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The Watson Room: Managing Compassion Fatigue in Clinical Nurses on the Front Line

Crystal Denise Crewe
Walden University

Walden University

College of Health Sciences

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Crystal Crewe

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Review Committee
Dr. Amelia Nichols, Committee Chairperson, Health Services Faculty
Dr. Kathleen Brewer, Committee Member, Health Services Faculty
Dr. Robert Anders, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

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MSN, Walden University, 2012

BSN, VCU School of Nursing, 2010

Project Submitted in Partial Fulfillment

of Requirements for the Degree of

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Abstract

The concept of compassion fatigue (CF) emerged in the early 1990s in North America to explain a phenomenon observed in nurses employed in emergency departments. A precursor to burnout, CF is a well-known phenomenon associated with emotional exhaustion, depersonalization, and an inability to work effectively. In nurses, CF has been shown to reduce productivity, increase staff turnover and sick days, and lead to patient dissatisfaction and risks to patient safety. The aim of this study was to determine if the use of a Watson Room designated as a "quiet zone" with warm colors on the wall, massage chair, and soothing sounds in the workplace environment, reduced CF in clinical nurses at the bedside in acute care settings. The data came from a survey of nurses (n = 19) working in a level 1 trauma center in an acute care setting. This quantitative study was conducted over a two week period. A single-group of nurses completed both a pre and post professional quality of life (ProQol) survey, a 30 item self-measurement of positive and negative aspects of caring. The ProQol operationalizes in three subcategories: compassion satisfaction (10 items), burnout (10 items), and CF (10 items). The ProQOL survey results showed statistically significant differences in the mean scores in all three categories. Paired samples t tests indicate the Watson Room proved to be successful in increasing compassion satisfaction (p = .009), decreasing burnout (p = .002*),* and decreasing secondary trauma/CF respectively (p = .02). This study shows the importance of nurses taking care of themselves while taking care of others. Understanding CF and devising and implementing interventions to address the subject are important for nurses and patients.

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Dedication

I dedicate this doctoral work to my beloved mother Carolyn O. Tatum who was my biggest cheerleader. I wish she was here to share my huge milestone. It was through the grace of GOD that I was able to remain in the DNP program during my mother's illness and death. I will keep on trusting Him for my future. Thank you, Lord.

Acknowledgments

First and above all, I owe my deepest gratitude to the Almighty God for His faithfulness throughout the good and difficult times in my DNP journey. The completion of this doctoral capstone project was possible with the support of several people. First, I would like to thank my capstone committee members for their dedications and support for this project. My committee chair, Dr. Amelia Nichols, EdD, please accept my sincere appreciation for your enthusiasm, intellectual guidance, and your tireless support at every stage of this work. Your broad scientific intuition, and experience you shared with me have helped shaped my line of thought, and have triggered many good ideas in this project. I am indeed very grateful to you. I would like to thank my family who stood by me during this journey. I could not have done it without their support and encouragement. I'd like to thank my mentor Mamoona Arif Rao PhD, who pushed me to my maximum, and then pushed me some more. You provided critical input on each step of the project implementation, and your ideas and contributions have been absolutely invaluable. It is because of her that I have a new found love for research. I would like to sincerely thank my Chief Nursing Officer Dr. Z for believing in my vision, and providing me the tools I needed to be successful. Last but not least I would like to thank all the staff and faculty members on Vascular Surgery (my pilot unit), who have contributed one way or the other to the success of my DNP journey.

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Section 1: Introduction

Introduction

The concept of CF emerged in the early 1990s in North America to explain a phenomenon observed in nurses employed in emergency departments (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). A precursor to burnout, CF is a well-known phenomenon associated with emotional exhaustion, depersonalization, and an inability to work effectively (Stamm, 2010). The symptoms of CF develop over time, are varied, and include sadness, depression, anxiety, intrusive images, flashbacks, numbness, avoidance behaviors, cynicism, and poor self-esteem (Drury et al., 2014).

In nurses, CF has been shown to reduce productivity, increase staff turnover and sick days, and lead to patient dissatisfaction and risks to patient safety (Hooper et al., 2010). Nursing care is a quality outcome that is increasingly publicized, measured, and targeted as a priority for all healthcare organizations (Burtson & Stichler, 2010). Caregivers who inherently have the ability to show compassion, and express empathy are at the greatest risk for CF when exposed to cumulative grief and loss in their work (Figley, 1995). CF has an impact on job satisfaction, the quality of patient care, and retention within nursing. Understanding CF, and devising and implementing interventions to address the subject, are important for nurses and patients. However, there is not much literature that address interventions for nurses who experience CF (Reimer, 2013).

The capacity for compassion and empathy seems to be at the core of nurses' ability to do the work, and at the core of their risk to be wounded by the work (Figley,

1999). Scholars have found that nurses use action-oriented, and problem-solving adaptive coping responses (Bush, 2009). Ultimately, the question remains: Can the nurse identify CF interventions, and feel effective to modify, adapt, and change within the work environment to meet the challenges they face on a daily basis? If not, chronic stress, disillusionment, and frustration may lead to ineffective coping responses, and the use of defensive mechanisms such as avoidance approaches, withdrawal, apathy, and food or substance abuse (Bush, 2009). Empathetic engagement is essential to the healing process in disciplines such as nursing.

Nurses must prepare their minds, bodies, souls, and spirits to become resilient when working with patients, and intense levels of interpersonal engagement (Bush, 2009). Raising awareness of CF may encourage the development of ongoing programs to provide support for nurses working in hospital environments. Understanding the concept of CF, recognizing its signs and symptoms, and identifying best practice interventions may help nurses maintain a caring attitude. A better understanding of the causes of CF may enable nurses to take necessary steps to recognize, and prevent the impending development of CF.

Problem Statement

Health outcomes, and in particular, patient health outcomes have become a driving force in the healthcare delivery, but little emphasis has been placed on the potential health consequences for the nurses providing care (Sabo, 2006). Some nurses lose sight of the need to take care of themselves until they are in crisis (Hooper et al., 2010), and sometimes the warning signs and symptoms go unrecognized by either the

nurses themselves or their peers. Environmental factors in nurses' workplaces can either promote or detract from their ability to meet their motivational needs (Burtson & Stichler, 2010).

An ever-changing healthcare arena and the loss of experienced, knowledgeable nurses are significant to the outcomes of healthcare organizations. Bedside nurses, educators, and mentors are all impacted by retention issues resulting from CF. Interventions designed to recognize and manage stressors, retain nurses, and improve the work environment must be developed. CF can be very costly personally and professionally for nurses, and financially for institutions (Lombardo & Eyre, 2011). Thus, in this project, I sought to answer the question: Does the use of a "quiet zone" in the workplace environment reduce CF in clinical nurses at the bedside in acute care settings?

Purpose Statement and Project Objectives

The purpose of the project was to determine if a "quiet zone" in the workplace setting would help decrease, or prevent CF in nurses at the bedside in acute care settings. Additionally, I sought to raise awareness of CF, and emphasize the mental, physical, and emotional impact of caring for patients.

I implemented and oversaw where this project in which nurses used a work "quiet zone" that fostered compassion, and promoted self-care. This quite zone was a pre-existing space that was redecorated using fresh paint with a warm color, a comfortable massage chair, a waterfall fountain, and a flat screen television for scenic white noise, soft lighting, and a decorative rug.

This project was designed to help recognize, prevent, and treat CF. Nurses who used the quite space completed a pre and post ProQOL survey to assess their knowledge of how to recognize, prevent, and treat CF (see Appendix A for the full survey).

Significance to Practice

CF can result from taking on the emotional burden of a patient's agony, leading to feelings of stress and guilt. For instance, the blood-curdling sound of a parent screaming over the death of her infant daughter can cause staff major distress. It is at that instant when the mother's world totally collapsed, and there was nothing anyone could do to change it. Sometimes those sounds or images stay with a nurse for a considerable time. Empathetic interactions with patients, coupled with their experience of cumulative grief, places nurses at the bedside at a particularly high risk of CF because of persistent sadness and loss.

Figley (1995) explained that CF is experienced by those who help others in distress. These helpers may be subsequently traumatized through their efforts to empathize and show compassion. This often leads to inadequate self-care behaviors and increased self-sacrifice in the helper role (Lombardo & Eyre, 2011). Healthcare professionals must support each other, respect the contributions of all involved in health care, and reach out to others, particularly nurses in need of nurturing and renewal.

CF causes nurses to want to leave their job, and experience a sense of dread and helplessness. It manifests as a psychosocial condition with emotional, physical, mental, spiritual, and social constructs. Because of its multi-faceted expressions in nurses, CF requires a holistic approach to help alleviate the condition. The physical effects of CF

include a lower capacity and endurance to perform job requirements, and may lead to more clinical errors. Emotional symptoms include feeling overwhelmed, irritability, loss of enthusiasm, and indifference to suffering. Indicators of CF also include work related symptoms such as the frequent use of sick days, reduced levels of empathy towards patients and families, avoidance of working with certain patients, a lack of joyfulness, and a loss of objectivity (Lombardo & Eyre, 2011). CF has multiple triggers for nurses. Some triggers include caring for patients experiencing serious physical, emotional, or financial threats or imminent death; futile care, and the families' continued demand for futile care; the physicians not being honest about the patient's prognosis; and high census, heavy patient assignments, high acuity, overtime, and extra nurse days (Yoder, 2010). Nurses constantly prioritize and juggle multiple tasks simultaneously regarding emergency life or death situations. They ignore their feelings, or experience helplessness and anger, in response to the stress they feel while watching patients go through serious illnesses or trauma (Yoder, 2010).

It is important for nurses to become knowledgeable about CF symptoms and intervention strategies, and to develop a personal plan to achieve a healthy work-life balance (Lombardo & Eyre, 2011). Identifying best practice interventions may help nurses maintain a caring attitude with patients, and thereby contribute to patient satisfaction (Hooper et al., 2010). Organizations are encouraged to monitor their support systems routinely, and advocate for workplace interventions to manage this critical work related issue. The effects of CF are not limited to the psychological effects of the

caregiver. When nurses are incapable of caring for themselves, it may lead to a decreased level in the quality of care they provide their patients.

Project Question

Does the use of a "quiet zone" in the workplace environment reduce CF in clinical nurses at the bedside in acute care settings?

Evidence-Based Significance of Project

Professional nursing practice thrives when there is a caring, empathetic relationship between nurse and patient. However, this necessary empathetic relationship can also contribute to CF if conscious steps are not taken to avoid, and or lessen this condition (Lombardo & Eyre, 2011). Nurses need to be assertive, to express personal needs and values, and to view work-life balance as an achievable outcome. This relationship with self is essential for optimizing one's health, for being empathic with others, and for being a productive member of a work group within a healthcare facility. This project promoted self-care for nurses by establishing a quiet zone where they can go for brief periods of respite. Nurses can enjoy comfortable seating, white noise, waterfall fountains, and soothing scents in a relaxed, quiet, and comfortable environment. I named this quiet zone the "Watson Room" after the nursing theorist Dr. Jean Watson. Watson's theory of human caring advocates for relationship-based nursing, where nurses must care for themselves as well as others (Watson, 2010).

The proportion of acute patients entering the healthcare system through emergency departments continues to grow, the number of uninsured patients relying primarily on treatment in the emergency department is increasing, and patients' average

acuities are rising (Hooper et al., 2010). At the same time, support resources are limited. Reimbursement and reputation depends increasingly on publicly available measures of patient satisfaction. It is important to understand the potential effect of these pressures on nurses at the bedside.

Implications for Social Change in Practice

This project may have positive implications for staff, and improve patient satisfaction. Many nurses have acknowledged feeling less stressed, and more able to manage at work, after using a quiet zone (Lombardo & Eyre, 2011). Studies such as this, that detail the relationship between the level of occupational work support, and positive outcomes such as low turnover rates, decreased absenteeism, and lower patient mortality, may lend support to requests for contracting and obtaining resources for establishing quiet zones. Opportunities for nurse renewal, and leadership cultures that values renewal practices, may combat the negative effects of CF. These strategies support a positive impact on care provided to patients and their families, and ultimately decrease CF and high nurse attrition rates (Lombardo & Eyre, 2011).

This project also has positive implications for healthcare organizations by guiding their work in improving the health of nurses, increasing compassionate patient care, and generating more effective policies at the facility level for CF intervention. With less CF among nurses, hospitals can provide higher quality services, and see economic gains in retention of experienced, compassionate nurses (Smith, 2013). As Remen (1996) notes,

"The expectation that we can be immersed in suffering and loss daily, and not be touched by it, is as unrealistic as expecting to be able to walk through water without getting wet" (p. 1).

Definitions of Terms

CF is a term first coined by Joinson (1992) to describe the unique stressors that affect people in caregiving professions like nursing. Joinson envisioned CF as a unique and expanded form of burnout. Environmental stressors of the workplace negatively affect nurse caregivers. The patients' physical and emotional needs contribute to nurses becoming tired, depressed, angry, ineffective, and at the end of the continuum, apathetic and detached. Lewin (1996) described compassion as a complex emotion that allows caregivers to hold and sustain themselves in emotional balance, while holding patient's despair in one hand, and their hopefulness in the other.

Compassion Satisfaction and CF are two aspects of the ProQOL. They encompass the positive, and the negative parts of helping others who have experienced suffering. CF has two parts. The first part concerns things typical of burnout such as exhaustion, frustration, anger, and depression. The second part is secondary traumatic stress, a negative feeling driven by fear, and work-related trauma. It is important to remember that some trauma at work can be direct (primary) trauma. In other cases, work-related trauma becomes a combination of both primary and secondary trauma. If working with others suffering impacts one so deeply in negative ways that the understanding of yourself changes, this is vicarious traumatization. Learning from and understanding vicarious

traumatization may lead to vicarious transformation (ProQOL, 2012).

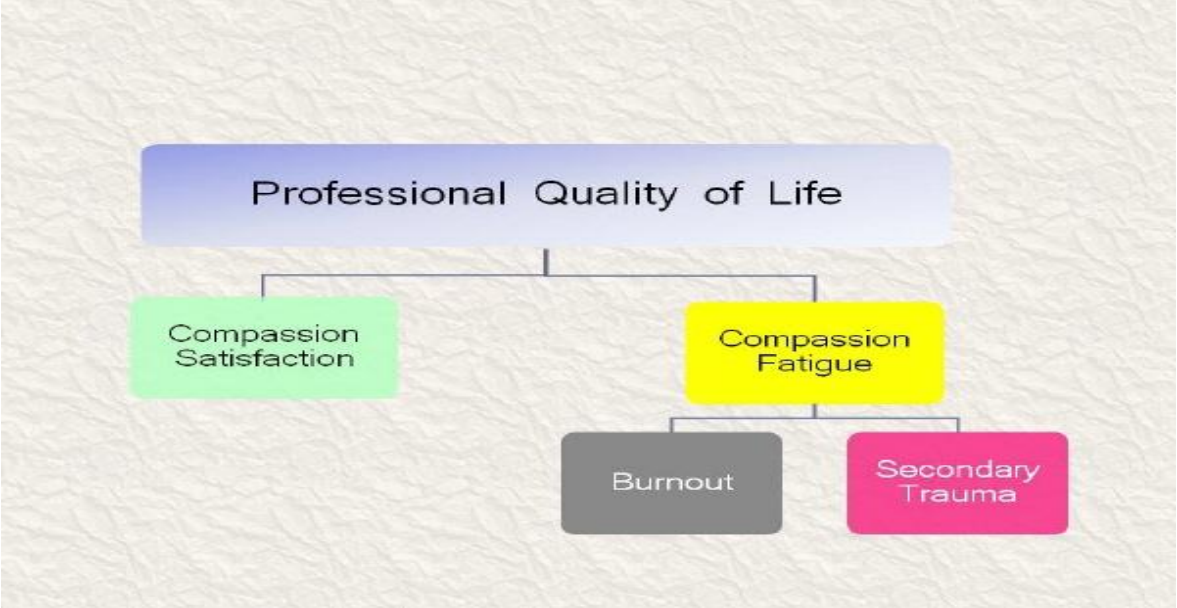

Figure 1. ProQOL model.

Assumptions and Limitations

CF is a natural, predictable, treatable, and unpreventable consequence of working with suffering and traumatized patients (Bush, 2009). Nursing care is the most influential dimension of patient advocacy, is predictive of patient satisfaction, and is a key motivational factor influencing recruitment and retention (Burtson & Stichler, 2010). The hospital turnover rate is on the rise, and nurses' satisfaction scores are low. This has profound financial and quality implications amidst a global nursing shortage that is projected to reach one million in the United States by 2020 (Burtson & Stichler, 2010). CF affects not only the nurse in terms of job satisfaction, and emotional and physical health, but also the workplace environment by decreasing productivity and increasing turnover (Lombardo & Eyre, 2011).

Limitations to this project included finding a workable, pre-existing space to transform into the quiet zone or "Watson Room." The census and acuity is high, and real-estate in the study site was prime. Finding enough nurses to independently volunteer and participate throughout the pilot also posed as a challenge. CF is a problem amongst nurses at the bedside. On the front line of care for the traumatized, dying, and chronically ill, nurses are continually called upon to demonstrate caring compassion, and empathy towards others. However, the act of continually providing empathic, compassionate nursing care may contribute to stress symptoms and job dissatisfaction, which can result in the development of CF (Lombardo & Eyre, 2011). Caregivers who suffer from CF are often inclined to justify their symptoms as part of the "cost of caring." Yet when the ability to provide healthcare is diminished by the poor health, and well-being of nurses, there is a serious need to acknowledge the condition, and integrate methods for alleviation into the workplace.

It is important for nurses to become knowledgeable about CF symptoms, and intervention strategies, and to develop a personal plan of care about how to achieve a healthy work-life balance. Lombardo and Eyre (2011) have noted that it is equally important that healthcare systems invest in creating healthy work environments that prevent CF, and address the needs of nurses who are experiencing CF. Creating a "quiet zone" for nurses to take a few minutes of "me time" is desperately needed for acute care nurses at the bedside in the level one trauma center setting. Nurses frequently leave their positions, work part time, or lose compassion for their patients, co-workers, and self. It is

sad to see the most trusted professionals in the world slowly decrease their compassion to care.

Section 2:

Review of Scholarly Evidence

A review of the literature was conducted using CINAHL, PubMed, and National Guideline Clearing House to access scholarly and clinical literature. For my searches, the following keywords were used: *compassion, nurses, burnout, fatigue, moral distress, nurse's turnover, motivation, stress* and *intervention*. My initial search resulted in 121 articles. When limited to the last five years, and adding the word compassion fatigue, 38 articles remained. As I reviewed the articles, I found 10 to be relevant to my project.

Table 1

Evidence Base Review of Literature

Category Level	Number of Studies	Overall Rating
Level I: Experimental (randomized controlled trial) or meta-analysis of RCT	2	A
Level II: Quasi-experimental	2	B
Level III: Non-experimental or qualitative	2	B
Level IV: Opinion of nationally recognized experts based on research evidence		
Level V: Opinion of individual expert based on non-research evidence	4	B

CF and burnout in the nursing profession have often been addressed in the specialty of palliative care, where nurse caregivers must come to terms with their own grief and loss, related to caring for dying patients. For the purpose of this project, nurses

at the bedside in acute care settings were the target population. CF may impact nurses in any specialty when, in the process of providing empathic support, they personally experience the pain of their patients and families (Lombardo & Eyre, 2011). Researchers have identified that organizational stressors, such as the workplace, role ambiguity, and workload contribute to nursing burnout. Prolonged exposures to stressful environments that consist of low staffing, and a lack of administrative and colleague support, keep nurses in a constant state of alertness and isolation that eventually creates physical and mental exhaustion, which leads to CF (Bush, 2009). CF is a complex phenomenon that gets worse gradually as a result of cumulative stress over time, often when caregivers ignore the symptoms of stress, and do not attend to their own emotional needs.

Nurses must be as compassionate, understanding, and forgiving of themselves as they are for their patients and loved ones, balancing their giving to others with giving to themselves (Bush, 2009). Symptoms of CF occur on a continuum from acute to chronic, and manifest in several domains (Figley, 1999). All of the symptoms may have a negative effect on work performance, including exhaustion, low motivation, absenteeism, and detachment or apathy.

Burnout and CF has similar symptoms. In burnout the onset is more progressive and may cause indifference, disengagement, and withdrawal from patients and the work environment. CF can be more acute in onset and precipitate over involvement in patient care (Lombardo & Eyre, 2011).

As mentioned previously, the symptoms of CF can include work-related physical and emotional symptoms. Any of these symptoms might indicate the occurrence of CF.

However, it is important to note that generally more than one symptom is demonstrated before a nurse is identified as having CF (Lombardo & Eyre, 2011). The nurse may start to question the meaning of life, of his or her own purpose in life, and the very belief systems, values, and commitments that provide feelings of emotional safety and trust (Bush, 2010). The onset of CF can be sudden, and have a faster recovery rate than does burnout (when recognized), as a result of secondary exposure to traumatic events (Hooper et al., 2010). A nurse experiencing CF may have a change in job performance, an increase in mistakes, a noticeable change in personality, and a decline in health, and may feel they need to leave the profession. Mental health professionals and/or nurse mentors, including nurse managers, clinical nurse specialists, and preceptors can help to identify the presence of CF. An essential first step in developing an intervention plan, is awareness of the problem (Lombardo & Eyre, 2011). When nurses are depleted, it is hard for them to recognize CF in themselves. It is easier to recognize CF in someone else. However, once it is recognized, a plan, and resources should be made available to staff (Mendes, 2014).

Most nurses enter the profession of nursing with the intent to help others, and provide empathetic care for patients with critical, physical, mental, emotional, and spiritual needs. Empathic and caring nurses however, can become victims of the continuing stress of meeting the often overwhelming needs of patients, and their families, resulting in CF (Lombardo & Eyre, 2011). Nurses nurse because they care, but that does not mean they have unlimited amounts of caring to go around (Mendes, 2014). Although empathic feelings are natural, it is important for nurses to recognize that in their

professional capacity, there are limits to what they can do (Mendes, 2014). The best thing nurses can do is recognize that being in a caring profession puts them at particular risk of experiencing CF, and they must make a conscious effort to renew themselves regularly (Mendes, 2014). CF affects the workplace environment by way of decreased productivity, and increased turnover. It is important for nurses to become knowledgeable about CF symptoms, and intervention strategies. They must develop a personal plan of care in order to achieve a healthy work-life balance. Equally important is that healthcare systems invest in creating healthy work environments that prevent CF, and address the needs of nurses who are experiencing it (Lombardo & Eyre, 2011).

In the midst of rising scrutiny, nurse caring is emerging as an important quality indicator (Burtson & Stichler, 2010). Theoretically, a work environment that meets a nurse's deficiency needs would foster self-actualization, thereby increasing nurse caring. Studies involving nurse caring incorporates the patients' and nurses' perspectives. The Watson's theory of human caring is grounded in the basic empathic relationship between the nurse and the patient; this approach advocates relationship-based nursing. The nurses' relationship with self is a core concept in managing CF. Nurses need to be assertive, to express personal needs and values, and to view work-life balance as an achievable outcome (Lombardo & Eyre, 2011). This relationship with self is essential for optimizing one's health, for being empathic with others, and for being a productive member of workgroups within a healthcare facility (Lombardo & Eyre, 2011). Professional nurses thrive within the context of a caring, empathetic relationship between nurse and patient. However, this necessary empathetic relationship can also contribute to CF if conscious

steps are not taken to avoid, and/or lessen this condition (Lombardo & Eyre, 2011). Having a quiet zone, in the immediate work environment, where staff can to go to decompress after stressful situations, is a great way for nurses to care for themselves.

Developing positive self-care strategies and healthy rituals are very important for a caregiver's recovery from CF. A commitment to taking care of one's self includes having adequate nutrition, hydration, sleep, and exercise. Nurses may need to be encouraged to try a new approach to self-care such as a yoga class, massage, meditation, or tai-chi. Lombardo and Eyre (2011) reported that their hospital system promotes self-care for nurses, through a relaxation center, where nurses can go for brief periods of respite. They go on to note that, at this center, nurses can receive reiki, light massage, or just relax in a quiet and comfortable setting. They reported that the staff at the organization enthusiastically expressed positive feedback regarding the relaxation room. A similar idea is to create a comfortable, relaxing environment in a designated place on the nursing unit. This is what I undertook in this DNP project. Such a space can be created by transforming a pre-existing space into a relaxation area (Lombardo & Eyre, 2011). Nurses can assist in selecting a soothing color for the walls, a small waterfall, comfortable chairs, a CD player, and/or a collection of relaxation CDs that can provide comforting stress relief (Lombardo & Eyre, 2011).

Caryl Eyre, a clinical nurse specialist from the United States who has done research in the area of CF, found that the risk is particularly high for those who care for the same patients repeatedly, or those who find themselves dealing with complex patients consecutively (Mendes, 2014). Eyre worked in an organization where they too created

what they called a Watson Room, named after the nursing theorist Jean Watson. The staff brought a partition into a room, used for environmental services, and transformed part of the room into a decompression room with warm curtains, a rug, fresh paint and a comfortable chair. The room is one of the hospital's stress free (and technology-free) zones, allowing nurses a space to take a few minutes where they can decompress at any time of day (Mendes, 2014). As with most organizations, money is tight, and no one has room in their budget to do these things, but it is amazing how far a little imagination can take you. There are numerous evidence based practice (EBP) projects in my organization that focus on patients being at the center of care. Some examples of these projects include the reduction of sepsis, urinary tract infection (UTI), ventilator associated pneumonia (VAP), strokes, and central line associated bloodstream infection (CLABSI) to name a few. In this EBP project, I have placed nurses at the center of care, an act that is long overdue and a refreshing change.

In review of the literature, I learned that CF levels can be measured, and found a great instrument to use for this project. The ProQOL measures CF, compassion satisfaction, and burn out. It is a valid and reliable instrument that was used to assess participants' level of CF. It is the most commonly used measure of the negative and positive effects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout, and CF (ProQOL, 2012). The ProQOL operationalizes compassion satisfaction (10 items), burnout (10 items), and CF (10 items), and is an instrument with three subscales and no summative score. It uses a six point Likert scale, and respondents are asked to rate the frequency of experiences

described from 0 “never” to 5 “very often” (Hooper et. al., 2010). Scoring requires summing the item responses for each 10-item subscale. A total of 5 items (1, 4, 15, 17, and 29) must be reverse scored prior to computing scores. The sub scale scores cannot be combined to compute the total score.

The most current scoring guidelines (Stamm & Figley, 1996) are based on a conservative quartile method whereby cut scores are based on the 75th percentile. As such, the guidelines suggest that a score of 33 or below on the compassion satisfaction scale may suggest job dissatisfaction. Guidelines for the burnout scales suggest that a score below 18 reflects positive feelings about someone ability to be effective in their work, and scores above 27 may be cause for concern in that he or she may not feel effective. Regarding the CF/secondary trauma scale, scores above 17 should be considered to reflect a potential problem in this domain (Stamm & Figley, 1996). Although the ProQOL was originally developed for emergency personnel and trauma counselors, the scale has been utilized internationally, and has been psychometrically validated in different studies for various target populations (Stamm, 2010).

Theoretical Frameworks

On the basis of the literature showing the connections between organizational commitment, and positive outcomes for nurses, this project explores the relationships between nurses caring for themselves, and the organizations commitment to supporting interventions to address CF. The stages of change transtheoretical model (TTM) is appropriate for CF, and consists of five phases of readiness (pre-contemplation, contemplation, decision/determination [sometimes called preparation], action, and

maintenance; Hodges & Videto, 2011). Those in the pre-contemplation phase are unaware that there is a problem and have no thoughts of changing. Those who recognize that there is a problem, and are intending to change, are said to be in the contemplation phase. Those who put their changes into effect are in the action stage. When nurses continue the health-enhancing activity, they are considered to be in the maintenance phase. The TTM focuses on the decision-making of the individual and is a model of intentional change. It operates on the assumption that people do not change behaviors quickly and decisively. Rather, change in behavior, especially habitual behavior, occurs continuously through a cyclical process (Prochaska and Velicer, 1997).

The Watson theory of human caring was used as the theoretical framework for understanding psychological motivations relevant to nurse caring (Watson, 2005). In theory, a work environment that meets nurses' needs would foster self-actualization, thereby increasing nurses' capacities for compassion. Stamm (2010) reported, that the characteristics in the work environment (organizational and task-wise), the individual's personal characteristics, and exposure to primary and secondary trauma in the work setting is the overall concept of the ProQOL. Figure 2 below helps illustrate the elements of ProQOL. In the center of the diagram are compassion satisfaction and CF. Compassion satisfaction names the positive aspects of helping others and CF names the negative aspects. The work environment, patient (or the person helped), and the person's environment all have a role to play. For example, a poor work environment may contribute to CF, at the same time, a person could feel compassion satisfaction that they could help others despite that poor work environment.

CF has two very different aspects, both of which have negative characteristics. Work-related trauma has a distinctive aspect of fear associated with it. While it is rarer than overall feelings of burnout, it is very powerful in its effect on a person. When both burnout and trauma are present in a person's life, their life can be very difficult. Figure 2 below shows the positive and negative outcomes of helping those who have experienced traumatic stress.

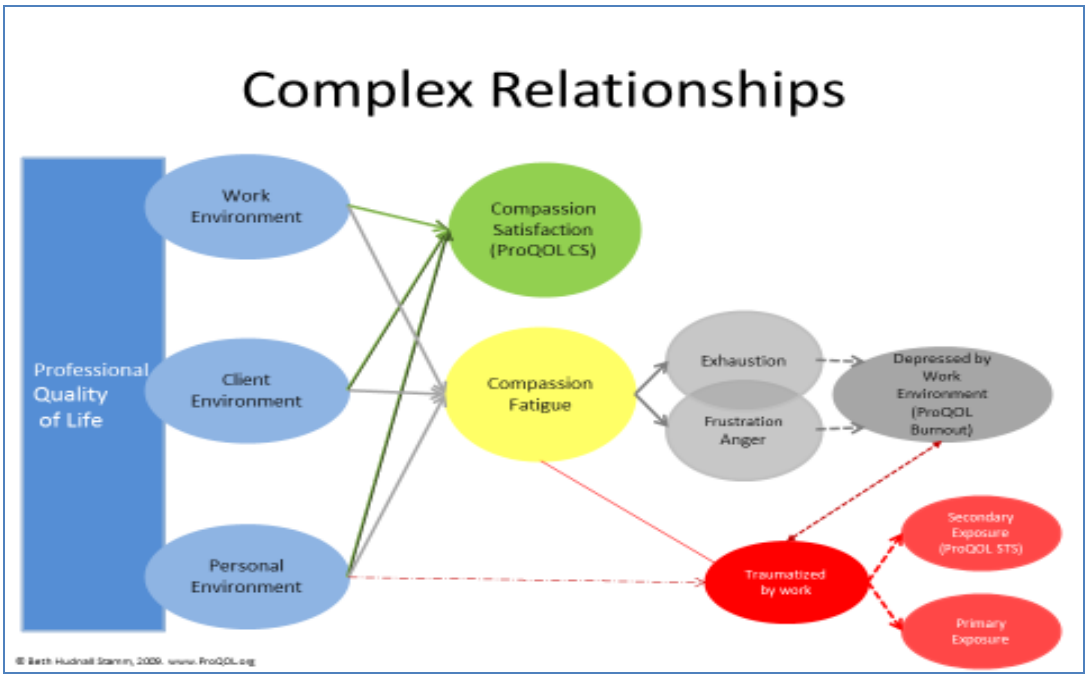

Figure 2. Theoretical path analysis.

Section 3

Design/Methods

The research was conducted in an urban, magnet recognized, level one trauma center, in an acute care setting. The single-group pre and post study design that I used supported the program plan, and the study participants served as both the target population, and the comparison group. I conducted an initial observation using a survey before implementing the program. My measurements and observations were related to the end users' characteristics (attitude, behavior, or condition) that the program was designed to change. The ProQOL pre-survey served as the baseline evaluation of CF. After completion of the pre-survey, staff participated in the program by using the Watson Room. After a period of fourteen days, I conducted a post-survey of the participants. The pre and post study survey questions were the same, just administered at different times. The objective of this program was aligned with CF and nurses in relation to a health-promotion and disease-prevention issue of national significance.

When designing the project, I focused on creating a "quiet zone" for bedside nurses to decompress after a stressful situation. I did this based on my review of best practices, and current evidence, regarding CF and nurses. I designed the Watson Room to be a quiet, relaxing environment in a designated, pre-existing place on the unit. Nurses chose a soothing color for the walls, a rug, a small waterfall, massage chair, soothing scents, and a flat screen television to display white noise to provide comforting stress relief, in a device free environment.

During the study, the Watson Room remained locked, and staff reported to the charge nurse (or designee) and signed in and out, before and after using the room. Upon approval from the charge nurse, each staff member stayed in the room up to 30 minutes to decompress as needed after stressful events. A buddy, or the charge nurse oversaw the patients of the nurse while he/she was in the Watson Room. After fourteen days of using the Watson Room, the participants completed the post-study survey to re-assess their level of compassion. The program design helped identify and define the elements that went into the delivery of this project. This design was comprehensive, attended to detail, and demonstrated internal consistency and integrity. Preserving and restoring a healthy, and safe work life balance for nurses, is a high priority for nurses and other team member.

Participants were engaged and eager to offer their support and time to implement the project. They were excited to have an area where they could go to decompress after stressful situations. In order to avoid the end points of the compassion continuum, between emotional over-involvement with patients, and emotional distance or CF, the key may be compassionate care for the self and "balanced" empathy. The Watson Room is designed to help nurses find a sense of self, and work-life balance, after a stressful situation with a patient, family or staff member. The prevention and treatment of CF begins with care for, and protection and healing of the mind.

Population and Sampling

A point-in-time survey was conducted in February, 2016. Registered nurses at the bedside in an acute care setting were the target population. Full and part-time nurses, with

a minimum of an eight-hour workweek, volunteered to participate in this DNP project. Participants included nurse managers, coordinators, educators, and other special project nurses. The study took place at a 675 bed level one trauma center, in an acute care setting. Patient health outcomes have become a driving force in health-care delivery, but according to Sabo (2006), there is little emphasis placed on the potential health consequences for nurses providing care, and caring within the health-care system.

Data Collection

My data collection method included collecting quantitative data via online surveys from nurses working in an acute care setting. The area of interest was CF and its effect on nurses at the bedside. The ProQOL survey was used as the data collection instrument. I recruited participants by way of emails, staff meeting interactions, and word of mouth. I sent participants who agreed to be part of the project an email with a link to the ProQOL survey via SurveyMonkey. Consent of participants was implied by the completion of the ProQOL survey. There were no personal identifiers on any of the study documents, thus protecting the anonymity of the respondents. I monitored the survey daily, and secured all data in a safe location.

The Walden Institutional Review Board (IRB) committee reviewed and approved my proposal January 31, 2016, and verified that there were no conflicts or unethical practices involved with this project. My IRB approval number is 02-01-16-0260922, and it expires January 31, 2017. The health system in which the study was conducted has resources to help staff in distress such as the chaplain, or employee assistant program in

the event they need individualized counselling. After stressful events, debriefings are typically held by the charge nurse and nurse manager.

Data was collected over a two-week period (February 2nd thru February 16th 2016) using SurveyMonkey. I made routine contact with nurses to encourage participation, and to assist them with submitting their completed survey when necessary. I programmed the ProQOL assessment into SurveyMonkey for staff to complete. Upon participant completion, I stored the surveys on a secure encrypted jump drive, and a secure hard drive on my computer. I will keep this survey data until my work is published, or up to five years. A sign-in and sign-out sheet was provided for staff to use to keep track of all participant uses of the Watson Room. Staff also completed an evaluation of their experience in the Watson Room after each use. I regularly monitored SurveyMonkey to evaluate compliance and completion. The pre-and post-study surveys were submitted on an honor system process. The sample size goal was to have at least 70% of the 36 staff complete the survey. When less than 70% of staff completed the survey during the pre- and post-assessment period, I sent another email to remind participants that the survey was still open. I also attended staff meetings to remind staff of the importance of their voluntarily participation.

In order to monitor who completed the pre-and post-survey, I had participants add unique identifiers to the beginning of the survey. These identifiers included the numerical portion of their street address and the two middle digits of their social security number. I used these numbers to link the pre-and post-study survey results. When the pre-survey

did not have the post-survey unique identifier to match, and vice versa, I did not included it in the results.

Data Analysis

Before and after the implementation of the Watson Room, I conducted a survey using the ProQOL to assess the participants' levels of CF. Nurses at the bedside participated in the survey on a voluntary basis. To analyze results, I used JMP Version 11.2.1 statistical software. Specifically I used the paired *t* test to measure mean differences in the survey results. A limitation to using the *t* test included a lack of a completed pre and post study survey that could be compared to the users of the Watson Room. For example, when a participant completed the pre survey, and not the post survey, or vice-versa, I did not use the *t* test to evaluate the results from that particular participant because the results would have been skewed. A total of six out of the 36 surveys were impacted by this issue. These limitations had a potential impact on the survey. However, the end results indicated that the use of a quiet zone after stressful events at work improved participants' compassion levels, decreased burnout, and decreased CF.

Evaluation Plan

Nurses and stakeholders must be involved in the selection of priorities (Hodges & Videto, 2011). Stakeholders invest in the program, are interested in the results of the evaluation, and have a stake in what will be done with the results of the evaluation. A key strategy I used was to partner with the nurse manager on the unit, to identify the best methods for recruiting, and maintaining participants.

Limitations to the project included a small sample size (n = 30), and a heavy workload where staff did not have time to use the Watson Room. Despite these limitations, this study represents an important preliminary step in identifying factors related to CF, and highlights the need for more research in this area. Strengths of this project include the fact that the Watson Room is conveniently located on the nursing unit. The chapel at the study site is two buildings over from most patient care areas, and staff members rarely have a chance to leave the department for 30 minutes outside of lunch. Having the Watson Room on the designated unit in a pre-existing space improves the chances that it will be used to its full purpose. Expectations were reinforced that the charge nurse must cover, or rearrange assignments for someone else to assume the care of patients, while the nurse use the Watson Room after stressful events. Figure 3 below is a visual presentation of the tool that I used to start, and maintain the integrity of the Watson Room pilot.

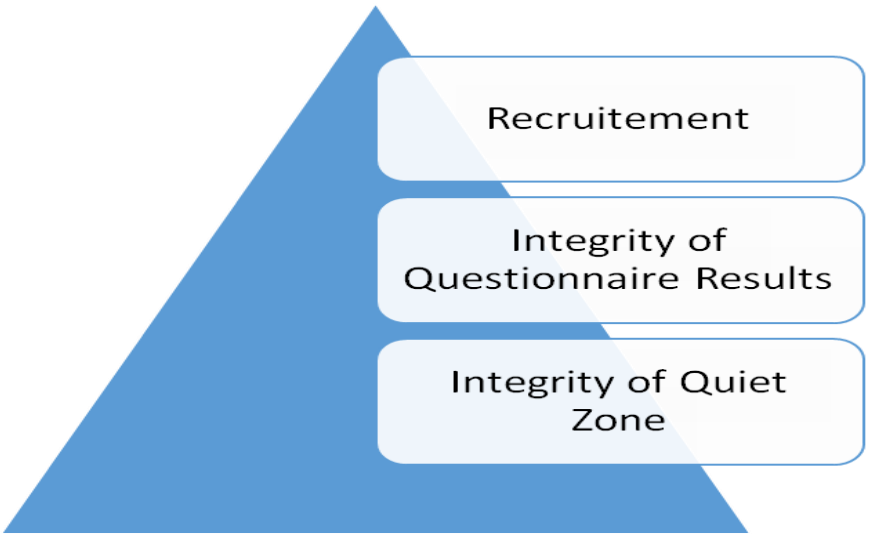

Figure 3. Evaluation.

Summary

Nurse leaders are faced with the competing demands of managing the satisfaction of patients, recruitment and retention of experienced nurses, and provision of quality and safe care customized to patients' needs and preferences. Understanding the concepts of compassion satisfaction, fatigue, and burnout, recognizing the signs and symptoms of CF, and identifying best practice interventions will help nurses maintain caring attitudes (Hooper et al., 2010). It was important that I recruited an appropriate sample size for this project to avoid limitations, and maintain the integrity of the results. I only counted one survey per participant and periodically monitored the Watson Room to ensure it was being used as designed.

Nurses at the study site shared with me that CF is present in their healthcare environment. Looking back over my years of working at a level one trauma center, the signs described in this study, are similar to those which I experienced over fifteen years ago. Some nurses work part time, and change positions trying to find the right job for them. Personal experience, and review of the literature, helped me understand it is the role of a nurse that is in jeopardy of getting CF, not necessarily the area they work.

Organizations have invested so much over the years to prevent blood stream infections, sepsis, falls and falls with injury, hospital acquired infections, and so on. It is long overdue for investments to go towards nurses to address their wellbeing. What better way to do this than to provide a nice quiet space, on a designated unit, where staff can go to take a little time for themselves to recover after difficult moments. The time is right to

protect our nurses, and provide support for them to better care for themselves, during stressful and difficult days and nights on the unit as a bedside nurse.

Section 4

Summary of Findings

The Watson Room was used by 30 of the 36 nurses who work on the pilot unit. However, only 63% (*n* = 19 nurses) completed both surveys and were included in the final analysis. These nurses had not used the Watson Room prior to enrolling in this pilot study. The preliminary compassion satisfaction scale revealed a score of 40.3, where a score of 33 or less indicate job dissatisfaction. This result indicates that staff were satisfied with their job. However, the post study survey result was as score of 42.6 which indicates that staff was even more satisfied with their job after using the Watson Room. The preliminary burnout score had a mean of 22.9, where a score of less than 18 indicates a positive feeling about their ability to be effective in their work, and a score above 27 is cause for alarm. Even though 22.9 in the preliminary study was greater than the goal of less than 18, the post study survey results after participants used the Watson Room revealed a score of 19.5, which is closer to the goal of 18 or below. This decrease indicates that participants were more positive about their ability to effectively do their work subsequent to the implementation of my project. When assessing CF, scores above 17 indicate a potential problem. The preliminary mean score in this category was 22.6. However, the mean score after participants used the Watson Room was 19.5, which was again improvement, and marked progress towards the goal of 17 or less.

The total mean scores and standard deviations of the ProQOL results are listed in Table 2. There were statistically significant differences in the mean scores in all three categories of the ProQOL survey as shown in Table 2. As I had expected, the Watson

Room proved to be successful in increasing compassion satisfaction, decreasing burnout, and decreasing secondary trauma/CF. There were no demographics collected on staff for this study. However, out of the 36 nurses on the pilot unit, there are 31 female and five male nurses, and 30 out of the 36 nurses work full time (36 hours/week or more).

Table 2

Pre and Post Comparison of ProQOL

	Pre		**Post**		
	Mean	**Std Dev**	**Mean**	**Std Dev**	***p*-value***
Compassion Satisfaction Scale	40.3	4.7	42.6	5.4	0.0095
Burnout Scale	22.9	3.6	19.5	4.4	0.0021
Secondary Trauma Scale	22.6	5.1	19.5	4.8	0.0172

* Using a paired t-test

Participant feedback on their uses of the Watson Room is summarized in Table 3. Most of the feedback was positive, however there is room for improvement, as noted in the table. As nurses took turns using the Watson Room, there was a logbook in the room for them to provide feedback as to their experience during, and after using the room.

Table 3

Feedback from Use of the Watson Room

Positive Comments	*Negative Comments*
Wonderful way to escape stress on the job	Better hand-off when using the room
Amazing way to relax in stressful environment	Calf massage was painful
Amazing! Felt so Zen	Need a reminder to turn off light
Great! Felt like I wasn't at work for 10 minutes	Acuity too high to use Watson Room
The room and chair is EVERYTHING!	
Very peaceful and relaxing	
Truly amazing! So nice to look forward to	
Great investment	

Discussion

The purpose of this study was to determine if a quiet zone in the workplace environment reduces CF in clinical nurses at the bedside in acute care settings, and to bringing awareness to the problem of CF. The Watson Room proved to be a huge success for the nurses on the pilot unit. Even though there were days when participants were too busy to take advantage of the Watson Room, they still found 30 opportunities to use the room during the two-week pilot. The Watson Room is more convenient than going across to another building, to visit the chapel, in order to decompress after a stressful event. I found it interesting to compare the pre and post data, and to find an overall improvement in the ProQOL scores.

The results from the pre and post surveys showed a positive correlation between using a quiet space to decompress after stressful events, and improved compassion satisfaction, decreased burnout, and decreased CF. Lombardo and Eyre (2011) reported similar results with the staff at their organization when they used a quiet space to decompress after stressful events. Their staff expressed positive feedback regarding the use of a "relaxation room." The nurses on the unit helped design the room by selecting wall colors and the massage chair, but they did not use the room prior to filling out the pre-study survey. After they used the Watson Room, nurses' compassion satisfaction scores improved as they felt more pleasure from being able to do their work well.

Participants completed evaluation forms after each use of the room. Even though there were several positive comments, one nurse shared that her patient's needs were not taken care of by the covering nurse. One of the rules for using the Watson Room is that nurse's hand off their patient to another nurse while in the room. Nurses must set boundaries and limits, learn to reach out for support, and apply action-oriented problem-solving behaviors to find solutions to delivering the best quality care, with the resources available in the stressful healthcare environment (Bush, 2009). Nurses found that utilizing the Watson Room was an action-oriented strategy that helped them relieve stress, and maintain compassion in a very stressful work environment.

Implications

Implications for Practice/Action

Caring for sick patients requires nurses to stay on guard, perform at optimal levels continuously for 8-12 hour shifts, and ensure that patients have the best outcomes. This project provided an opportunity for nurses to relieve stress, relax, and rejuvenate. If the stress that follows after caring for sick and dying patients is not addressed appropriately, then the nurses may evolve to a state where the results are beyond the nurses' endurance level, the energy expended has surpassed the restored reserve, and recovery power is lost. Many nurses on the pilot unit have acknowledged feeling less stressed and more able to manage at work after using a quiet zone.

Implications for Future Research

The concept of CF and its negative impact on nurses' physical and mental health has been studied extensively. However, more studies are needed to determine ways in which CF can be predicted, and perhaps avoided (Yoder, 2010). Even though the Watson Room in this study was created on a small unit, with a staff of less than 40 nurses, there was an improvement in compassion satisfaction, decreased burnout, and decreased CF. Future research should focus on the feasibility and impact of creating quiet zones in larger contexts. Many types of caregivers have been involved in situations that result in CF. CF has been described among cancer-care providers, emergency room personnel, chaplains, and first responders among others (Lombardo & Eyre, 2011). This fatigue may impact nurses in any specialty area. In the process of providing empathic support, they personally experience the pain of their patients and families, as noted by Lombardo and

Eyre (2011). Some nurses with CF need help and guidance from a mentor, consultant, supervisor, or professional counselor to assist with a personalized assessment and intervention process. Nurses may need to be encouraged to try new approaches to self-care such as relaxing in a quiet environment with soothing colors on the wall, a small waterfall, and comfortable massage chair (Lombardo & Eyre, 2011).

Implications for Social Change

Healing from CF takes time and dedication from the staff to recognize its effects. Employers need to take time to educate themselves about CF, and its effects, and to teach staff in continuing education courses to overcome the everyday stressors that nurses deal with routinely. Strategies should be put in place to help heal our healers (Jenkins & Warren, 2012). Positive beliefs about oneself, understanding other people and their cultures, continuing to address the needs of both the patient and oneself, and listening to what the mind and body are telling one are just a few ways to begin to avoid CF. Self-awareness and balance are key to maintaining health, and the ability to assist in the healing of oneself and others (Jenkins & Warren, 2012). This project highlights a need for additional research regarding the development of interventions, institutional policies, and support programs related to burnout, CF, compassion satisfaction, and secondary traumatic stress in nurses caring for trauma patients.

Figure 4. Compassion fatigue educational flyer.

Strengths and Limitations

Strengths

The strengths of this project are nurses as the stakeholders were involved with the design of the room. The nurses were educated on the term CF and its effect on working in a care givers role. The participants were excited to have the Watson Room on their unit to determine if a quiet space where they can go after stressful situations would be beneficial. Having the Watson Room located on the unit, allowed easy access to get away without leaving the unit. The cost to create the room is doable, due to the conversion of a pre-

existing space. Hospital administration supported the creation of the Watson Room. Other nurse leaders in our organization are creating Watson Rooms for their staff, and found it easy to replicate.

Limitations

This study was limited to one acute care setting with a small sample size. Because of these limitations, the results were not generalizable to nurses as a whole. As an employee of the organization in which the project was implemented, and being known by many nurses, this firsthand acquaintance may have affected participation, or the information staff shared. Other limitations included a busy work environment where some nurses could not complete the surveys, and/or utilize the Watson Room as part of my data collection. The data collection regarding the use of the Watson Room was conducted over two weeks' periods. The Watson Room was used 36 times during the two weeks of utilization.

Recommendations

In order to remediate the above limitations, this project should be offered to multiple areas within the organization, to include the intensive care, oncology and emergency room nurses. Implementation in other similar organization may help decrease bias with the researcher being know by the participants in the study. It would be helpful to repeat this project with a larger sample of nurses working in various departments. The study should be extended over a longer period of time, to include one month for the pre-study survey, one month to use the Watson Room, and one month to collect post-data to increase the sample size. The use of qualitative methods such as, individual interviews,

focus groups, or direct observation can be used for the future research for a more comprehensive picture.

Analysis of Self

As Scholar

The practice doctorate in nursing provides the terminal academic preparation for nursing practice, (AACN, 2006). As a DNP scholar, I possess a wide range of knowledge gleaned from the sciences, and can translate knowledge effectively to benefit patients in the daily demands of practice environments. As a result of my DNP program, I am educated, eager and prepared to translate new knowledge, and understand that change is not always well received. Making sure staff understands the goal of the project, getting them engaged in the process, and reinforcing support of my project has enhanced my skills as a transformational leader. These skills will help me further develop and implement any pending or future projects.

As Practitioner

Nursing science frames the development of middle range theories and concepts to guide nursing practice. This practice includes direct care, as well as a focus on the needs of a panel of patients, a target population, a set of populations, or a broad community. As a practitioner, I will conceptualize new care delivery models that are based in contemporary nursing science, and that are feasible within current organizational, political, cultural, and economic perspectives. I will lead in todays' increasing complex health care system, apply evolving best practices, to make significant improvements in nurses and patients care.

As Project Developer

As a project developer, I apply concepts, methods, models and theories into practice. I designed, implemented, evaluated, and disseminated scholarship that addressed a need or problem in a focused area such as CF and how it affect nurses. As a project developer I was able to use my expertise to educate our current and next generation of future leaders. Other nurses throughout the organization have inquired as to how they can implement a Watson Room on their unit. Consultants from outside of the organization have contacted nursing administration in our organization to determine if staff has a quiet place to go to relax for a few minutes after stressful or traumatized events.

Future Professional Development

This project will help others create a template for the future professional development of nurses' compassion level in the work place. The Watson Room can be easily replicated, is low cost, and beneficial to all staff working with sick and traumatized patients. Policies can be developed to support care of self by way of using a stress free, device free, relaxing atmosphere, in a pre-existing work space on the unit.

Figure 5. The Watson Room.

Conclusions

The Watson Room proved to be a place where nurses look forward to going to decompress after stressful events. The creation of the Watson Room came into existence by transforming a small work space, with two computers in the room that staff used for educational modules. Staff was consulted, to see if they would mind giving up this sparsely used space, in order to get a quiet zone, where they can decompress after stressful situations. Needless to say, the staff on my pilot unit was more than happy to give up the pre-existing space for what is now known as the Watson Room.

As mentioned earlier, the name of the Watson Room was named after the nursing theorist Jean Watson. I contacted Dr. Watson via email to let her know about my DNP project, and that I have been following her work on relationship based care to self, and as a result, named the quiet zone the Watson Room in honor of her work. After a few emails to Jean Watson, and consults with my organizational leaders, arrangements have been made for Jean Watson to visit our organization September 2016. Dr. Watson will present grand rounds to talk about her work regarding relationship based care to self- theory, and visit nurses on the unit in our organization. I dared to imagine I could get Dr. Watson to visit our Health System to validate my work, but it is confirmed, and she is coming to our organization to do just that. She stated she want to see the Watson Room, and is honored to be part of my DNP journey. During grand rounds I will have the privilege of introducing Dr. Watson to the organization, how cool is that?

Even though my sample size was small, the results show that having a quiet space in the environment, in a pre-existing space, helps nurses fell less burnt out, more satisfied with their work, and less CF. We've invested so much to make sure our patients are given the best quality and compassionate care possible. It is time we make sure the staffs that are providing care to others are also being equally as cared for.

Section 5

Project Summary and Evaluation Report

In this project, I found that a quiet zone in the work environment improves compassion levels and decreases burnout. CF is a phenomenon that affects nurses who work with sick and traumatized patients. Being aware of stressors in the workplace, and developing coping strategies, may help the nurse and upper management deal with the inevitable stressors which nurses face on a daily basis (Yoder, 2010). We can support the nursing role by acknowledging the risk of CF, exploring what might protect the nurse as he or she faces the suffering that the patient experiences, and supporting the use of helpful strategies.

As staff used the Watson Room to decompress, they reported feeling an immediate sense of relief from stress and CF. They reported that the Watson Room is a wonderful way to "escape" stress on the job, and that they were able to truly relax and feel transported away from the hospital during their 15-30 minutes of "me time." The relaxing environment, sounds of ocean waves, and aromatherapy in the room gave staff another reason to look forward to coming to work.

Grant Proposal

The project was funded by the Health Systems Nursing Administration. The total cost for the project was $2,250.00. The biggest expense for the project was the massage chair and the painting of the walls. Table 4 shows the breakdown of expenses.

Table 4

Cost of the Watson Room

Items for Watson Room	Cost
Massage chair	$1,500
Paint for the walls	$500.00
New flooring	$125.00
Water fall with soft lighting	$40.00
Flat screen television	Donated-pre-existed on the unit
Aroma therapy	$20.00
Relaxing waterfall and Zen DVD's	$30.00
Small rug	$25.00

There are 3.1 million registered nurses in the United States; they comprise the largest group of healthcare workers in the country (Health Resources and Services Administration, 2010; Lombardo & Eyre, 2011). CF is a nursing occupational hazard that results from providing empathic, relationship-based care to patients and families (Lombardo & Eyre, 2011). It is important for nurses to become knowledgeable about CF symptoms and intervention strategies, and to develop a personal plan of care in order to and achieve a healthy work-life balance (Lombardo & Eyre, 2011). As a result of this DNP project I have a better understanding of CF, and a better appreciation for taking care of myself in the workplace environment. When I take time to care for myself, I am better prepared to care for others.

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APPENDIX A: ProQOL Survey

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SECTION 8: THE PROQOL TEST AND HANDOUT 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.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your

scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test and then you can compare your score to the interpretation below.
To find your score on **each section,** total the questions listed on the left in each section and then find your score in the table on the right of the section.

Compassion Satisfaction Scale:

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total: _____

The sum of my Compassion Satisfaction Questions	**So My Score Equals**	**My Level of Compassion**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale:

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

The sum of my Burnout Questions	**So My Score Equals**	**My Level of Burnout**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Reverse the scores for those that are starred.
0=0, 1=5, 2=4, 3=3, 4=2, 5=1
Total: _____

Secondary Trauma Scale:

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: _____

The sum of my Secondary Traumatic Stress Questions	**So My Score Equals**	**My Level of Secondary Traumatic Stress**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High