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Walden University

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Walden University

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Dionne Hutson Hendy

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Walden University
2016

Abstract

Compassion Fatigue in Emergency Department Nurses

by

Dionne Hutson Hendy

MSN, Walden University, 2014

BSN, Felician College, 2012

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2016

Abstract

Compassion fatigue (CF) is a problem seen within healthcare institutions worldwide, especially critical care units and emergency departments (EDs). The problem identified in this quality improvement (QI) project was CF, experienced by nurses in the ED. The effects of CF cross nurse–patient boundaries and negatively impact a patient's expectations of having a quality care experience. The Iowa model's evidence-based team approach was used to guide the development of the education initiative for nurses on recognizing, preventing, and identifying methods of coping with CF in the ED. The outcome products for the project included an extensive review of the literature, a curriculum plan to educate ED nurses on CF, and a pretest/posttest to validate ED nurses knowledge about CF. The content of the project was measured by 2 master's-level prepared education experts using a dichotomous scale. The format evaluated content material using total scores of 1 for content *(not met)* and total scores of 2 for content *(met)*. The average score was 2, which demonstrated the objectives for the education initiative were identified and the goals were met. The content experts also conducted content validation of each of the 14 pretest/posttest items using a 4-point Likert scale ranging from 1 *(not relevant)* to 4 (*very relevant*) that resulted in a content validation index of 1.00, showing that the test items were covered in the curriculum. Recommendations were made for item construction improvement and omission of the Iowa model from the curriculum plan and pretest/posttest. The project promotes social change through the facilitation of patient satisfaction, quality of patient care, and prevention of CF on nursing staff.

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Dedication

This project is dedicated to my family for the encouragement and support you have shown me as I pursued my dream for earning this doctoral degree. A special thank you to my mother, June Hutson, "you have remained by my side throughout the good, the bad and the indifferent". An extra special thank you to my husband Marvin Hendy Sr. and my children, Erwin, Marvin, and Quincy, this degree is for you. Thank you for enduring the trials and tribulations with me as I embarked and persevered throughout this educational journey. “I love you to the moon and back” and I am grateful for each of you and your unique purpose in my life. Thank you. :)

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A special thank you to my Lord and Savior—JESUS CHRIST, thank you for blessing me with health, strength, and wisdom, without you this would not be possible. A very special acknowledgement to my Walden University faculty chairwoman, Dr. Joan Moon; the patience you have shown to me and my peers throughout the doctoral project development process has exceeded what we ever expected. Thank you for sharing your love for the nursing profession by making positive contributions through your mentorship, experience, and personal knowledge.

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Section 1: Compassion Fatigue in Emergency Department Nurses

Introduction

The Essentials of Doctoral Education for Advanced Nursing Practice competencies were developed to represent foundational expectations for Doctor of Nursing Practice (DNP) nurses in their role to eliminate health disparities and promote patient safety and excellence in practice (American Association of Colleges of Nursing [AACN], 2006; Zaccagnini, 2011). This DNP project pertained to Essentials II: Organizational and Systems Leadership. Essentials II indicate that students must be proficient in quality improvement strategies and in creating and sustaining changes at the organizational and policy levels (Zaccagnini, 2011). Improvements in practice are neither sustainable nor measurable without corresponding changes in organizational arrangements, organizational and professional culture, and the financial structures to support practice (AACN, 2006).

Nurses employed within the emergency department (ED) of a Level II trauma center located on the east coast of the United States were experiencing the condition known as *compassion fatigue*, as demonstrated by the increased use of sick time resulting in decreased staffing and delayed patient care. In addition, some patients verbalized to call-back nurses who followed up after care at the healthcare facility that they were dissatisfied with the care received and were concerned about increased wait times for medications potentially making their medical conditions worse.

Compassion fatigue (CF) is described as an emotional, physical, and mental disconnect whereby empathy is lacking. CF affects medical and nursing providers by inhibiting their ability to provide adequate, safe, high-quality care (Coetzee & Klopper, 2010; Mealer & Jones, 2013). Nurses who are affected by CF have expressed feelings of depression, which may be related to the constant emotional trauma they experience because of being employed in critical care areas such as hospice, ICU units, and EDs. Providing education on how to recognize, prevent and, identify methods for coping with CF to minimize the negative nursing effects and patient outcomes caused by CF. The early identification of risk factors can help nurses and organizational leaders identify interventions to guide the healing process (Flarity, Gentry, & Mesnikoff, 2013).

Background

Compassion was defined by Harris and Griffin (2015) as an act of providing assistance to families, individuals, and communities when they require guidance to cope with physical, spiritual, and emotional distress. *Compassion fatigue* in nurses refers to a lack of empathy and an inability to provide nurturing care or connection on a personal level with the patient's pain and anguish (Harris & Griffin, 2015). Compassion fatigue has increased within the nursing profession and affects nurses and patients differently. Hunsaker, Chen, Maughan, and Heaston (2015) completed a study to determine the prevalence of compassion satisfaction (CS), CF, and burnout (BO) in ED nurses, and to identify risk factors exposing nurses to the conditions. The study included registered nurses (RNs) with at least 1 year of ED experience who were currently employed in an

ED with patient care interaction on average of at least 8 hours per week. The study indicated that the longer a nurse is employed in these critical care areas or exposed to trauma, the more likely he or she is to have CF. As noted by Sacco, Ciurzynski, Harvey, and Ingersoll (2015), six standards for establishing and maintaining a healthy environment for both patients and employees can help organizations identify the factors that promote a healthy work environment. The problem of CF has a direct negative impact on an organization's goals for patient safety, patient satisfaction, and employee job satisfaction.

MacKusick and Minick (2010), reviewed studies of analyzed work environments and work-related stressors and found that nurses employed in critical areas are exposed to and are more likely to be affected by mental and physical exhaustion, causing more missed days of work. According to Harris and Griffin (2015), common symptoms experienced by nurses that are essential to a diagnosis of CF include spiritual, decreased sense of fulfillment, disconnectedness to people, lack of motivation, sensation of fatigue, personal and career dissatisfaction, and feelings of helplessness related to unrelenting sacrifice of self and/or prolonged exposure to trauma. These symptoms are exhibited by nurses employed in critical care areas because of the repeated emptiness emotional exposure to trauma they experience.

The escalation of symptoms from emotional to physical and then to psychological can be seen over time and usually begins with subtle problems, such as loss of work-related satisfaction (Shepard, 2015; Stamm, 2015). Accompanying symptoms of low

morale, physical and emotional exhaustion, impaired job performance, absenteeism, and decreased nursing retention within departments are described by nurses who have left the profession as the only viable means to escape CF (Mackusick & Minick, 2010). Educating ED nurses about CF is a necessity for the delivery of quality patient care and positive outcomes. Nurses may acquire coping skills after being educated about the problem, ensuring they are mentally and physically equipped to perform their duties (Harris & Griffin, 2014).

Problem Statement

The problem addressed in this quality improvement (QI) DNP project was CF, which is experienced by nurses in the ED. The effects of CF cross nurse–patient boundaries and affect patients and what they expect as part of their quality care experience. At the study site, patients verbalized concerns to call-back nurses about delays in patient care as well as care received from nurses who appeared overwhelmed by their assignments. The ED nurses brought their concerns to the leadership team in an effort to develop interventions to decrease patient and nursing dissatisfaction. The ED has seen an increase of nurse turnover due to several contributing factors, such as increased census, higher patient acuity, nurses advancing into other professions or obtaining higher nursing degrees, and nurses transferring into other departments or units to avoid the demands of ED nursing and CF (Harris & Griffin, 2015).

ED nurses often experience an influx of complex patients and challenging nursing assignments that cause feelings of fatigue, exhaustion, being overwhelmed, and trauma at

the end of their shifts (Coetzee & Klopper, 2010). CF symptoms develop over time and progress from emotional and physical to psychological complaints affecting the individual's well-being and ability to cope (Coetzee & Klopper, 2010; Mealer & Jones, 2013). The symptoms of CF can be difficult to recognize because of their similarities to symptoms of other conditions such as posttraumatic stress disorder (PTSD), a condition whereby individuals are negatively affected by a previous traumatic experience; depression, a feeling of hopelessness and worthlessness; and secondary traumatic stress, a condition that affects those who are friends, family members, or caretakers of individuals who have experienced traumatic events (Dominguez-Gomez & Rutledge, 2009; Figley, 1995; Mealer & Jones, 2013).

I have observed the above-mentioned contributing factors within the healthcare organization with the realization that CF is partially responsible for the decrease in nursing retention. Continuous fatigue and exposure to complex nursing assignments have caused many nurses to feel mentally debilitated and unable to react as needed to prevent delayed patient care (Mealer & Jones, 2013). Nurses in the ED exhibit symptoms of CF dependent upon independent risk factors, including patient assignments or other work-related and personal factors, and identifying symptoms is essential to early recognition of CF and prevention of misdiagnosis. According to Shepard (2015), nurses may still have compassion when the emotional aspect of the profession renders them apathetic. The problem of CF continues to transition from an issue only affecting nurses' assignments while at work to an issue also affecting nurses' personal lives.

Purpose Statement

The purpose of this DNP project was to develop an initiative to educate ED nurses on recognizing, preventing and identifying methods of coping with CF. According to Collins and Long (2003), nurses affected by CF exhibit behaviors that may cause harm to themselves and the patients entrusted to their care, and if nurses are educated about CF risk factors and coping strategies, the outcomes can be different if they are affected.

Goal and Outcomes

The goal of this doctoral project is to bring awareness of CF among ED nurses through an educational initiative. The outcomes are as follows:

- Literature review matrix
- Professional Quality of Life (ProQOL) satisfaction scale
- Curriculum plan
- Pretest/posttest

Project Model

The Iowa model of evidence-based practice (EBP) was applied to the project. According to Brown (2014), the Iowa model can help nurses and other healthcare providers translate research findings into clinical practice while improving outcomes for patients. Brown stated that the Iowa model identifies problem-focused triggers such as problems that derive from risk management data, financial data, or the identification of a clinical problem (e.g., patient falls or medication errors) or knowledge-focused triggers (information that has clinical relevance to the problem) where an EBP

change might be warranted. Using the Iowa model, evidence-based literature was reviewed to guide the development of an intervention plan to provide the desired outcome for nurses, the ED, and the organization. Titler, Kleiber, Steelman, Rakel, Budreau, Everett, and Goode, (2001) found that the use of specific criteria is helpful when the findings of evidence-based literature or research are being considered for implementation into practice. Titler et al., (2001) encouraged the use of research and literature that shares similarities including relevance, feasibility of the findings, type and quality of study, and risk-benefit ratios of the problem. Doody and Doody (2011) reported that the Iowa model focuses on organization and collaboration incorporating research, knowledge, and problem-focused triggers leading staff to question current nursing practices and whether care can be improved using current research findings.

Nature of the Project

Brown (2014) identified the steps of the Iowa model as a process that allows for smooth transition of evidence into clinical practice. I received permission to use the Iowa model framework to guide the development of my initiative. Step 1 of the Iowa model is to identify the problem; for this project, the problem was identified as compassion fatigue in ED nurses. The purpose and goal of this project was achieved through me, as the team leader, leading a team of stakeholders within the organization, whose members include the following:

- Director of nursing for emergency services.
- Clinical nurse educator of ED.

- Manager and assistant managers of the ED.
- Nurses who are at risk for or affected by CF.

Step 2 of the Iowa model involved forming a team for an extensive evidence-based analysis and synthesis of the literature. The third step in the Iowa model was the retrieval of evidence, and the fourth step was reviewing the evidence, which was presented to the committee, whose members used the evidence to guide the development of the educational initiative. The fifth step of the Iowa model was development of the the plan and was be completed by me and the team of stakeholders identified above. Implementation is Step 6 of the Iowa model and will be completed by me after graduation. Last, Step 7, the evaluation, was guided by the team of stakeholders and included a content evaluation by content experts, a content validation index score provided by content experts, and a summative open-ended questionnaire completed by the stakeholders on the products, the process, and my leadership.

Definitions

The following terms were used in this project about CF.

Burnout (BO): The experience of emotional exhaustion, loss of motivation, depersonalization, and reduced personal accomplishment (Harris & Griffin, 2015).

Compassion fatigue (CF): Involves emotional, physical, and spiritual weariness of nurses causing inability to nurture, lack of empathy, and emotional disconnect from patients' anguish (Smart, English, James, Wilson, Daratha, Childers, and Magera, 2014).

Compassion satisfaction (CS): Positive feelings derived from helping others through traumatic situations (Dunn, 2009, Sacco et. al., 2015; Stamm, 2015).

Evidence-based practice (EBP): Conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of quality, cost-effective healthcare (Grove, Burns and Gray, 2014).

Posttraumatic stress disorder (PTSD): A mental health problem that develops following exposure to a stressful event or a situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (Practice Nurse, 2016).

Secondary traumatic stress (STS): The affected individual is not the primary person who was affected by the trauma but has a relationship with traumatized clients (Figley, 1995).

Assumptions

According to Grove, Burns, and Gray (2014), assumptions are defined as statements that are taken for granted or considered true, that are unrecognized, and that require introspection to be uncovered. The assumptions for the project included the following:

- Nurses want to feel better about their job performance and not be overwhelmed by their profession.
- Organizational leaders are concerned about the well-being of their staff and support this educational initiative.

Scope

The scope of the project include ED nurses, the leadership team, and nurses from the follow up team.

Significance of the Project

CF affects nurses who are employed in critical care areas including the ED. Presently, nurses are unaware and unsure of how to prevent and cope with the symptoms of CF (Harris & Griffin, 2015). Literature reviews have focused on the contributing factors that increase nurses' risk for exposure to CF, such as working long hours leading to exhaustion, having challenging patient assignments with decreased staffing, and other non-work-related personal matters. According to Hooper, Craig, Janvrin, Wetsel, and Reimels, (2010) nurses across the nation are struggling to balance demands for improved patient satisfaction and outcomes with demands for greater efficiency at a time when patients expect improved service. In addition, this doctoral project will assist the organization's leaders with cost containment by identifying factors that contribute to decreased nursing retention in the department. The project has the potential to support a stronger, healthier, and satisfied workforce, and provide methods for coping to nurses that can help with improving job performance and patient satisfaction.

Summary

In Section 1, CF has been defined as a combination of symptoms including chronic or prolonged exposure to trauma or stressful situations that affects a nurse's

ability to nurture or empathize, leading to a lower quality patient care experience. In the next section of this project, I discuss the framework under which the project was developed and present an extensive review of the literature to better understand CF and identify best practices in avoiding and managing CF.

Section 2: Review of Scholarly Literature

Introduction

The problem addressed in this doctoral project is CF experienced by nurses in the ED. The purpose of the project is to develop an initiative to educate ED nurses on how to recognize, prevent, and identify methods for coping with CF. In this section of the project, evidence-based literature about CF is reviewed to identify the gap between what is currently happening in the ED and what is identified in the literature. A review of the literature contributes to evidence-based practice, thus improving the nursing profession and how nursing care is rendered (Terry, 2015).

The phenomenon of CF was first introduced to the nursing workforce in the 1990s in scholarly literature reviewing complaints verbalized and observed in nurses employed in EDs (Boyle, 2011; Coetzee & Klopper, 2010; Potter, Deshields, Berger, Clarke, Olsen, and Chen, 2010). Evidence-based literature has identified CF as a major work-related condition that has emotional, physical, and mental symptoms (Shepard, 2015). Hooper et al., (2010) stated that an individual who is affected by CF may have varied symptoms such as sadness, depression, anxiety, intrusive images, flashbacks, numbness, avoidance behaviors, cynicism, poor self-esteem, and survivor guilt. Mealer and Jones (2013) identified nurses as being at an increased risk for posttraumatic stress disorder (PTSD) due to work-related stress, particularly in specialty areas such as the intensive care unit, emergency room, and oncology units, where the organizational philosophy or expectation is to save lives. For people affected by symptoms of CF, continued exposure to suffering

eventually leads to reduced productivity, increased staff turnover, sick days, patient dissatisfaction, and risks to patient safety (Hegney, Craigie, Hemsworth, Osseiran-Moisson, Aoun, Francis and Drury (2014). Sacco, Ciurzynski, Harvey, and Ingersoll (2015) cited Dunn (2009) and Stamm (2015) identifying the primary reason that nurses remain in the nursing profession as seeking to maintain a sense of compassion satisfaction.

Literature Search Strategy

Evidence-based and scholarly articles including researches were examined for the purpose of this DNP project using the World Wide Web (www), search engines such as Bing and Google, nursing databases such as Cumulative Index of Nursing and Allied Health (CINAHL) and Medline for peer-reviewed nursing journals and articles via Walden University, and scholarly books. The key terms used when conducting the literature search included *compassion fatigue (CF)*, *burnout (BO)*, *evidence-based interventions for CF*, *nurse retention*, *patient satisfaction*, *sick days*, *fatigue*, *barriers to nursing retention*, *interventions for CF*, *coping with CF*, and *Iowa model*. The 46 references chosen for the literature review were peer reviewed and ranged in year of publication from 1992 to the present.

Iowa Logic Model

The Iowa model is a framework used by healthcare organizations to organize and guide the translation of evidence-based research findings into clinical practice while improving outcomes for patients (Brown, 2014). The Iowa model is comprised of seven

steps and provides a detailed path for implementing change. White and Spruce (2015) stated that the use of the Iowa model focuses on organization and collaboration, allowing nurses to target knowledge and problem-focused triggers, as well as encouraging personnel to question current nursing practices and determine whether care can be improved by using current research findings. Schaffer, Sandau, and Diedrick (2013) identified the Iowa model as a process that leads to the formation of a team whose members search, critique, and synthesize the literature. The second decision point involves considering the adequacy of evidence to change practice. Inadequate evidence leads the practitioner to a choice between conducting research and using alternative types of evidence. When adequate evidence is found, a pilot of the change is conducted. Evaluation of the pilot leads to the third decision point, which involves whether to adopt the change in practice. Ongoing evaluation of the change and dissemination of results are further components of the Iowa model.

Compassion Fatigue

A review of the literature contributes to evidence-based practice, thus improving the nursing profession and how nursing care is rendered (Terry, 2015). CF affects patient satisfaction and outcomes, nursing retention, and nursing attendance. The biggest problem with CF is misdiagnosing and confusing the condition with other conditions such as BO. Compassion fatigue can occur over time and is caused by a lack of empathy, unlike BO, which has a gradual onset and is associated with factors such as high patient acuity, overcrowding, and problems with administration (Flarity et al., 2013).

Risk Factors for Compassion Fatigue

ED nurses encounter a variety of traumatic nursing experiences, work-related stressors, and personal factors that place them at risk for CF (Coetzee & Klopper, 2010). In addition to risk factors, occupational factors such as working long hours, staffing shortages, and increased census can contribute to CF, placing ED nurses in a continuous emotional state of being overwhelmed (Houck, 2014). Hunsaker et al. (2015) conducted a study to determine the prevalence of CS, CF, and BO in ED nurses. The study was a nonexperimental, descriptive, and predictive study using a self-administered survey. Randomly chosen nurses from different states within the United States were mailed survey packets that included a demographic questionnaire and the Professional Quality of Life Scale, Version 5 (ProQOL 5). The ProQOL 5 scale was used to measure the prevalence of CS, CF, and BO among ED nurses. Multiple regression using a stepwise solution was employed to determine which variables of demographics and work-related characteristics predicted the prevalence of CS, CF, and BO (Hunsaker et al., 2015).

Nurses who are employed in high-acuity units such as critical intensive care units and EDs are at increased risk for CF exposure; these critical care nurses experience higher patient turnover and patient acuity compared to nurses in other units in the hospital (Hunsaker et al., 2015). In addition, Hunsaker et al., (2015) identified correlations with CF and the length of time the affected nurse had worked in the critical care unit, the

length of time the affected nurse had practiced nursing, and the number of hours the affected nurse worked per week.

Hunsaker Chen, Maughan, and Heaston (2015) identified through their research that the more years a nurse has practiced, the higher the level of CS and the lower the level of BO the nurse will experience. Nurses reported acknowledging signs and symptoms of CF due to increased workload yet continued to provide care, stating that the outcome of knowing that they were helping patients outweighed their feelings of exhaustion (Hunsaker et al., 2015). The results revealed average to low levels of CF and BO and average to high levels of CS among this group of ED nurses. Demographic and work-related characteristics, such as age, educational background, and years as a nurse, influenced the prevalence of CS, CF, and BO among ED nurses (Hunsaker et al., 2015). In addition, no significant relationship existed between the years a nurse worked in the ED and the level of CF, or between the average number of hours that ED nurses worked per week and levels of CS, CF, and BO. Further, there was no significant difference in CF between nurses who worked 8 to 10-hour shifts and those who worked 12-hour and other shifts. Hunsaker et al., (2015) stated that the results of their study varied, indicating a low to average level of CF and BO among ED nurses, which was not consistent with the results of previous studies related to ED nurses who perceived significantly higher levels of these two negative phenomena.

According to Harris and Griffin (2015), CF does not discriminate and can affect both novice and experienced nurses. In addition, stress is the main contributing factor

related to CF (Casey & Hancock, 2004). Casey and Hancock (2004) stated that novice nurses reported increased stress, feelings of incompetence, and lack of confidence during their first year. The findings of the study identified nurses experiencing stressful life events after entering the nursing profession. The findings revealed that 89.2% were exposed to a stressful event within the first 3 months as a nurse and that of these nurses 65.8% experienced an event directly happening to them, 60.6% witnessed a stressful event, and 66.7% learned about a stressful event happening to someone close to them. During the time of the survey, a large percentage of nurses, 34.5%, witnessed a particularly stressful life event, while 26.7% witnessed or experienced a life-threatening illness or injury, 26.75% witnessed severe human suffering, and 13.4% witnessed unexpected death (Meyer Li, Klaristenfeld, and Gold, (2015).

Sawatzky and Enns (2012) stated that factors for predicting CF can be influential factors such as organizational climate and person (i.e., personal/demographic) and include job satisfaction, engagement, professional quality of life (i.e., CS, CF, and BO), and caring. Sawatzky and Enns (2012) conducted a cross-sectional survey with 261 registered nurses employed in EDs within rural, urban community, and tertiary hospitals in Manitoba, Canada. The study set out to identify factors that would predict the retention of nurses and the organizational climate of the healthcare institutions where they were employed. The findings revealed that a quarter of the nurses surveyed would remain employed over the next year and that major factors that affect nursing retention are closely associated with job satisfaction, CF, and BO. In addition, nursing

management, professional practice, collaboration with physicians, staffing resources, and shift work emerged as significant influencing factors for engagement, which was the other factor identified as a nursing retention barrier. ED nurses encounter contributing factors of CF that may predict when CF and BO are occurring. Factors that improve satisfaction at work require the development of strategies to guide how affected nurses provide excellent care without compromising their own health and happiness.

Recognition of Compassion Fatigue

The signs and symptoms of CF can be mild initially, with complaints of weakness, fatigue, or headaches, or they may be moderate, with symptoms that may include anxiety, loss of appetite, insomnia, or diminished performance at work. Severe symptoms of CF include loss of endurance, inability to concentrate, and lack of empathy (Hooper et al., 2010). Nurses affected by CF exhibit behaviors that may cause harm to themselves and the patients entrusted to their care (Hooper et al., 2010). White and Brown (2012) stated that maximizing nursing staff ensures quality care and patient safety. Hooper, Craig, Janvrin, Wetsel, and Reimels (2010) completed a research study to compare patterns of CS, BO, and CF among nurses working in EDs with those of nurses working in other inpatient specialties to identify the severity of risk factors and the onset of symptoms. The research consisted of 139 surveys being distributed to ED nurses; 114 surveys were returned completed. The participants were all nurses; the majority were ED nurses, and others were from specialty units such as oncology, intensive care, and nephrology. The majority of ED nurses who responded, 61%, worked

the day shift, while 39% worked nights (Hooper et al., 2010). The results were that approximately 82% of emergency nurses had moderate to high levels of BO, and nearly 86% had moderate to high levels of CF.

Assessing Compassion Fatigue

According to Smart et al., (2014), the Professional Quality of Life Scale (ProQOL) helps in identifying modifiable risks and developing protective interventions for work-related factors contributing to CF. Smart et al., (2014) reported in their study that outcomes for workers affected by CF include disengagement from patients, poor attitude on the job, lack of concern, and lateness and/or absenteeism. In addition, Sacco et al., (2015) reported that the ProQOL questionnaire helps to identify positive and negative factors affecting patient care to achieve a balance in patient and employee satisfaction.

Coping Methods for Compassion Fatigue

The Indiana State Nurses Association (ISNA; 2012) reported that self-awareness and self-care are the first steps in combating the debilitation associated with CF. In addition, the ISNA identified self-reflection, finding balance in daily activities, spending time alone, and setting boundaries (saying “no”) as effective strategies for coping with CF. ED nurses are unsure how to cope with the sudden onset of CF symptoms as they work through their long shifts and provide care to patients with traumatic and complex illnesses (Smart, 2014). The ISNA recommended several methods for coping with CF. The recommendations include, changing one’s personal engagement level with a patient

or situation, changing the nature of the work involvement by transferring or going to a part-time position, changing shifts, taking extra days off, seeking help from colleagues for informal debriefing, recharging at a retreat or creating a “stress-free zone”, developing a career plan, and nurturing positive relationships at work and at home. CF progresses from emotional and physical to psychological symptoms for ED nurses because of an inability to accept the problem as an occupational hazard caused by related factors (Bush, 2009; Hegney et al., 2014; Rourke, 2007).

Patient Satisfaction and Compassion Fatigue

According to Hunsaker et al., (2015), patient satisfaction is a quality care initiative measure used by healthcare organizations to identify patient experience. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a hospital survey measuring patients’ experience, and the results from these surveys help healthcare organizations develop initiatives for improvement (Huppertz & Smith, 2014). The Centers for Medicaid and Medicare Services (2011) implemented a pay-for-service plan whereby healthcare organizations receive monetary incentives for meeting the national standards and goals identified for the patient population served. The patient rates the health care provider’s performance for quality care and satisfaction, which determines whether reimbursements are disbursed. Healthcare organizations that do not meet these expected goals will not receive incentives and are expected to improve their areas of identified weakness by implementing unit-based initiatives to educate the staff. The ED provides follow-up calls to discharged patients in addition to mailing out surveys

to have patients rate their hospital visit and patient care experience. The information received provide the ED with a better understanding of where its weaknesses are, as well as which current methods should be considered or discontinued.

Sick Days and Compassion Fatigue

Nursing in an ED can be challenging; nurses experience complex patient assignments and can become overwhelmed. CF affects nurses and the manner in which they provide patient care. According to Puetz and Thomas (1996), excessive absenteeism interrupts the continuity and quality of patient care. Sick calls have become the coping action used by nurses to detach them from CF (Boyle, 2011). In a study completed by Survey Responses (2006), nurses were asked if their facility supported their decision not to come to work; 49% reported yes, while 51% reported no. Nurses reported feeling fatigued, frustrated, overwhelmed, and burnt out due to complex nursing assignments and working with less than adequate staffing. In this situation, nurses may call out sick from work, stating that they are tired and unable to unwind when faced with the knowledge that they must return to the same working conditions every time that they are scheduled to work (Boyle, 2011). In addition, Boyle (2011) reported, a nurse's job performance may be assessed through measurement of productivity (on a daily basis and in terms of sick days) and efficiency (work execution and association with errors), which, if CF symptoms are present, may be impaired.

Absenteeism in the ED by nurses increases costs for the organization, causing the organization to pay overtime to another nurse or use an emergency nursing agency.

Hurst and Smith (2011) conducted a study that included healthcare organizations that employed permanent and temporary staff, in order to identify differences in quality of patient care. The medical units were divided into 368 units in which only permanent staff were employed and 237 wards with permanent and temporary staff present during the observation studies. The research findings identified that workload and time out (sickness, absence, etc.) were greater in wards employing temporary staff than in units with permanent staff only, thereby justifying hiring short-term staff. Wards with temporary and permanent staff were more expensive to run, and working styles were different. Overall quality scores, however, were no different in the two types of ward (Hurst & Smith, 2011). The use of sick time by nurses affected by CF, as an alternative to other coping methods, decreases the continuity and quality of patient care. According to Hunsaker et al., (2015), CF and BO may cause a nurse to become detached from patient care, and nurses are unable to meet the expectation of delivering quality patient care or have patients experience satisfaction with care rendered if there are no interventions or coping strategies in place for CF. In addition, feelings of low morale in the workplace increase absenteeism (Jones & Gates, 2007; Portnoy, 2011).

Nurse Retention and Compassion Fatigue

According to Sawatzky and Enns (2012), key factors influencing nursing retention in the ED include factors relating to BO in addition to the stressors of providing nursing care to critically ill patients. The retention of ED nurses will reduce health-care costs and optimize patient and nursing work–life outcomes (Sawatzky & Enns, 2012).

According to Hunsaker et al., (2015) recognizing factors that improve satisfaction at work may be useful in retaining ED nurses, and developing strategies to support, and provide excellent care without compromising their own health and happiness. Dominguez-Gomez and Rutledge (2009) used the Secondary Traumatic Stress (STS) tool to measure CF exposure for ED and inpatient specialty unit nurses, they reported high levels of CF among the ED nurse respondents that may affect patient care and contribute to BO. STS is defined as the emotional, physical or psychological reaction of an individual to someone else's exposure to a traumatic experience (Dominguez-Gomez and Rutledge, 2009). Hooper et al., (2010) researched the effects of nursing retention and CF by comparing the effects of stress measured through the Professional Quality of Life (ProQOL) satisfaction scale. Their study did not show a significantly statistical difference in CF levels of the nurses in specialty units and did attest that ED nurses were at risk for less CS; however, having the ability to recognize symptoms of CS, CF, and BO will help nurses maintain caring attitudes with patients and work closely with managers and colleagues to develop interventions for best practice for nursing retention and patient satisfaction.

Outcomes of Compassion Fatigue

Patient outcomes are negatively impacted when nurses are unable to remove themselves from the source of distress causing them to feel apathetic. Nurses explain feeling frustrated, fatigued, and resentful of the demands accompanying their patient assignments that cause patients to receive less than quality care (Boyle, 2011). The

outcomes for nurses who are affected by CF are to have decreased symptoms through early identification of risk factors and by implementing coping strategies before symptom escalation. Hegney et al., (2014) researched anxiety, stress, and depression in the nursing workforce along with the concepts of CF, CS, and BO to identify appropriate strategies to build and maintain psychological wellness in nurses. The results of their study showed when the factors of depression, anxiety, and stress were examined together the risk for CF increased; BO, and secondary traumatic stress were significantly related to higher anxiety and depression levels. Higher anxiety levels were correlated with nurses who were younger, worked full-time, and without a postgraduate qualification. Twenty percent of the nurses surveyed had elevated levels of compassion fatigue, 7.6% having a very distressed profile. At-risk nurses' stress and depression scores were significantly higher than nurses with higher compassion satisfaction scores (Hegney et al., 2014). The symptoms of CF (how nurses react to stressors pertaining to patients), CS (the emotional gratification experienced by nurses when providing patient care), and BO (workplace stressors for which the nurse has no control) presents differently for each nurse who is affected, and the ability to identify these conditions is essential for implementing the correct interventions to avoid escalation of CF (Boyle, 2011).

Summary

The literature review section of this project summarized peer reviewed articles that speak to the problem of CF and how the symptoms of CF can progress from mild to severe. The evidence-based review found the residual effects of CF included decreased

nursing retention in units that employ nurses who experience CF and decreased patient satisfaction because of poor nursing care (Harris & Griffin, 2015). The project helps nurses to cope with CF, provide quality patient care, and re-evaluate wanting to leave the unit or profession. Section 3 of this project discusses the project approach, methods used to gather data, and the educational initiative plan to teach ED nurses about coping with signs and symptoms of CF.

Section 3: Approach and Methods

Introduction

The purpose of this Doctor of Nursing Practice project was to develop an educational initiative to inform ED nurses on recognizing, preventing, and identifying methods of coping with CF. In the following section, I discussed the approach and methods.

Approach

Multidisciplinary Team

The second step in the Iowa model focused on team development. For this project, the team included stakeholders such as me as the leader of the team, the director of nursing education for the healthcare organization, the director of nursing for emergency services, the clinical nurse educator of the ED, manager and assistant managers, and nurses who may be affected by CF. The team members were essential to project plan, each participant had a valuable role in determining how CF should be managed. Hodges and Videto (2011) stated that the involvement of individuals affected by a problem in the planning process to promote a change in practice will develop program ownership to propel the acceptance of a new change and education plan.

Role of the Leader

I provided an extensive literature review to the team about CF, and developed an educational plan to help ED nurses recognize and cope with CF.

Role of the Team

The team consisted of stakeholders in the ED who contributed to the recognition, prevention, and methods for coping with CF in the ED. The team included the following:

- *Director of nursing for emergency services*: Responsible for overseeing the overall management of the ED and reviewing the plan to determine if the ED budget can accommodate the intervention plan.
- *Director of nursing education for the site*: Responsible for the general education of nursing staff in the healthcare organization.
- *Clinical nursing educator for the ED*: Ensures that nurses in the ED are competent in their nursing skills and up to date with the latest evidence-based practice research, enabling them to provide quality care to all patients entering the ED.
- *Manager/assistant managers*: Needed in the plan to review how CF has increased sick calls, affected staffing, and affected the flow of nursing care in the department.
- *Nurses who may be affected by CF*: Vital to the team to provide testimony about risk factors, symptoms, and potential interventions that can assist with the management of CF.

Evidence Retrieval

The third step in the Iowa model is retrieval of evidence, wherein the stakeholders identify the key terms (Goody & Goody, 2011).

Outcomes

- Literature review matrix
- Professional Quality of Life (ProQOL) Satisfaction Scale (Stamm, 2015)
- Curriculum plan
- Pretest/posttest

Population for the Project

- Team members
- Content experts

Evaluation/Data Collection/Analysis

Two content experts evaluated the content of the curriculum and the pretest/posttest. The education experts are graduate-level professional registered nurses who are certified in nursing education and employed as nursing educators. Quantitative data was collected from the content experts through completion of the evaluation of the Curriculum Plan (Appendix D) and the Pretest/Posttest Expert Content Validation (Appendix H) form. A Qualitative Summative Evaluation (Appendix J) of the project, the process, and my leadership was conducted at the completion of the project with qualitative thematic responses.

Curriculum Content Evaluation

The purpose of the evaluation of the curriculum was to ensure the appropriateness of the learning objectives, to improve the course by identifying gaps in the curriculum plan and what is currently occurring in the ED.

Pretest/Posttest Expert Content Validation

The purpose of the Pretest/Posttest Content Validation (Appendix H) was to assure the test items match the objectives and content of the curriculum. The form was completed by the content experts, and the item construction was reviewed by a doctor of Philosophy (PhD) prepared expert in assessment. A Content Validation Index Summary (Appendix F) for the pretest/posttest was determined based on a Likert-type scale of 1-4 responses.

Qualitative Summative Evaluation

An open-ended questionnaire was completed by stakeholders related to the project, the process, and my leadership. The stakeholders evaluated the themes collected from the questionnaires. The dataset consisted of thematic analysis of open-ended responses.

Ethical Considerations

Approval for this DNP project was obtained from the Walden University Institutional Review Board (IRB). The Walden University IRB approved the project on June 13, 2016, issuing approval number 0379147 and an approved oversight agreement was received via email from the project site on June 14, 2016.

Summary

In this section of the project, the development of an education initiative for ED nurses to bring awareness about CF was presented. The project included identification of work-related risk factors and personal factors that affect the ability of ED nurses to

provide safe and effective patient care. A collaborative team of stakeholders from the ED reviewed evidence-based literature about coping interventions for CF and worked closely to guide the development of strategies and methods to manage CF. The Content Expert Evaluation of the Curriculum Plan form (Appendix E) was reviewed by two content experts using *met* or *not met* choices. The dataset consisted of descriptive analysis of the education. The pretest/posttest items were validated by two content experts in education for the CVI, and item construction was reviewed by an assessment and measurement expert. The dataset consisted of a content validation index summary (Appendix F). Lastly, section 4 covers the findings and evaluation of the project.

Section 4: Discussion and Implications

Introduction

The purpose of this DNP QI project was to develop an initiative to educate ED nurses on recognizing, preventing, and identifying methods of coping with CF. In this section, the findings and evaluations/content validation of the educational initiative are discussed, along with a summative evaluation of me as the team leader, as a scholar, as a practitioner, and as the project developer, as well as how the project has contributed to my professional development.

The goal of the project was to bring awareness of CF among ED nurses through an educational initiative. The outcome products for the project included the literature review matrix, the ProQOL satisfaction scale tool, the curriculum plan, and the pretest/posttest. The implications for positive social change include ensuring nurses are prepared with the educational tools needed to bring about an increase of nursing and patient satisfaction while recognizing a condition that will affect the outcomes of patient care and their well-being.

Evaluation/Findings and Discussions

The project was framed within the Iowa model (Appendix K) with the use of a team approach (Brown, 2014).

Expert Review and Content Validation of the Project

The team reviewed the evidence-based literature that I presented related to the problem of CF and strategies to implement measures for coping with CF. Two masters-

level prepared clinical nursing educators evaluated the educational curriculum and provided content validation of the pretest/posttest items. A PhD holder with expertise in assessment reviewed the pretest/posttest item construction, and lastly, a qualitative summative evaluation of the project was completed by the team members. The findings and evaluation/validation are listed below:

Outcome 1: Literature Review Matrix (Appendix A)

Discussion. The project design and evidence-based literature were presented to the team members, who discussed and identified pertinent literature.

Evaluation. The team agreed that the articles chosen for the project in the literature review matrix provided ED nurses with the evidence of how CF can be prevented and recognized, and methods for coping identified.

Recommendation. None.

Outcome 2: Professional Quality of Life Scale (Appendix B)

Discussion. The ProQOL satisfaction measurement tool was reviewed with the team (Stamm, 2015). The results of the ProQOL scale can be incorporated into the initiative to help isolate and identify concerns shared by the staff.

Evaluation. The team felt the ProQOL satisfaction measurement tool will benefit the education initiative by providing nurses an opportunity to have their voices heard.

Data. None.

Recommendation. The team agreed that the scale should be anonymous.

Outcome 3: Curriculum Plan (Appendix D)

Discussion. The educational plan was developed from the literature review matrix and included the objectives, content, method of instruction, evaluation, and grading of evidence. Content was included introducing the Iowa model, CF risk factors, signs and symptoms, and methods of coping with CF for ED nurses.

Evaluation (Appendix E). The content of the project was measured by 2 master's-level prepared education experts using a dichotomous scale. The format evaluated content material using total scores of 1 for content " *not met*" and total scores of 2 for content "met". The average score was 2, which demonstrated the objectives for the education initiative were identified and the goals were met.

Data. Average score was 2, indicating that the objectives were met.

Recommendations. The team reviewed the results of the content experts and was concerned that CF would be overshadowed by the information presented about the Iowa model. The team felt that the Iowa model content should be removed from the curriculum plan to maintain the focus of the presentation.

Outcome 4: Pretest/Posttest (Appendix G)

Discussion. A PhD holder with expertise in assessment evaluated the construction of the pretest/posttest items. Two content experts reviewed the 14 pretest/posttest items to assure that the items reflected the content and course objectives.

Pretest/PosttestContent validation (Appendix I). The content experts validated the 14-item pretest/posttest using a 4-point Likert-type rating scale ranging from *not relevant* = 1 to *very relevant* = 4.

Data. Content Validation Index = 1.0.

Recommendation. The PhD expert recommended that a variety of question choices, such as fill-in and true/false items, be added in addition to multiple-choice testing items.

Qualitative Summative Evaluation (Appendix J)

A 7 item open-ended questionnaire was given to the 4 team members and 4 questionnaires were returned anonymously. Each team member was provided with an envelope containing a copy of the project paper, curriculum plan, literature review matrix, pretest/posttest items, and summative evaluation form. The project package was hand delivered, and each participant was instructed to anonymously return the evaluation form to the designated location of the assistant nurse manager's office on a specific date when I would not be present in the department. The team members returned their evaluation forms anonymously to the assistant nurse manager's office with their evaluations included.

Evaluation. The team evaluated the team approach, effectiveness of the project, the stakeholder and team member involvement, and the outcome products.

Data. Emerging themes from the evaluation included the following:

- Effective leadership

- Knowledge about the topic
- Accurate and current evidence-based literature

Recommendations. The team recommends including nurses from all shifts, 7a to 7p, 11a – 11p, and 7p to 7a, determining which shift experiences the worst exposure. The team is interested in identifying the contributing factors specific to each shift that causes an increased risk of CF.

Implications

According to Sacco et al. (2015), establishing the prevalence of compassion satisfaction and compassion fatigue in critical care nurses is linked to contributing demographic, unit, and organizational characteristics such as sex, age, educational level, unit, acuity, change in nursing management, and major systems change. The implications for positive social change include ensuring nurses are prepared with the educational tools needed to bring about an increase of nursing and patient satisfaction while recognizing a condition that will affect the outcomes of patient care and their well-being.

Policy

The negative exposure of CF and the negative impact of the symptoms of CF can leave nurses feeling unsure about the status of their employment should the condition worsen. An employee assistance program for nurses with extreme exposure to CF could be developed that would assist with developing an effective methods for coping plan. Kelly, Runge and Spencer (2015), examined the problem of CF and CS in acute care nurses in a hospital-based setting and identified predictors for burnout which included

lack of meaningful recognition. In addition, other predictors were nurses with more years of experience, and nurses in the "Millennial" generation (ages 21–33 years) were at increased risk for CF. The study determined when nurses received meaningful recognition they were less likely to have CF, and experienced a positive impact and have higher job satisfaction.

Practice

The implementation of this project should bring awareness to the problem of CF by providing ED nurses with an education initiative that will help them to identify the risk factors and contributing factors. The ED nurses will have the information needed to intervene on their own behalf in an effort to stop the escalation of symptoms that can impede quality patient care. Hunsaker et al., (2015) suggest improving recognition and awareness of CF in an effort to prevent emotional exhaustion, and help identify interventions that will help nurses remain empathetic and compassionate professionals.

Research

The implication for this project in research includes a decrease in nursing sick time used and increased patient satisfaction. The use of research in practice provides a positive outlook for the healthcare organization and demonstrates where the priority of care is focused. As stated by Smeltzer, Sharts-Hopko, Cantrell, Heverly, Nthenge, and Jenkinson, (2015) the translation of research into safe, high-quality, and cost-effective care is recognized in nursing and is improving through the use of nurses and their contribution to the profession as nurse scientists, and practice leaders.

Social Change

Health care organizations are aware of CF, however, they have not identified the best outcomes for nurses employed in critical care departments, thus far, due to their continued exposure. The project promotes social change through the facilitation of patient satisfaction, the quality of patient care, and prevention of CF on nursing staff. The education initiative provided the emergency department with the best evidence-based literature currently available to assist staff and improve patient and nursing outcomes.

Strengths and Limitations

The strengths of this project included the literature review that provided the history about CF, and current evidence based interventions used to help the organization develop strategies for coping, thus improving quality care. Another strength is the willingness of the leadership team to be involved, and to empower myself to develop this QI initiative to educate my peers. The limitation of this project includes the inability to implement the developed strategies for coping within the ED until after graduation.

Analysis of Self

The following section will consist of a self-analysis of my role in the project.

As Scholar

The process of developing this project exposed me to many aspects of research and quality improvement I never knew existed. The evidence-based information I reviewed advanced my knowledge base about concepts, frameworks and designs that are needed to make a project successful. The project preparation experience has increased

my knowledge about literature reviews, evidence based practice and research, the institutional review board process, my scholarly writing and factors that will help to strengthen my clinical practice.

As Practitioner

The nursing profession has evolved from the days when nurses were viewed as maids to their patients to the current status where nurses are at the forefront of clinical practice. Nurses are now empowered as practitioners to provide primary care with the collaboration of a medical provider. As a practitioner, developing a rapport with patients is essential to helping them achieve and meet their health goals. The ability to provide quality care, identify challenges to quality care, and developing a plan to ensure patients are satisfied are the key elements practitioners should have. The DNP program helped prepare me for the other aspects of patient care required as a DNP such as evidence-based research, educational initiatives to improve quality care, and improving the workforce through communication and teamwork.

As Project Developer

The process of preparing this DNP project has provided me with the knowledge about research study, and the methods to designing an evidence based quality initiative quality improvement educational plan. Throughout the project development, I learned to be patient and to appreciate the process of the institutional review board as they work diligently behind the scenes to ensure an ethical approach to protect those involved in the project. The team contributed to the project by helping me to identify the best

communication tool to relay information regarding the project and for organizing team meetings.

Contribution to My Professional Development

The DNP project preparation process has prepared me for the higher level leadership role expected of the DNP degree. I learned how analyzing findings are a key part for translating research in to clinical practice. The project process has contributed to my professional development by strengthening my knowledge of how teamwork can be instrumental when evaluating results from educational initiatives and evidence-based practice combined, and can improve patient outcomes, patient safety, quality care, and employee relations thus promoting employee satisfaction.

Summary

The goal of this DNP project was to provide an educational initiative to ED nurses employed at the project site about risk factors and methods for coping with CF. The project provided ED nurses with valuable information that will help them to cope with CF. Through the educational initiative, nurses are better informed about contributing factors, risk factors, signs and symptoms, and methods to early identification and coping. The plan for dissemination of the project will be presented in Section 5.

Section 5: Scholarly Project Dissemination

Compassion fatigue is a problem seen within healthcare institutions worldwide, especially critical care units and emergency departments. The effects of compassion fatigue cross nurse–patient boundaries, and negatively impact patients expectations of having a quality care experience. The Iowa model's evidence-based team approach was used to guide the development of the education initiative for nurses on recognizing, preventing, and identifying methods of coping with CF in the ED. The outcome products for the project included an extensive review of the literature, a curriculum plan to educate ED nurses on CF, and a pretest/posttest to validate ED nurses knowledge about CF. The content of the project was measured by 2 masters-level prepared education experts using a dichotomous scale. The scale evaluated content material using total scores of 1 for content "*not met*" and total scores of 2 for content "*met*". The average score was 2, which demonstrated the objectives for the education initiative were identified and the goals were met. The content experts also conducted content validation of each of the 14 item pretest/posttest items using a 4-point Likert scale ranging from *"not relevant = 1 to very relevant = 4"* that resulted in a content validation index of 1.00 showing that the test items were covered in the curriculum. Recommendations were made for item construction improvement and omission of the Iowa model from the curriculum plan and pretest/posttest. The project promotes social change through the facilitation of patient satisfaction, the quality of patient care, and prevention of CF on nursing staff. The implications for positive social change include ensuring nurses are prepared with the educational tools needed to bring about an increase of nursing, and patient satisfaction while recognizing a condition that will affect the outcomes of patient care and their well-being. This project was developed to help nurses, patients and the healthcare organization identify a relevant problem in emergency departments that hinders the provision of quality care.

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Appendix A: Literature Review Matrix

Full reference	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Research methodology	Analysis & results	Conclusions	Grading
Boyle D., (2011) Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Issues in Nursing 16*(1):1-1. doi:10.3912/OJIN.Vol16No01Man02	Middle Range Theory	The article's focus is on how compassion fatigue can be minimized for nurses and how their workplace develops interventions to confront compassion fatigue.	Qualitative Literature review	Encouraging self-care strategies and offering workplace interventions is essential for addressing the negative effects of compassion fatigue for nurses.	Addressing the real but unrecognized phenomenon of compassion fatigue in nursing has the potential to influence both the recruitment and retention of highly effective nurses.	Level V
Brown, C. G., (2014). The Iowa model of evidence-based practice to promote quality care: An illustrated example in oncology nursing. *Clinical Journal of Oncology Nursing, 18*(2), 157-159. doi:10.1188/14.CJON.157-159	Grand Theory and Conceptual Theory	The article's focus provides a detailed review of the IOWA model and how it is implemented into clinical practice. What is the correct and best process when using the Iowa model for clinical practice changes?	Concept Analysis	The Iowa model provides organizations with an evidence-based problem-solving approach to clinical decision.	Nurses want to implement interventions in their practice based on the highest levels of evidence. The use of the Iowa model can help nurses organize the practice change and cut organizational cost with a systematic approach.	Level IV

Bush N. J., (2009). Compassion fatigue: Are you at risk? *Oncology Nursing Forum, 36*(1), 24-28. Retrieved from http://dx.doi.org/10.1188/09.ONF.24-28	Middle Range Theory and Descriptive Theory	The article's focus is on defining compassion fatigue and determining who is at risk for being affected. What methods can be used to identify the risk factors and contributing factors for compassion fatigue?	Qualitative Literature review Participant Interviews	The article reviewed and identified an association between personal stressors, professional stressors, and workplace stressors that contribute to specific negative behaviors and somatic complaints.	Nursing research has helped to identify risk factors, which cause compassion fatigue, and identified organizational stressors, such as the workplace, role ambiguity, and workload, contribute to the risk for compassion fatigue, compassion satisfaction and burn out leading to physical and mental exhaustion.	Level V
Coetzee, S., & Klopper, H., (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences, 12*(2), 235-243.	Middle Range Theory, Practice Theory, and Conceptual Theory.	The article's focus is on identifying the concept of compassion fatigue and its effects on nursing practice. How does compassion fatigue affect nurses and nursing practice?	Concept Analysis Research case studies	Compassion fatigue requires prompt intervention when signs and symptoms are detected in order to help prevent the escalation of worsening effects such as depression.	The manifestations of compassion fatigue are progressive and affect nurses and nursing process by limiting the ability to empathize and provide adequate patient care.	Level III

Collins, S. & Long, A., (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatry & Mental Health Nursing. 10*, 17–27.	Grand Theory and Descriptive Theory	The article's focus is on the psychological effects felt by critical care nurses working within critical care areas. Is there a psychological component to compassion fatigue and how can the symptoms be managed?	Mixed Method 13 healthcare workers employed in trauma and recovery team (TRT) set up were chosen to participate. Quantitative data were collected using the compassion satisfaction/com-passion fatigue test and The Life Status Review Questionnaire. Qualitative data regarding positive and negative aspects of working with traumatized individuals, as well as caregiver's experience leaving the TRT, were gathered using open-ended questions.	Qualitative data were reduced into themes using content analysis in the form of open-ended questions. Quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS) for the Windows computer program. Initial analysis concerned itself with descriptive and inferential statistics.	The study highlights the need for educators, managers and caregivers to be aware of the possible consequences of dealing with trauma and to take positive steps to minimize the negative effects.	Level III

Doody, C. M. & Doody, O., (2011). Introd ucing evidence into nursing practice: Using the IOWA model. *British Journal of Nursing, 20*(11), 661-664.	Middle Range Theory, Conceptual Theory and Descriptive Theory	The article's focus is on the process of the IOWA model, and how evidence is applied to nursing practice. How is evidence applied to nursing practice offering practical advice and explanation of the issues concerning nurses in practice?	Qualitative	EBP is based on several factors however, it is dependent on the nurse's ability to gather and appraise the evidence on which they base their care and take into account the quality of evidence the plan to use in practice.	Providing the best quality care requires using the best tool to transition the evidence from research into practice	Level IV
Dominguez-Gomez, E., & Rutledge, D. N., (2009). Prevalence of secondary traumatic stress among emergency nurses. *Journal of Emergency Nursing, 35*(3), 199–204.	Middle Range Theory	The article's focus is on stress as a major contributing factor for compassion fatigue exposure and its effects on emergency department nurses. How can organizations help with stress management to promote safer patient care and satisfaction?	Qualitative Surveys were distributed to 111 registered nurses with 6 months or more experience in the emergency department. Sixty-seven nurses completed and returned the Secondary Traumatic Stress Survey.	Analyses using *t* tests with a Bonferroni correction to decrease the chance of type I error ($P = .01$) found no significant differences among nurses based on demographic groups.	Emergency department nurses play a critical role in ensuring quality care. The high prevalence of Secondary traumatic stress in this sample indicates that large numbers of emergency nurses may be experiencing the negative effects of secondary traumatic stress.	Level III

Dunn, D. J. (2009). The internationality of compassion energy. *Holistic Nursing Practice Journal. 23*(4), 222-229.	Grand Theory	The article's focus is a literature review about compassion energy and how it affects a nurse's response to provide care. What is the contributing factors causing nurses to lack empathy and how can it be reversed?	Mixed method, Literature review	Identifying a core variable or developing social experiences of compassion fatigue is among the contributing factors causing compassion fatigue in emergency department nurses.	The article reviewed the necessity of compassion for employees in the healthcare profession as a propel quality care.	Level V
Flarity, K., Gentry J. E., & Mesnikoff, N., (2013). The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal, 35*(3), 247–258.	Intervention Theory	The article's focus is on the effectiveness of an educational initiative designed for emergency department nurses teaching methods of how to prevent compassion fatigue included group exercises, watching media resources & reading handouts and journals about compassion fatigue. Is compassion fatigue a condition that is expected and worst for the seasoned nurse or the novice?	Mixed method Literature review Questionnaires (pre-/posttest design) 73 emergency department nurses participated in the study and all the nurses returned the Professional Quality of Life pretest.	Data was recorded and scored using Statistical Package for the Social Sciences Version 20 for the Professional Quality of Life questionnaire and Microsoft Excel for demographics. All nurses returned the questionnaires & fifty-nine posttests were returned and included for analysis. Twenty-seven participants had been a registered nurse for 20+ years, and 42 participants had worked less than 8 years as an emergency nurse.	The program intervention is beneficial in decreasing compassion fatigue and increasing compassion satisfaction in this sample and justifies continuing to offer this training. Study replication is recommended in other emergency departments and inpatient units and for military health care providers	Level III

Grove, S. K., Burns, N., & Gray, J. R., (2013). The practice of nursing research: Appraisal, synthesis, and generation of evidence (7th Ed.). St. Louis, MO: Saunders Elsevier.	Middle Range Theory	This scholarly book introduces readers to the basics of nursing research.	Quantitative approach.	The process of conducting research requires guidelines to ensure the data is analyzed correctly to give accurate results.	Consistency in the research process provides and organized study and helps to prevent mistakes and inaccurate findings	Level IV
Harris, C. & Griffin, T. Q., 2015). Nursing on empty: Compassion fatigue signs, symptoms and interventions. *J ournal of Christian Nursing, 32*(2), 80-87. doi:10.1097/CNJ.0000000000000155	Descriptive and Prescriptive Theory.	The article's focus is on reviewing the signs, symptoms, and interventions of compassion fatigue and its effects on nurses. How can nurses protect themselves from exposure to risk factors that cause compassion fatigue?	Qualitative Literature review	The development of specific interventions to help emergency department nurses identify and cope with compassion fatigue should be facilitated by emergency department nurses and the management team for the best results.	Nurses and organizations must acknowledge the importance of compassion fatigue and have a thorough understanding of the concept to recognize when someone may be experiencing compassion fatigue, and intervene.	Level IV
Hegney, D. G., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V., (2014). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Study1 results. *Journal of Nursing Management, 22*(4), 506-518. doi:10.1111/jonm.12160.	Middle Range Theory	The article's focus is on the research study completed about the quality of work-life and other contributing and co-existing factors such as depression, anxiety and stress as it relates to compassion fatigue e.	Mixed Method Surveys were distributed to 374 emergency department nurses at an acute care tertiary hospital in Australia, 132 surveys were completed and returned.	The results showed a definite pattern of risk progression for the six factors (depression, anxiety, stress, compassion satisfaction, secondary trauma & burn out) examined for each risk profile.	The results of the study raised significant concern about the possible negative impacts of elevated levels of compassion fatigue and negative mood symptoms on the quality of patient care and staff retention.	Level III

Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E., (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 36*(5), 420–427.	Middle Range Theory	The article's focus is on the factors and prevalence of compassion fatigue, compassion satisfaction and burnout, among emergency nurses and nurses in other selected inpatient specialties. Are emergency department nurses at an increased risk for compassion fatigue and compassion fatigue because of the demands required from frequent patient turnover or because of caring for patients who use the emergency department as their primary care? Can the symptoms of compassion fatigue affect critical care nurses who are experiencing burnout and are not caring for patients that are not terminally ill?	Mixed Method Surveys were distributed to 138 nurses employed in the emergency department, intensive care unit, and Nephrology and Oncology units; 114 surveys were returned.	The results state over 80% of the emergency department nurses that participated had moderate to high levels of burn out and compassion fatigue and the differences between ED nurses and those working in specialty areas (oncology, nephrology, and intensive care). The emergency department nurses were evidenced at risk for less compassion satisfaction, while intensive care nurses demonstrated a higher risk for burnout and oncology nurses reflected a risk for higher compassion fatigue.	Nurses become preoccupied with patient care and forget to take care of themselves until they are in crisis and the signs and symptoms of compassion fatigue can be unrecognized by the affected nurses or their colleagues. The need to educate nurses about compassion fatigue, its signs and symptoms and preventative methods is essential to halting its progression and can raise awareness about the mental and emotional impact of caring for patients.	Level III

Houck, D., (2014). Helping nurses cope with grief and compassion fatigue: An educational intervention. *Clinical Journal of Oncology Nursing, 18*(4), 454-458. doi:10.1188/14 CJON, 454-458	Middle Range Theory and Prescriptive Theory	The article's focus is on reviewing coping methods and available resources such as education, counseling, and opportunities to grieve that should be provided to nurses in an effort to identify the work-life balance, self-care strategies, and communication skills. Which educational methods are helpful for nurses to assist with developing the coping skills and inner resources necessary to maintain their emotional and physical health when exposed to or affected by compassion fatigue?	Qualitative Literature review	Through the literature review, resources for coping were developed and nurses were able to identify their individual risk for exposure to compassion fatigue.	Nurses were equipped with tools and resources for self-care, as well as the ability to articulate helpful institutional resources.	Level V

Hunsaker, S., Chen, H., Maughan, D. & Heaston, S., (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship, 47*(2), 186-194. doi:10.1111/jnj.12122	Middle Range Theory and Descriptive Theory	The article's focus is on identifying the prevalence of, compassion fatigue, compassion satisfaction and burnout in emergency department nurses throughout the United States and to examine which demographic and work-related components affect their development. What are the factors that cause exposure to compassion fatigue?	Mixed Method. 1000 participants (emergency department nurses) were mailed surveys and 284 returned their completed surveys of which six were removed for not meeting the inclusion criteria of working more than 8 hours per shift.	The results revealed overall low to average levels of compassion fatigue and burnout, and generally average to high levels of compassion satisfaction among this group of emergency department nurses. The low level of manager support was a significant predictor of higher levels of burnout and compassion fatigue among emergency department nurses, while a high level of manager support contributed to a higher level of compassion satisfaction.	The results identified factors reported by emergency department nurses regarding work and life that are related to compassion satisfaction and factors associated with higher levels of compassion fatigue and burnout.	Level III

Huppertz, J. W., & Smith, R., (2014). The value of patient's handwritten comments on HCAPS surveys. *Journal of Healthcare Management, 59*(1), 31-47.	Grand Theory	The article's focus is to review the positive and negative comments reported by patients after their discharge via surveys. Should the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys include a section specific to compassion fatigue, if patients felt their nurse lacked empathy, and what factors did the patients observe to make these inferences?	Mixed Method. The Centers for Medicare & Medicaid Services distributes reimbursements to hospitals' dependent upon their HCAHPS scores as part of the Hospital Value-Based Purchasing program. The new measures help to improve the patient experience through identifying the hospitals strengths and weaknesses.	The results state many patients bypass specific questions pertinent to gathering data to analyze if there was quality care rendered which caused discrepancies in the result.	In several surveys, missing data were noted, sometimes because the patient simply failed to answer a question and at other times, because the question became irrelevant depending on the patient's situation or need.	Level III

Hurst, K & Smith, A., (2011). Temporary nursing staff-cost and quality issues. *Journal of Advanced Nursing, 67*(2), 287-296. doi:10.1111/j.1365-648.2010.05471.x	Middle Range Theory	The article's focus is on reviewing the comparative study of temporary and permanent staff work activity, cost and quality of care. What impact does a temporary worker (nurse) have on patient care?	Qualitative. Observation. Interviews. Six hundred and five random hospital wards were chosen for participation. These wards were divided into two groups: 368 employing only permanent staff during data collection and 237 with permanent and temporary staff in the ward team at the time when the observations were made.	Workloads and time out (sickness absence, etc.) in wards employing temporary staff were greater than in units with permanent staff only, thereby justifying hiring short-term staff. Wards with temporary and permanent staff were more expensive to run and working styles were different.	Ward managers need to monitor temporary staffing and the effect they have on nursing activity and quality.	Level III
Jones, C. B., & Gates, M., (2007). The costs and benefits of nurse turnover: A business case for nurse retention. *Online Journal of Issues in Nursing, 12*(3), Manuscript 4.	Middle Range Theory	The article's focus is on the cost and benefits of nursing turnover and retention as it relates to nurses providing quality care. Is nursing turnover becoming a factor that places nurses at risk for compassion fatigue and patients at risk for decreased quality care?	Mixed method. Literature review.	Efforts are needed to determine the mechanisms through which nurse turnove r and retention contr ibute to the overall value of nursing and as a risk factor to conditions such as compassion fatigue, compassion satisfaction and burnout.	Future efforts are needed to quantify the costs and benefits of n urse turnover and retention across different types of nurses, so as to determine the societal effects of nurse turnover and retention.	

Mackusick, C. & Minick, P., (2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *MedSurg Nursing, 19*(6), 335–340.	Descriptive Theory	The article's focus is to identify factors that influence registered nurses to leave clinical nursing practice. What are the factors causing nurses to leave the profession?	Qualitative Interview Questionnaires 187 nurses who were no longer in clinical practice were interviewed	Nurses described the 3 major reasons for leaving the nursing profession as unfriendly workplace, emotional distress related to patient care, and fatigue and exhaustion.	Nurses who have left the profession state if certain strategies such as recognizing when colleagues appear to be distressed, frustrated, or socially isolated, especially as new registered nurses were in place, it may have helped them and can help retain future nurses if implemented now.	Level III
Mealer, M. & Jones, J., 2013). Posttraumatic stress disorder in the nursing Population: A Concept Analysis. *Nursing Forum*. *48*(4), 279-288.	Middle Range Theory and Conceptual Theory	The article focuses on an analysis of the posttraumatic stress disorder (PTSD) concept as a contributing factor to compassion fatigue. How can nurses avoid PTSD in clinical practice if stress is one of the major risk factors for compassion fatigue?	Qualitative Concept analysis.	The concepts of vicarious traumatization, compassion fatigue, and secondary traumatic stress provide insights into the broader notion of PTSD by measuring symptoms, they do not capture the total impact of the traumatic experience and how this changes the notion of human experience.	The Nurse as Wounded Healer theory identifies that all nursing professionals experience personal and professional trauma, and provides guidance for the way in which nurses cope with trauma. This has a direct impact on patient care and determines whether nurses are walking wounded or wounded healers.	Level IV

Sacco, T., Ciurzynski, S., Harvey, M., & Ingersoll, G., (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse, 35*(4), 32-44. doi: 10.4037/ccn2015392	Middle Range Theory	The article's focus is to establish the prevalence of compassion satisfaction and compassion fatigue in critical care nurses and to describe potential contributing demographic, unit, and organizational characteristics to compassion fatigue. Is compassion fatigue and compassion satisfaction exposure increased risk factors within the critical care units?	Mixed method. Survey. Questionnaires 221 critical care nurses responded to the survey questions about compassion fatigue and compassion satisfaction based on sex, age, educational level, unit, acuity, change in nursing management, and major systems change.	The participating nurses reported significant differences in compassion fatigue and compassion satisfaction based on different variables.	Understanding the elements of professional quality of life and its relationship to standards for healthy work environment can have a positive effect on patient outcomes.	Level III
Sawatzky, J. V., & Enns, C.L., 2012). Exploring the key predictors of retention in emergency nurses. *Journal of Nursing Management, 20*(5), 696-707. doi:10.1111/j.1365-2834.2012.01355.x	Descriptive Theory	The article's focus is to identify factors that predict the decrease of retention with emergency department nurses. What are the factors that hinder nursing retention in emergency departments?	Mixed method. 261 registered nurses working in the 12 designated emergency departments within rural, urban community and tertiary hospitals in Manitoba, Canada.	Twenty-six per cent of the respondents will probably/definitely leave their current emergency department jobs within the next year. Engagement was the key predictor of intention to leave ($P < 0.001$) and was associated with job satisfaction, compassion fatigue, compassion satisfaction and burnout ($P < 0.05$). In an ordinal least-squares model ($R2 = 0.44$), nursing management, professional practice, collaboration with physicians, staffing resources and shift work emerged as significant influencing factors.	Engagement plays a central role in emergency department nurses intention to leave. Addressing the factors that influence engagement may reduce emergency department nurses intentions to leave.	Level III

Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C., (2014). Compassion fatigue and satisfaction. A cross-sectional survey among US healthcare workers. *Nursing & Health Sciences, 16*(1). 3-10, doi: 10.1111/nhs.12068	Middle Range Theory, Descriptive Theory	The article's focus is on compassion fatigue and compassion satisfaction levels as measured by the Professional Quality of Life Scale self-report instrument in a community hospital in the United States. What are the differences in levels of self-reported professional quality of life among groups of healthcare workers?	Mixed method. Survey. 253 participants, which included registered nurses, physicians, and nursing assistants, were chosen to complete the survey to measure their compassion fatigue and compassion satisfaction levels, 139 participants returned their surveys.	The study was analyzed using Statistical Package for the Social Sciences version 17.0 software. The results were based upon descriptive characteristics related to hours worked, years of experience as a nurse and years of employment in the emergency department.	Relationships between professional quality of life ratings and individual and organizational variables identified in this study build on what is understood about compassion fatigue and compassion satisfaction. Differences in self-reported burnout can be found among work units, and critical care environments may provide some protection when compared to less critical units.	Level III

Appendix B: Professional Quality of Life (ProQOL) Scale Permission

Permission for Use of the ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.proqol.org

Accompanied by the email to you, this document grants you permission to use for your study or project

> ***The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.ProQOL.org***

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

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Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.

Stamm, B. H. (2010). The ProQOL (*Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue*). Pocatello, ID: ProQOL.org. retrieved [date] www.proqol.org

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Appendix C: Professional Quality of Life Scale

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

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

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

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

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Appendix D: Curriculum Plan

Problem: The problem addressed in this design-only Doctorate of Nursing Practice (DNP) project is compassion fatigue (CF) which is experienced by nurses in the emergency department (ED).

Purpose: The purpose of this DNP project is to develop an initiative to educate ED nurses on recognizing, preventing, and identifying methods of coping with CF.

Goal: The goal of this DNP project is to bring awareness of CF among ED nurses through an educational initiative.

Administer Pretest **Administer Satisfaction tool**					
Objectives At the conclusion of this educational experience ED nurses will be able to identify.	**Content Outline**	**Evidence**	**Method of Presenting**	**Method of Evaluation P/P Item**	**Grading the Evidence**
The learner will identify the project significance and purpose of the curriculum plan developed to educate ED nurses about CF.	1) Introduction 1. Project Significance a. Nursing exposure b. Increased risk factors for ED nurses c. Importance of identifying the problem before symptoms worsen d. Negative Organizational impact 2) Purpose of Curriculum a. Introduction to CF b. Identifying the contributing factors for CF c. Review of coping methods for CF.	a. Boyle D. (2011) b. Coetzee, S., & Klopper, H. (2010). c. Flarity, K., Gentry J. E., & Mesnikoff, N. (2013). d. Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). e. Hunsaker, S., Chen, H., Maughan, D. & Heaston, S. (2015). f. Mackusick, C. & Minick, P. (2010). g. Sacco, T., Ciurzynski, S., Harvey, M., & Ingersoll, G. (2015). S h. Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C. (2014).	Oral and Power point presentation , group discussion	1, 2	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3 f. Level 3 g. Level 3 h. Level 3

The learner will distinguish contributing factors of CF tha increase effects and exposure to CF.	3) Background 1. What is CF a. Lack of empathy b. Loss of ability to connect with patients 2. What are the contributing factors? a. Burn out b. Critical Care Units c. Stress 3. What are the effects? a. Decreased work performance. b. Decreased employee satisfaction. c. Increased sick calls d. Decreased quality patient care. e. Decreased patient satisfaction.	a. Boyle D. (2011) b. Coetzee, S., & Klopper, H. (2010). c. Harris, C. & Griffin, T. Q. (2015). d. Hunsaker, S., Chen, H., Maughan, D. & Heaston, S. (2015). e. Sacco, T., Ciurzynski, S., Harvey, M., & Ingersoll, G. (2015).	Oral and Power point presentation , group discussion	3 - 5	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3
The learner will distinguish factors placing nurses employed in critical care area at higher risk for the exposur to CF.	4) Risk Factors a. Burn out (working long hours) b. Stress (personal or work related) c. Emotional trauma such as crying or feeling angry and frustrated	a. Bush N. J. (2009). b. Flarity, Gentry, & Mesnikoff, 2013 c. Harris, C. & Griffin, T. Q. (2015). d. Hunsaker, S., Chen, H., Maughan, D. & Heaston, S. (2015). e. Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C. (2014).	Oral and Power point presentation , group discussion	6 - 8	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3
The learner will identify the different levels of symptoms, methods for recognizing CF, and the signs and symptoms.	5) Recognizing CF 1) Levels of symptoms a. Mild & emotional symptoms (fatigue & lack of empathy) b. Moderate & physical symptoms (weakness, headaches, poor appetite c. Severe & psychological symptoms (anxiety, depression, and poor job	a. Dunn, D. J. (2009). b. Harris, C. & Griffin, T. Q. (2015). c. Hegney, D. G., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V. (2014).	Oral and Power point presentation , group discussion	9 - 11	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3 f. Level 3

	performance).	d. Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). e. Hunsaker, S., Chen, H., Maughan, D. & Heaston, S. (2015). f. Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C. (2014).			

The learner will identify the psychological conditions that are used interchangeably with CF.	6) Misdiagnosing CF 1) Psychological components a. Depression b. Secondary Traumatic Stress (STS) – emotions or symptoms caused by someone else's traumatic experience. c. Post-traumatic Stress Disorder (PTSD) – psychological effect of an actual traumatic experience such as nightmares and flashbacks d. Difference of STS and PTSD (reaction of actual condition versus reaction to someone's reaction of the condition).	a. Collins, S. & Long, A. (2003). b. Dominguez-Gomez, E., & Rutledge, D. N. (2009). c. Hegney, D. G., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V. (2014). d. Mackusick & Minick, (2010). e. Mealer, M. & Jones, J. (2013).	Oral and Power point presentation , group discussion	12, 13	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3
The learner will identify and describe negative impacts caused by CF on the healthca organization, nurses and patient care.	7) Organizational Barriers 1) Negative Impacts a. Increased nursing sick calls. b. Decreased nursing retention. c. Decreased patient satisfaction.	a. Boyle D. (2011) b. Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010) c. Hunsaker, S., Chen, H., Maughan, D. &	Oral and Power point presentation , group discussion	17	a. Level 3 b. Level 3 c. Level 3 d. Level 3 e. Level 3

		Heaston, S. (2015). d. Huppertz, J. W., & Smith, R. (2014). e. Hurst, K & Smith, A. (2011). f. Jones, C. B., & Gates, M. (2007). g. Mackusick, C. & Minick, P. (2010). h. Sawatzky, J. V., & Enns, C.L. (2012).			f. Level 3 g. Level 3 h. Level 3 and 4
The learner will identify and discuss methods for coping a managing CF based upon the literature review.	8) Outcomes 1. Interventions and coping strategies. a. .Balancing nursing assignments by reevaluating the nurse to patient ratio. b. Implementing a journal club and self-paced teaching module in the ED. c. d. Providing resources for therapy on and off site. 2) What are the coping options? a. Working less hours. b. Collaborating with management to improve employee satisfaction and decrease BO. Informing management when contributing factors and increase risk are present.	a. Dunn, D. J. (2009). b. Flarity, K., Gentry J. E., & Mesnikoff, N. (2013). c. Harris, C. & Griffin, T. Q. (2015). d. Houck, D. (2014). Hegney, D. G., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V. (2014).	Oral and Power point presentation, group discussion	18	a. Level 3 b. Level 3 c. Level 3 d. Level 3 Level 3
Administer Post Test					

Appendix E: Content Expert Evaluation of Curriculum Plan

Product for Review: Literature Review Matrix, Curriculum Plan, Pretest/Posttest

Instructions: Please review each objective related to the curriculum plan, content and matrix. The answer will be a met or not met with comments if there is a problem understanding the content or if the content does not speak to the objective.

At the conclusion of this educational experience, the participant will be able to:

Not Met = 1 Met = 2

Objective	Evaluator 1	Evaluator 2	Average Score
I. identify the project significance and purpose of the curriculum plan developed to educate ED nurses about CF. Met Not Met	2	2	2
II. distinguish contributing factors of CF that increase effects and exposure to CF. Met Not Met	2	2	2
III. distinguish factors placing nurses employed i critical care areas at higher risk for the exposure to CF. Met Not Met	2	2	2
IV. identify the different levels of symptoms, methods for recognizing CF, and the signs and symptoms. Met Not Met	2	2	2
V. identify the psychological conditions that are used interchangeably with CF. Met Not Met	2	2	2

VI. identify and describe negative impacts caused by CF on the healthcare organization, nurses and patient care. Met Not Met	2	2	2
VII. identify and discuss methods for coping and managing CF based upon the literature review. Met Not Met	2	2	2

Recommendations:

Appendix F: Content Validation Index Summary by Content Experts of Curriculum Plan

Not Relevant = 1, Somewhat Relevant = 2, Relevant = 3, Very Relevant = 4

Objective	Evaluator 1 Score	Evaluator 2 Score	Avg. Score
I. identify the project significance and purpose of the curriculum plan developed to educate ED nurses about CF.	4	4	1
II. distinguish contributing factors of CF that increase effects and exposure to CF	4	4	1
III. distinguish factors placing nurses employed in critical care areas at higher risk for the exposure to CF.	4	4	1
IV. identify the different levels of symptoms, methods for recognizing CF, and the signs and symptoms.	4	4	1
V. identify the psychological conditions that are used interchangeably with CF.	4	4	1
VI. identify and describe negative impacts caused by CF on the healthcare organization, nurses and patient care.	4	4	1

VII. identify and discuss methods for coping and managing CF based upon the literature review.	4	4	1
Content Validation Score	x	x	1.0

Recommendations:

Appendix G: Pretest/Posttest

Questions
1. The major risk factors for compassion fatigue include (**select all that apply)** *a.* ***Burnout*** *b.* ***Stress*** *c.* ***Emotional trauma*** d. Increased Census
2. Name two effects of compassion fatigue on the patient (**select all that apply**) a. Decreased quality patient care b. Decreased work performance *c.* ***Decreased patient satisfaction*** *d.* ***Decreased empathy***
3. Research studies have found compassion fatigue affects nurses who a. Are employed in critical care areas and exposed to trauma daily b. Have work related stressors and no organizational support c. Care for one patient per day d. Call out sick to a repeat of the previous days assignment *e.* ***A and B only***
4. What is compassion fatigue? a. Increased sympathy for patients b. Increased empathy for patients c. ***Loss of connection with patients*** d. All of the above
5. Contributing factors to compassion fatigue exposure include all **EXCEPT** a. Working long hours b. Career dissatisfaction *c.* Staffing shortages *d.* ***Increased absenteeism***
6. The scale used to measure the prevalence of compassion satisfaction in nurses is a. Stress scale *b.* ***ProQOL scale*** c. Life scale d. Burnout scale
7. Weakness and headaches are signs of which level of compassion fatigue? a. Mild ***b. Moderate*** c. Severe d. All of the above
8. Recognition of compassion fatigue is noted when nurses exhibit symptoms such as

a. ***Disengagement from patients*** b. Attending to patients concerns and request c. Advocating for patient care d. Following up on patient results
9. Psychological components of compassion fatigue include *a.* ***Depression, Secondary Traumatic Stress & Post Traumatic Stress Disorder*** b. Anxiety and mania c. Obsessive compulsivity d. Suicidal and homicidal ideations
10. Name two effects of compassion fatigue on the employee (**fill in the blank)** • ***decreased work performance*** • ***increased sick calls***
11. Signs that the organization is negatively impacted by compassion fatigue is evident when a. Nursing sick calls increase. b. Nursing retention decreases. c. Patient satisfaction decreases. *d.* ***All of the above.***
12. Outcomes for compassion fatigue will be effective when a. Nurses are able to remove themselves from the source of distress. b. Nurses can identify risk factors and coping methods. c. Nurses are able to implement the correct coping strategies before symptoms escalate. *d.* ***Leaders collaborate with the nursing staff on the identification and prevention of compassion fatigue.***
13. Compassion fatigue is described as an emotional, physical and mental disconnect that affects the ability of nurses to empathize with patients and their illness. ***True*** or False.
14. The difference between Secondary Traumatic Stress (STS) and Post-Traumatic Stress Disorder (PTSD) is: STS is caused by the effects from an actual exposure while PTSD is a reaction to someone else's exposure. True or ***False***

Appendix H: Pretest/Posttest Expert Content Validation

INSTRUCTIONS: Please circle each item to see if the question is representative of the course objective and the correct answer is reflected in the course content.

Test Item # 1 Not Relevant Somewhat Relevant Relevant <u>Very Relevant</u>

1. The major risk factors for compassion fatigue include (**select all that apply)**
   a. ***Burnout***
   b. ***Stress***
   c. ***Emotional trauma***
   d. Increased Census

Comments:

Test Item # 2 Not Relevant Somewhat Relevant Relevant <u>Very Relevant</u>

2. Name two effects of compassion fatigue on the patient (**select all that apply**)

   a. Decreased quality patient care
   b. Decreased work performance
   c. ***Decreased patient satisfaction***
   d. ***Decreased empathy***

Comments:

Test Item # 3 Not Relevant Somewhat Relevant Relevant Very Relevant

3. Research studies have found compassion fatigue affects nurses who
   a. Are employed in critical care areas and exposed to trauma daily
   b. Have work related stressors and no organizational support
   c. Care for one patient per day
   d. Call out sick to a repeat of the previous days assignment
   e. ***A and B only***

Comments:

Test Item # 4 Not Relevant Somewhat Relevant Relevant Very Relevant

4. What is compassion fatigue?
   a. Increased sympathy for patients
   b. Increased empathy for patients
   c. ***Loss of connection with patients***
   d. All of the above

Comments:

Test Item # 5 Not Relevant Somewhat Relevant Relevant Very Relevant

5. Contributing factors to compassion fatigue exposure include all **EXCEPT**
   a. Working long hours
   b. dissatisfaction
   c. Staffing shortages
   d. ***Increased absenteeism***

Comments:

Test Item # 6 Not Relevant Somewhat Relevant Relevant Very Relevant

6. The scale used to measure the prevalence of compassion satisfaction in nurses is
   a. Stress scale
   b. ***ProQOL scale***
   c. Life scale
   d. . Burnout scale

Comments:

Test Item # 7 Not Relevant Somewhat Relevant Relevant Very Relevant

7. Weakness and headaches are signs of which level of compassion fatigue?
   a. Mild
   b. Moderate
   c. Severe
   d. All of the above

Comments:

Test Item # 8 Not Relevant Somewhat Relevant Relevant Very Relevant

8. Recognition of compassion fatigue is noted when nurses exhibit symptoms such as
   a. Disengagement from patients
   b. Attending to patients concerns and request
   c. Advocating for patient care
   d. Following up on patient results

Comments:

Test Item # 9 Not Relevant Somewhat Relevant Relevant Very Relevant

9. Psychological components of compassion fatigue include
   a. ***Depression, STS & PTSD***
   b. Anxiety and mania
   c. Obsessive compulsivity
   d. Suicidal and homicidal ideations

Comments:

Test Item # 10 Not Relevant Somewhat Relevant Relevant Very Relevant

10. Name two effects of Compassion Fatigue on the employee (**fill in the blank)**
    - ***Decreased work performance***
    - ***Increased sick calls***

Comments:

Test Item # 11 Not Relevant Somewhat Relevant Relevant Very Relevant

11. Signs that the organization is negatively impacted by compassion fatigue is evident when
    a. Sick calls increase
    b. Retention decreases.
    c. Patient satisfaction decreases.
    d. ***All of the above.***

Comments:

Test Item # 12 Not Relevant Somewhat Relevant Relevant Very Relevant

12. Outcomes for compassion fatigue will be effective when

    a. Nurses are able to remove themselves from the source of distress.
    b. Nurses can identify risk factors and coping methods.
    c. Nurses are able to implement the correct coping strategies before symptoms escalate.
    d. ***Leaders collaborate with the nursing staff on identification and prevention of compassion fatigue***

Comments:

Test Item # 13 Not Relevant Somewhat Relevant Relevant Very Relevant

13. Compassion fatigue is described as an emotional, physical and mental disconnect that affects the ability of nurses to empathize with patients and their illness.

    True or False.

Comments:

Test Item # 14 Not Relevant Somewhat Relevant Relevant Very Relevant

14. The difference between Secondary Traumatic Stress (STS) and Post Traumatic Stress Disorder (PTSD) is:
    STS is caused by the effects from an actual exposure while PTSD is a reaction to someone else's exposure.

    True or ***False***

Comments:

Appendix I: Pretest/Posttest Expert Content Validation Index Summary

Not Relevant = 1, Somewhat Relevant = 2, Relevant = 3, Very Relevant = 4

Test Item	Evaluator 1 Score	Evaluato r 2 Score	CVI
1. The major risk factors for compassion fatigue include (select all that apply) ***a. Burnout*** ***b. Stress*** **c. *Emotional trauma*** d. Increased Census	4	4	1
2. Name two effects of compassion fatigue on the patient a. Decreased quality patient care *b.* Work performance ***c. Decreased patient satisfaction*** ***d. Decreased empathy***	4	4	1
3. Research studies have found compassion fatigue affects nurses who a. Are employed in critical care areas and exposed to trauma daily b. Have work related stressors and no organizational support c. Care for one patient per day d. Call out sick to a repeat of the previous days assignment ***e. A and B only***	4	4	1
4. What is compassion fatigue? a. Increased sympathy for patients b. Increased empathy for patients ***c. Loss of connection with patients*** d. All of the above	4	4	1

5. Contributing factors to compassion fatigue exposure include all EXCEPT a. Working long hours b. Career dissatisfaction c. Staffing shortages ***d. Increased absenteeism***	4	4	1
6. The scale used to measure the prevalence of compassion satisfaction in nurses is a. stress scale ***b. ProQOL scale*** c. Life scale d. Burnout scale	4	4	1
7. Weakness and headaches are signs of which level of compassion fatigue? a. Mild ***b. Moderate*** c. Severe d. all of the above	4	4	1
8. Psychological components of compassion fatigue include ***a. Depression, Secondary Traumatic Stress & Post Traumatic Stress Disorder*** b. Anxiety and mania c. Obsessive compulsivity d. Suicidal and homicidal ideations	4	4	1
9. Name two effects of compassion fatigue on the employee (fill in the blank) • ***Decreased work performance*** • ***Increased sick calls***	4	4	1

10. Signs that the organization is negatively impacted by compassion fatigue is evident when a. Nursing sick calls increase. b. Nursing retention decreases. c. Satisfaction decreases. d. ***All of the above.***	4	4	1
11. Compassion fatigue is described as an emotional, physical and mental disconnect that affects the ability of nurses to empathize with patients and their illness. ***True*** or False.	4	4	1
12. Outcomes for compassion fatigue will be effective when a. Nurses are able to remove themselves from the source of distress. b. Nurses can identify risk factors and coping methods. c. Nurses are able to implement the correct coping strategies before symptoms escalate. d. ***Leaders collaborate with the nursing staff on the identification and prevention of compassion fatigue.***	4	4	1
13. The difference between Secondary Traumatic Stress (STS) and Post-Traumatic Stress Disorder (PTSD) is: STS is caused by the effects from an actual exposure while PTSD is a reaction to someone else's exposure. True or ***False***	4	4	1
14. Recognition of compassion fatigue is noted when nurses exhibit symptoms such as ***a. Disengagement from patients*** b. Attending to patients concerns and request c. Advocating for patient care d. Following up on patient results	4	4	1
Content Validation Index			1.0

Recommendations:

Appendix J: Qualitative Summative Evaluation

Thank you for completing the summative evaluation on my project. Please complete and return anonymously to assistant nurse manager's office:

A. This project was a team approach with the student as the team leader.

1. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.

- Effective leadership style
- Provided an accurate and relevant subject matter to the team
- Provided current evidence-based literature and implementations towards the quality improvement project

2. How do you feel about your involvement as a stakeholder/committee member?

- Participation is needed to ensure the desired outcome of helping nurses to recognize CF and providing patient satisfaction.

3. What aspects of the committee process would you like to see improved?

- Managing meeting times to accommodate the other team members.

B. There were outcome products involved in this project the curriculum plan, curriculum content evaluation, pretest/posttest and pretest/posttest content validation.

1. Describe your involvement in participating in the development/approval of the products.

- Reviewed and contributed to the choosing of the most appropriate and relevant content presented in each product.

2. Share how you might have liked to have participated in another way in developing the products.

- Assisting with the actual choice of literature used in the literature review matrix.

C. The role of the student was to be the team leader.

1. As a team leader how did the student direct the team to meet the project goals?

- Effective leadership
- Knowledgeable of content

2. How did the leader support the team members in meeting the project goals?

- Ensured literature was available to address each of the factors presented as challenges for the nurses in the ED.

D. Please offer suggestions for improvement.

- Report any additional changes that may be worth adding to the project plan.

Appendix K: Iowa Model Permission

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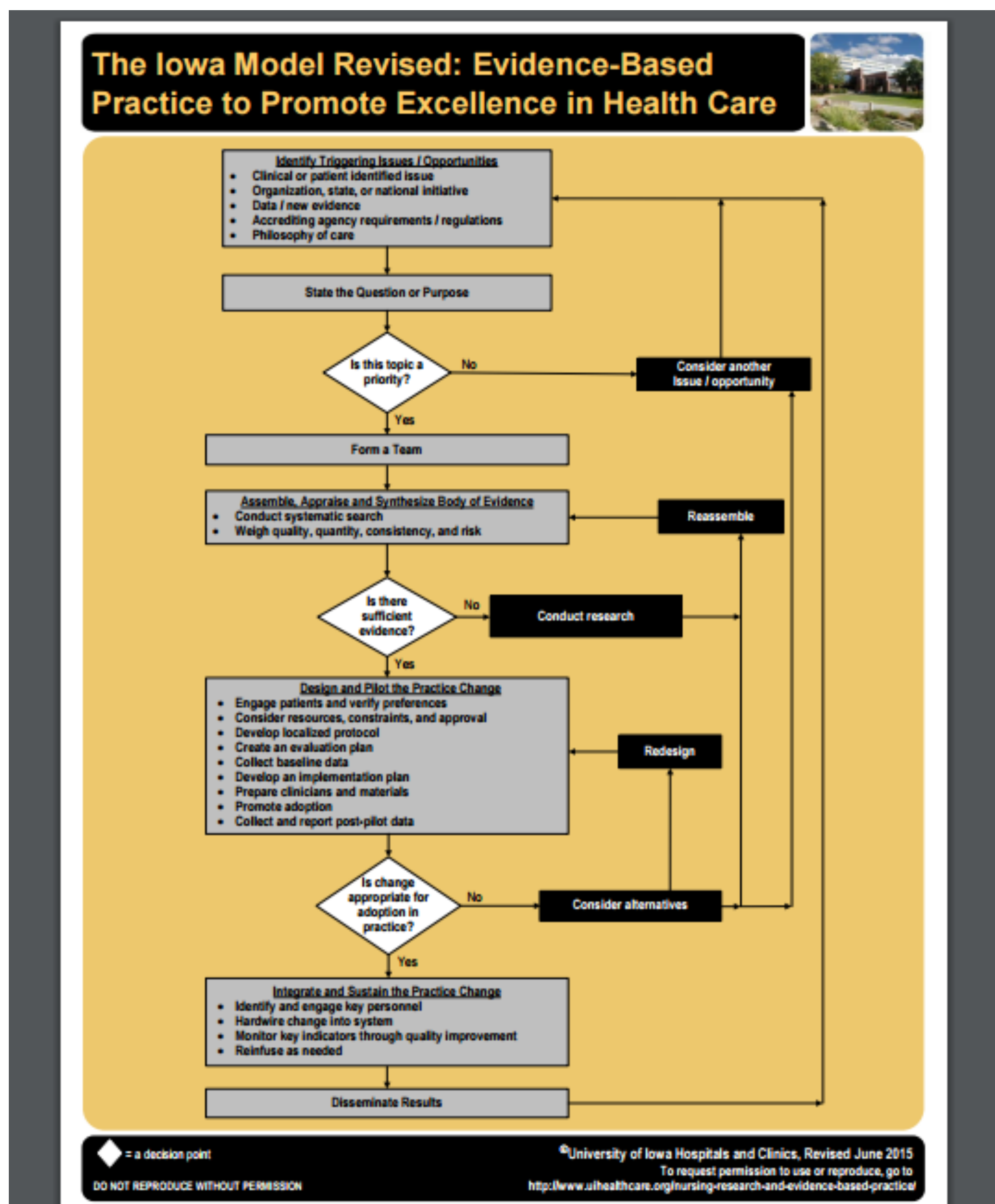

Appendix L: Poster Board Abstract Guidelines for New York State Emergency Nurses Association Annual Conference

Abstract Guidelines

The paper and poster sessions are focused on topics that are of interest and importance to nurses, managers, educators, researchers and others who practice in emergency care settings. Abstracts must reflect either completed projects or projects in the final stages of completion with results available for inclusion in the poster presentation. Suggested topics include, but are not limited to, abstracts, which address clinical practice, education, research, injury prevention, quality & patient safety, trauma, government affairs, pediatrics, telephone triage, emergency medical services, forensics, etc.

Authors may submit abstracts for more than one paper and/or poster. ENA prefers to accept posters and papers from a variety of authors. A primary presenter is the individual who registers for the conference (registration **is** required) and who presents the paper or poster at the conference. This presenter will have their poster hung at the conference but the presenter does not need to stay at poster, they may attend classes at the conference.
Note: Primary presenters are expected to adhere to the guidelines and schedules concerning dates and time periods of poster display as well as the specific time periods the presenters are required to be at their posters in order to answer questions and/or discuss poster content with conference attendees. “Poster Instructions” outlining these requirements are sent via e-mail to the primary contact and primary presenter prior to the date of the conference.
Any presenter who deviates from the guidelines and schedule will forfeit his/her stipend.

Poster Awards Program: Sponsored by the NYSENA, the Poster Awards Program is open to all authors of presented posters (both ENA members and non-members).Two awards will be given out – one for the best Research poster, and one for the best Evidence-based Practice poster. To be eligible for this award, the poster must be set up at the start of the conference - NO exceptions.

NYSENA abstract reviewers will review and select the abstracts for poster and/or paper presentations
based on written expression as well as the abstract content set out below.

Abstract Content

Structured abstracts include only essential information for communicating the nature and results of the study or project. **Note: The seven headings listed below MUST be included in ALL abstracts.**

Purpose: Begin with one to two background sentences stating the scope or nature of the problem you are addressing in your research or evidence-based project; i.e., the rationale supporting the need for the endeavor. Clearly state the objective of your study/project.

Design: For research studies, state the design using appropriate terminology (e.g., utilization, prospective, descriptive, qualitative, quasi-experimental, experimental, etc.). For evidence-based projects, describe whether this was a staff development project, quality assurance project, etc.

Setting: Describe the study/project setting (e.g., a teaching, urban level I trauma center).

Participants/Subjects: Describe the characteristics of participants and include the procedures for selecting the participants with inclusion/exclusion criteria (e.g., adult, white, male, mean age 26, trauma patients randomly selected during the two-week study period). Identify measures to protect human subjects, if appropriate to the study or project. Evidence-based practice abstracts must also include this section; a response of “n/a” is not acceptable.

Methods: Describe the study/project procedures, interventions, and evaluation methods or data analyses. Instruments or tools (including questionnaires) should be described in detail. Variables and measurements should be defined.

Results/Outcomes: Present the specific data that address your research questions or project purpose. Include statistical data, if appropriate. Evaluate the outcomes of this study/project in relation to the need for this study/project. For research in progress, present the preliminary findings.

Implications: State reasoned conclusions based on the data presented and implications for emergency nursing research, education, practice, and/or policy. Provide

recommendations for managers, leaders, nurses, and researchers as appropriate. For research in progress, provide anticipated or projected outcomes of the study.

Abstract Format & Submission Instructions

Abstracts not meeting the format/deadline requirements will be returned to the author without review.

DO:	DO NOT:
• Limit your abstract to 500 words or less	• Do not use all caps
• Use creative titles limited to 10 words or less	• Do not use bold or underline
• Use an 11 point Arial font	• Do not include author identification in the abstract
• Use single spacing and a 1-inch margin	• Do not include the institution name in the abstract
• Send documentation as MS Office 2000 (minimum version) attachments	• **Do not send in PDF format**; documentation in PDF format will be returned
	• Do not use acronyms in the abstract title, e.g., ED, STEMI, CAUTI, EKG, etc.
	• Do not write using the first person, i.e., I, we, our
	• Do not include graphs, charts, bullet points or lists – abstract should be entirely in narrative format
	• Do not cite references in the abstract

- **Abstracts must be submitted via E-MAIL**
- Include one copy of the Abstract Cover Sheet

Examples are available in the Journal of Emergency Nursing, April 2005, 31(2), 132-136

Criteria for Evaluating Posters: Judges will evaluate posters based on the following criteria:

• Clarity and conciseness of the problem statement

• Clarity and appropriateness of methods

• Appropriateness of data analysis, if applicable

• Conclusions aligned with the data and/or observations.

• Implications for emergency nursing practice discussed

• Demonstration of contribution to the emergency nursing knowledge base

• Clear organization of the poster

• Content of the poster is well written and concise

• Visually appealing

Awards: Three awards will be presented at the annual conference; one for research' one for evidence-based practice and one for performance improvement. Each award winner will receive:

1. An award certificate
2. A monetary award in the amount of $100
3. Their poster displayed as a "Poster Award Winner" for the duration of the conference.
4. Their name(s) will be published in the conference publications and announced during the conference.
5. Publication of their name as an award winner in *Connection*
6. Published in NYSENA Setting the Pace newsletter.

Appendix M: Poster Board Presentation for New York State Emergency Nurses Association Annual Conference