted a systematic literature search to identify current, high-quality evidence to inform development of the staff education project. Databases searched included CINAHL Complete, PubMed/MEDLINE, PsycINFO, and Google Scholar to ensure comprehensive coverage of nursing, medical, and psychological literature related to CF. Keywords and search terms included combinations of *compassion fatigue, burnout, moral distress, nurses, acute care, critical care, emergency nursing, mindfulness, resilience, coping strategies, self-care, staff education, and leadership support*. Boolean operators (AND, OR) were used to refine the search and ensure relevance to the practice question. Inclusion criteria consisted of peer-reviewed articles published within the past 10 years, studies focused on nurses in acute or high-acuity care settings, and research examining education, mindfulness, coping, resilience, or organizational strategies to mitigate CF. Exclusion criteria included studies not involving nurses, opinion pieces without empirical support, and research conducted in non-clinical settings.

I used the Johns Hopkins Evidence-Based Practice (JH-EBP) model to appraise and grade the evidence for quality and strength (Dang et al., 2022). This process revealed consistent Level II and Level III, good-to-high quality evidence supporting structured staff education, mindfulness practices, coping skill training, and leadership involvement as effective strategies for addressing CF. The literature consistently identifies that nurses often lack formal education on recognizing, preventing, and managing CF despite its high prevalence. Abou Hashish and Ghanem-Atalla (2023) found that active coping strategies significantly reduce CF and improve professional attitudes when nurses are educated on how to employ them. Similarly, Cocker and Joss (2016) identified that

prolonged exposure to trauma without adequate organizational and educational support contributes to CF, while education, peer support, and self-care strategies improve coping behaviors and help-seeking attitudes. Additional evidence indicates that frequent exposure to high-intensity clinical events such as cardiopulmonary resuscitation increases secondary traumatic stress and CF, highlighting the need for structured debriefing and coping skill development for acute care nurses (El-Ashry et al., 2023).

Mindfulness-based and resilience-focused educational interventions have demonstrated measurable reductions in CF and improvements in nurse resilience. Delaney (2018) reported that an 8-week mindful self-compassion program significantly reduced CF while increasing resilience and emotional self-awareness among hospital nurses. Wei et al. (2025) further established that mindful self-care practices reduce CF through the mediating effect of resilience and strengthened professional identity. Organizational and leadership support were also repeatedly identified as critical components for sustainable mitigation of CF, as education alone without visible leadership engagement has limited long-term effect (Alharbi et al., 2019; Pan et al., 2025).

Thus, several key points emerged as I reviewed the research evidence. First, CF is a significant yet often understated problem that is not consistently addressed in high-acuity clinical environments such as VA hospitals, where nurses are routinely exposed to trauma, moral complexity, and emotionally demanding patient care (Cocker & Joss, 2016; El-Ashry et al., 2023; Yu & Gui, 2022). Second, the evidence clearly demonstrates that mindfulness, meditation, and self-compassion strategies are effective approaches for

reducing CF while strengthening resilience and emotional regulation among nurses (Delaney, 2018; Wei et al., 2025; Robinson et al., 2022).

Finally, the literature emphasizes that education alone is not sufficient; leadership engagement, peer support, and organizational commitment are essential to sustain the positive effects of these interventions and to create a culture where nurse well-being is openly supported and normalized (Alharbi et al.; 2019; Pan et al., 2025).

### **Staff Education Project Development**

I developed the staff education project as an evidence-based intervention directly informed by the findings reviewed and synthesized. Participants included acute care staff nurses employed within the VA healthcare setting who routinely provide care to medically complex and emotionally vulnerable patient populations. The educational intervention was designed to translate best evidence recommendations into a practical, applicable learning experience that addressed the identified gap in nurse knowledge and coping skill utilization related to CF.

The education session included four primary components derived from the literature: (a) recognition and normalization of CF and moral distress as occupational risks, (b) mindfulness and self-compassion techniques to promote emotional regulation, (c) development of active coping skills and resilience practices, and (d) structured reflection and peer discussion to reduce emotional isolation (see Appendix). Evidence from Abou Hashish and Ghanem-Atalla (2023) and Cocker and Joss (2016) guided inclusion of coping skill education and normalization of CF as a professional risk. Mindfulness and resilience content were informed by Delaney (2018) and Wei et al. (2025), whose findings demonstrated measurable reductions in CF following mindful

self-compassion and self-care interventions. The importance of peer support and debriefing opportunities was supported by El-Ashry et al. (2023) and Robinson et al. (2022), who found that structured discussion and stress-reduction education reduced secondary traumatic stress in emergency nurses.

Leadership presence during the education session was intentionally incorporated based on evidence that organizational and leadership engagement are critical for sustaining emotional well-being initiatives (Alharbi et al., 2019; Pan et al., 2025). This component reinforced psychological safety and communicated organizational commitment to nurse well-being. Educational materials included guided reflection prompts, mindfulness exercises, and practical coping strategies nurses could immediately apply in clinical practice.

Evaluation of the project included pre- and post-education assessments designed to measure changes in nurse knowledge, attitudes, and confidence related to recognizing and managing CF (see Appendix). Measures were aligned with instruments commonly cited in the literature, such as the Professional Quality of Life Scale (ProQOL), resilience scales, and self-report coping inventories identified across multiple studies used in the project. Participant feedback and self-reported applicability to practice were elements used to evaluate perceived usefulness and relevance of the intervention (see Appendix).

The education project development process ensured direct alignment between the strongest available evidence and the educational strategies delivered to participants, thereby operationalizing the best evidence recommendations identified in the Johns Hopkins synthesis into a feasible, practice-based intervention for VA nurses.

## Results

Although many more nurses participated in the training ( $N = 65$ ) there were 20 nurses who answered all of the 10 questions on the pretest which was paired to the posttest. The first question was about familiarity with the term CF, which increased from a mean score of 2.35 ( $SD = 1.04$ ) to 3.75 ( $SD = 0.910$ ). This was a statistically significant improvement ( $t(19) = -5.085, p < .001$ ).

Confidence in recognizing early signs of CF in oneself increased from  $M = 2.65$  ( $SD = .875$ ) to  $M = 3.60$  ( $SD = .821$ ), and this change was statistically significant,  $t(19) = -3.226, p = .004$ . This means the improvement was unlikely due to chance and reflects a real increase in nurses' ability to identify symptoms of CF in their own experiences.

Similarly, confidence in recognizing CF in colleagues increased from  $M = 2.40$  ( $SD = .821$ ) to  $M = 3.15$  ( $SD = .671$ ), which was also statistically significant,  $t(19) = -2.775, p = .012$ . This indicates that nurses not only became more aware of their own emotional state but also more attuned to signs of distress within their team.

The significance of these results is that the education moved nurses beyond simply knowing what CF is. It improved their practical ability to recognize it in real time, both personally and among peers. This level of awareness is critical for early intervention, peer support, and fostering a culture where emotional well-being is acknowledged and addressed in the clinical environment.

Agreement that CF is a normal and expected risk in caregiving slightly decreased from  $M = 3.45$  ( $SD = 1.05$ ) to  $M = 3.05$  ( $SD = 1.27$ ), but this change was not statistically significant,  $t(19) = 1.116, p = .278$ . This suggests that the education may have helped nurses reconsider the idea that CF should simply be accepted as "part of the job." Instead,

nurses may have begun to view it as a preventable and manageable condition rather than an unavoidable expectation.

Perception of organizational support increased slightly from  $M = 2.75$  ( $SD = .967$ ) to  $M = 2.95$  ( $SD = .686$ ), but this was also not statistically significant,  $t(19) = -.847, p = .408$ . This indicates that while the education improved individual awareness and coping confidence, it did not substantially change nurses' perceptions of how much organizational support exists. This reinforces the need for leadership engagement and system-level efforts alongside education.

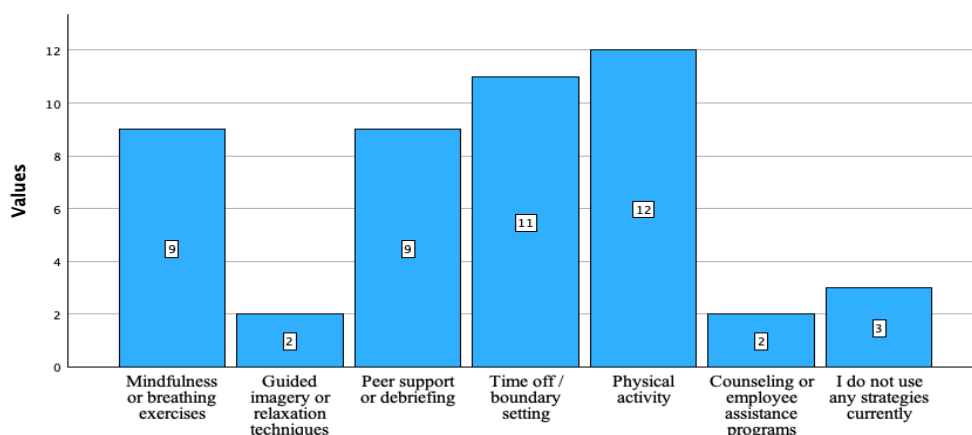
Importantly, agreement with the statement that seeking help for CF is a sign of professional weakness decreased from  $M = 2.00$  ( $SD = .503$ ) to  $M = 1.40$  ( $SD = .951$ ), and this change was statistically significant,  $t(19) = 2.449, p = .024$ . This is a critical finding. It shows that the education successfully reduced stigma around asking for help and reframed help-seeking as an appropriate and healthy professional behavior. Together, these findings show that the education had its strongest impact on reducing stigma and reshaping personal beliefs, even though perceptions of organizational support remained largely unchanged.

Prior to the education session, nurses were already attempting to manage stress using a variety of personal strategies, although these approaches were largely informal and inconsistent. The pretest revealed that there were 48 reported answers from 20 nurses who completed the pretest and answered this *check all that apply* question (see Table 1). The most frequently reported methods included physical activity (12), setting boundaries or taking time off (11), mindfulness or breathing exercises (nine), and peer support or debriefing (nine).

**Table 1***Pretest Strategies in Use*

		Responses	
		<i>n</i>	Percent
Pretest self care options <sup>a</sup>	Mindfulness or breathing exercises	9	18.8%
	Guided imagery or relaxation techniques	2	4.2%
	Peer support or debriefing	9	18.8%
	Time off / boundary setting	11	22.9%
	Physical activity	12	25.0%
	Counseling or employee assistance programs	2	4.2%
	I do not use any strategies currently	3	6.3%
	Total	48	100.0%

Very few participants reported using guided relaxation techniques (two) or noted accessing counseling or employee assistance program (two). Of interest, three participants reported not using any strategy at all to manage CF on the pretest. These findings suggest that while nurses recognized the need to cope with stress, overall, the education helped shift nurses toward more structured coping methods, even if not every strategy changed significantly.

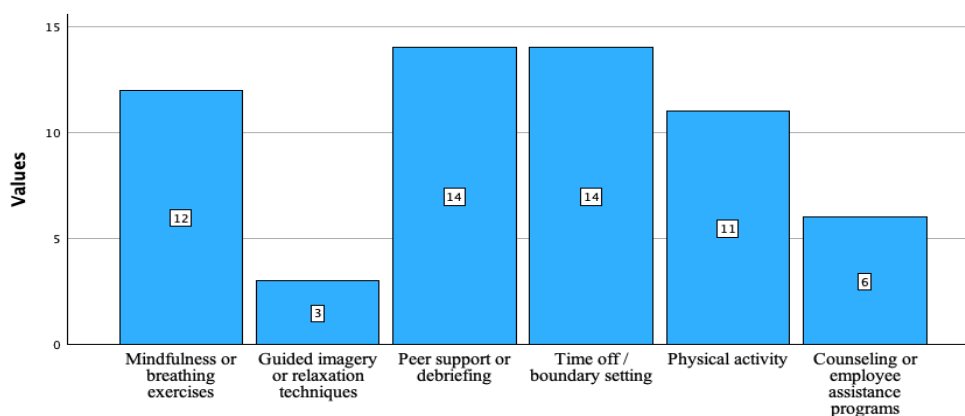
**Figure 1***Pretest Strategies for Managing CF*

A clear shift in the strategies nurses reported after the education session is depicted in Table 2. There were 60 responses from the same 20 nurses who answered this multiple response question on the pretest. Mindfulness or breathing exercises increased from 12 on the pretest for peer support and debriefing rose to 14 on the posttest. Boundary setting and taking time off also increased to 14 on the posttest from 11 on the pretest moved from two on the pretest to six on the posttest. Use of counseling or employee assistance programs increased from two to six. Guided imagery and relaxation techniques increased to three on the posttest from two on the pretest.

**Table 2***Posttest Strategies Frequency Table*

		Responses	
		<i>n</i>	Percent
Posttest Strategies <sup>a</sup>	Mindfulness or breathing exercises	12	20.0%
	Guided imagery or relaxation techniques	3	5.0%
	Peer support or debriefing	14	23.3%
	Time off / boundary setting	14	23.3%
	Physical activity	11	18.3%
	Counseling or employee assistance programs	6	10.0%
Total		60	100.0%

These changes reflect a direct connection between the education content and the strategies nurses felt confident using afterward. Nurses moved toward more structured, evidence-based approaches rather than relying solely on informal coping habits.

**Figure 2***Posttest CF Strategies*

Before the education session, most nurses already had a basic understanding of what CF meant, with about 90% selecting the correct definition on the pretest and on the posttest. This suggests that the term itself was familiar to participants prior to the intervention. However, two individuals selected an incorrect response on both the pretest and posttest, indicating that the education session did not fully correct all misunderstandings related to the concept.

This finding is important because it shows that while nurses may recognize the term CF, this recognition does not always translate into a deeper or more accurate understanding of what it truly involves in practice. The education session therefore played a more meaningful role in improving nurses' awareness, confidence, and coping behaviors rather than simply teaching the definition. This reinforces the idea that effective education on CF must move beyond terminology and focus on helping nurses recognize how it manifests in themselves and others within the clinical environment.

The major limitation in the project was the small number of paired surveys from pre- to posttest; in fact, less than 1/3 of the total participants in the education sessions. However, the results are telling regardless and point to important insights and directions for the staff at the VA medical center. There were only RNs who participated in the survey process, however CF concepts are relevant to all direct care patient support staff and there are implications for broader inclusion across the medical center. Finally, only four nursing units were included in the education opportunity and many more staff members could benefit.

## Conclusions

This project had a meaningful impact on the organization by improving nurses' awareness, confidence, and use of evidence-based strategies to recognize and manage CF. Nurses left the education session better able to identify early signs of CF in themselves and in their colleagues and demonstrated a shift toward healthier coping behaviors such as mindfulness, peer support, and boundary setting. Although perceptions of organizational support did not significantly change, the results showed that individual nurses felt more equipped to care for their own emotional well-being while continuing to provide high-quality patient care. This contributes to a stronger culture of psychological safety, supports nurse retention efforts, and aligns with broader patient safety and workforce well-being priorities within the VA setting.

Several recommendations emerge from this project. CF education should be integrated into routine staff development, annual competencies, and onboarding for new nurses. Brief mindfulness and coping practices can be embedded into daily huddles and staff meetings to reinforce learning. Leadership presence and visible support for nurse well-being initiatives should be strengthened to help bridge the gap between individual awareness and organizational culture. Expanding this program to additional units and VA facilities would further support nurse resilience across settings where emotional demands are high.

The implications for nursing practice extend beyond this single site. This project reinforces that CF is not a personal weakness but an occupational risk that can be addressed through education, awareness, and supportive environments. Normalizing conversations about emotional well-being promotes equity by acknowledging the

invisible emotional labor nurses carry, particularly in high-acuity and trauma-rich settings. By reducing stigma around seeking help and promoting peer awareness, this work supports fostering a workplace culture where all nurses feel safe, supported, and valued. Ultimately, strengthening nurse resilience contributes not only to healthier nurses but also to safer, more compassionate care for the patients and communities they serve.

## References

- Abou Hashish, E. A., & Ghanem Atalla, A. D. (2023). The relationship between coping strategies, compassion satisfaction, and compassion fatigue during the COVID-19 pandemic. *SAGE Open Nursing*, *9*, 23779608231160463. <https://doi.org/10.1177/23779608231160463>
- Alharbi Jalal, Jackson, D., & Usher, K. (2019). Compassion fatigue in critical care nurses. *Saudi Medical Journal*, *40*(11), 1087–1097. <https://doi.org/10.15537/smj.2019.11.24569>
- Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*(6),618. <https://doi.org/10.3390/ijerph13060618>
- Dang, D., Dearholt, S.L., Bissett, K., Ascenzi, J., & Whalen, M. (2022). John Hopkins evidence-based practice for nurses and healthcare professionals: Model and guidelines (4<sup>th</sup> ed.). Sigma Theta Tau International.
- Delaney, M. C. (2018). Caring for the caregivers: Evaluation of the effect of an eight-week pilot mindful self-compassion training program on nurses' compassion fatigue and resilience. *PLOS ONE*, *13*(11), e0207261. <https://doi.org/10.1371/journal.pone.0207261>
- El-Ashry, A. M., et al. (2023). Compassion fatigue and stress related to cardiopulmonary resuscitation. *BMC Nursing*, *22*(1),482. <https://link.springer.com/article/10.1186/s12912-023-01640-y>

- Gustafsson, T., & Hemberg, J. (2022). Compassion fatigue as bruises in the soul. *Nursing Ethics*, 29(1), 157–170. <https://doi.org/10.1177/09697330211003215>
- Pan, Y., Wang, X., & Jin, W. (2025). Risk of compassion fatigue among emergency department nurses. *BMC Emergency Medicine*, 25(1),155. <https://doi.org/10.1186/s12873-025-01314-9>
- Robinson, L. K., et al. (2022). A secondary traumatic stress reduction program in emergency room nurses. *SAGE Open Nursing*, 8,23779608221094530. <https://doi.org/10.1177/23779608221094530>
- Wei, J., et al. (2025). Mindful self-care and compassion fatigue in nurses. *Journal of Nursing Management*, 8572654. <https://doi.org/10.1155/jonm/8572654>
- Yin, J., et al. (2024). Compassion fatigue, moral distress, and resilience among nurses. *Frontiers in Public Health*, 12, 1402532. <https://doi.org/10.3389/fpubh.2024.1402532>
- Yu, H., & Gui, L. (2022). Compassion fatigue, burnout and compassion satisfaction among emergency nurses. *Journal of Advanced Nursing*, 78(5), 1294–1304. <https://doi.org/10.1111/jan.15034>

## Appendix

### Staff Education Planning Grid Project Materials

**Education Type:** Brief, embedded staff education

**Delivery Method:** Live micro-sessions during huddles / in-service blocks

**Frequency:** Multiple offerings across shifts (45-60 minutes)

<p>Learning Outcome(s):</p> <p><b>Nursing Professional Development:</b></p> <ul style="list-style-type: none"> <li>- Nurses will recognize early signs of compassion fatigue and identify themselves and peers.</li> <li>- Nurses will demonstrate at least two mindfulness-based coping strategies applicable during a shift.</li> </ul> <p><b>Patient Outcome:</b></p> <ul style="list-style-type: none"> <li>- Improved nurse engagement and presence emotional regulation, and therapeutic engagement with patients.</li> </ul> <p><b>Organizational Outcome:</b></p> <ul style="list-style-type: none"> <li>- Improved staff awareness of well-being resources.</li> <li>- Improved unit culture around psychological safety and peer support.</li> <li>- Support for retention and resilience initiatives.</li> </ul>			
Topical Content Outline	Time frame	References	Teaching method/learner engagement and Evaluation method
Introduction and Welcome: Psychological Safety Framing	5 mins	<p>Ozan, (2024). Determination of compassion fatigue in intensive care nurses.</p> <p>Pan et al., (2025). Risk of compassion fatigue among emergency department nurses.</p> <p>Wei et al., (2025). Mindful self-care and compassion fatigue in nurses: Resilience as a mediator.</p> <p>Yu, H., &amp; Gui, L. (2022). Compassion fatigue, burnout, and compassion satisfaction among emergency department clinicians.</p>	<p>Facilitated Discussion “One-word check-in” (participants name one word describing how work has felt lately)</p> <p>Informal observation</p>

<p>What is Compassion Fatigue?</p>	<p>10 mins</p>	<p>Gustafsson, T. &amp; Hemberg, J., (2021). Compassion fatigue as bruises in the soul: Nurses lived experience.</p> <p>Ozan, (2024). Determination of compassion fatigue in intensive care nurses.</p> <p>Pan et al., (2025). Risk of compassion fatigue among emergency department nurses.</p> <p>Wei et al., (2025). Mindful self-care and compassion fatigue in nurses: Resilience as a mediator.</p> <p>Yin et al., (2024). Compassion fatigue, moral distress, and resilience among nurses.</p>	<p>Brief Lecture with visuals Think-Pair-Share: “Which signs do you see most on your unit?”</p> <p>Verbal responses</p>
<p>Impact on Nurses, Teams, and Care</p>	<p>10 mins</p>	<p>Alharbi et al., (2019). Compassion fatigue in critical care nurses.</p> <p>Delaney, (2018). Evaluation of the effect of an eight-week mindful self-compassion training intervention on nurses; compassion fatigue and resilience.</p> <p>El-Ashry et al., (2023). Compassion fatigue and stress related cardiopulmonary resuscitation: A S=study of critical care nurses’ experiences.</p> <p>Gustafsson, T. &amp; Hemberg, J. (2021). Compassion fatigue as bruises in the soul: Nurses lived experiences.</p>	<p>Cased-based discussion Small-group reflection on a realistic shift scenario</p> <p>Group report-out</p>

		<p>Pan et al., (2025). Risk of compassion fatigue among emergency department nurses.</p> <p>Yu, H &amp; Gui, L (2022). Compassion fatigue, burnout, and compassion satisfaction among emergency department clinicians.</p>	
Mindfulness-Based Coping Strategies (Evidence-Based)	15 mins	<p>Abou Hashish &amp; Ghanem-Atalla, (2023). Coping strategies, compassion satisfaction, and compassions fatigue among nurses.</p> <p>Cocker &amp; Joss, (2016). Compassion fatigue among healthcare, emergency, and community service workers: A systemic review.</p> <p>Delaney, (2018). Evaluating of the effect of an eight-week mindful self-compassion training intervention on nurse's' compassion fatigue and resilience.</p> <p>Wei et al., (2025). Mindful self-care and compassion fatigue in nurses: Resilience as a mediator.</p>	<p>Demonstration &amp; guided practice Guided breathing + grounding exercise (2-3 minutes each)</p> <p>Facilitator observation</p>
Workflow Integration: Making It Real	10 mins	<p>Abou Hashish &amp; Ghanem-Atalla, (2023). Coping strategies, compassion satisfaction, and compassions fatigue among nurses.</p> <p>Alharbi et al., (2019). Compassion fatigue in critical care nurses.</p>	<p>Interactive brainstorming Participants identify when/where strategies fit into their shift</p> <p>Written commitment</p>

		<p>Cocker &amp; Joss, (2016). Compassion fatigue among healthcare, emergency, and community service workers: A systemic review.</p> <p>Delaney, (2018). Evaluating of the effect of an eight-week mindful self-compassion training intervention on nurse’s compassion fatigue and resilience.</p> <p>Ozan, (2024). Determination of compassion fatigue in intensive care nurses.</p> <p>Pan et al., (2025). Risk of compassion fatigue among emergency department nurses.</p>	
Reflection, Resources & Wrap-Up	5-10 mins	<p>Cocker &amp; Joss, (2016). Compassion fatigue among healthcare, emergency, and community service workers: A systemic review.</p> <p>El-Ashry et al., (2023). Compassion fatigue and stress related cardiopulmonary resuscitation: A study of critical care nurses’ experiences.</p> <p>Robinson et al., (2022). A secondary traumatic stress reduction program for emergency nurses.</p> <p>Wei et al., (2025). Mindful self-care and compassion fatigue in nurses: Resilience as a mediator.</p>	<p>Open discussion “One strategy I will try this week”</p> <p>Post-test</p>

Evaluation Method: Pre and Posttest (manual data collection before and after the training)

Compassion Fatigue Knowledge, Skills, and Attitudes Survey

Estimated completion time: 3–5 minutes

Instructions to respondents:

Please answer the following questions based on your current understanding and experience

Section 1: Knowledge

1. How familiar are you with the term “compassion fatigue”?

- Not at all familiar
- Slightly familiar
- Moderately familiar
- Very familiar
- Extremely familiar

2. Which of the following best describes compassion fatigue? (*Select one*)

- General job dissatisfaction
- Emotional and physical exhaustion from prolonged caregiving
- Lack of clinical competence
- Poor work–life balance only
- Unsure

Section 2: Skills

3. How confident are you in recognizing early signs of compassion fatigue in yourself?

- Not confident
- Slightly confident
- Moderately confident
- Very confident
- Extremely confident

4. How confident are you in recognizing compassion fatigue in colleagues or team members?

- Not confident
- Slightly confident
- Moderately confident
- Very confident
- Extremely confident

5. Which strategies do you currently use to manage or reduce compassion fatigue?  
(*Select all that apply*)

- Mindfulness or breathing exercises
- Guided imagery or relaxation techniques
- Peer support or debriefing
- Time off / boundary setting
- Physical activity
- Counseling or employee assistance programs
- I do not use any strategies currently

### Section 3: Attitudes

6. Compassion fatigue is a normal and expected risk in caregiving roles.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

7. I feel supported by my organization or leadership in addressing compassion fatigue.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

8. Seeking help for compassion fatigue is a sign of professional weakness.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

#### Section 4: Readiness and Improvement

9. How interested are you in learning additional strategies to prevent or manage compassion fatigue?

- Not interested
- Slightly interested
- Moderately interested
- Very interested
- Extremely interested

10. What additional support or resources would help you better manage compassion fatigue? (*Optional – open text*)

- Open text response