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Walden University

College of Health Sciences

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Gregory D. Friesz

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Walden University
2019

Abstract

Reducing Compassion Fatigue in Hospice Nurses Through Education

by

Gregory D. Friesz

MSN, Walden University, 2008

BSN, California State University Bakersfield, 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2019

Abstract

Compassion fatigue is a secondary stress reaction that results from providing care to those undergoing traumatic life events. Frequent exposure to dying patients with complex medical concerns has been identified as a contributing factor to compassion fatigue and resultant turnover among hospice nurses. The purpose of this project was to assess whether the provision of education to hospice nurses regarding compassion fatigue resulted in a demonstrable improvement in their levels of compassion fatigue. Watson's theory of human caring and Roy's adaptation model provided the theoretical foundation for this project. The practice-focused question for this project asked whether a reduction in compassion fatigue among hospice nurses would result after providing them with educational material focused on compassion fatigue. Twenty-three hospice nurse participants were administered Stamm's Professional Quality of Life Scale to measure their compassion fatigue levels before and after being presented with an educational booklet. Scores for this project were compared using a before-and-after quality improvement design and percent difference to measure the impact of the educational offering. Results demonstrated an 8.6% reduction in compassion fatigue among the hospice nurse participants, indicating that educational interventions support a positive effect in reducing compassion fatigue. Positive social change might result from this project by improving nurses' awareness of the need for self-care that contributes to resiliency and prevention of compassion fatigue.

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Dedication

This project is dedicated to my mom and dad. It is also dedicated to my children, Corey, Ryan, Aidan, Taylor, and Sydney, and my grandson, Noah, and will hopefully show them that it's never too late to return to school to meet your goals.

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I would like to thank my committee chair, Dr. Patty Schweickert, for her assistance and guidance throughout this process. I would also like to thank my preceptors during the course of the program, Dr. Qamar Arfeen and Dr. Ruthie Robinson, for their assistance and support. Most of all, I would like to thank my incredible wife, Shanna, for her patience and unwavering encouragement while I have worked on this program for the past four and a half years.

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Section 1: Nature of the Project

Rogers (2001) stated that he had always been better at caring for others than he had been at caring for himself; this statement is applicable to many nurses as well. Expressing compassion for patients and their families who are experiencing illness is a hallmark of the nursing profession. Over time, expressing compassion can become psychologically and emotionally taxing for nurses, resulting in a condition identified as *compassion fatigue*, a term coined by Joinson (1992) in her study of occupational burnout in emergency room nurses. Compassion fatigue is a secondary stress reaction that can result from providing care to those undergoing traumatic life events and is often worsened in nurses when they fail to provide self-care (Gentry, Baranowsky, & Dunning, 2015). In recent years, the responsibilities required of nurses and the complexity of the nursing profession have increased (Henry, 2014). Empathetic caring and interpersonal skills are at the core of the nursing role, but they can contribute to caregiver compassion fatigue. The severity of the stress symptoms caused by compassion fatigue, which include forgetfulness, irritability, apathy, anxiousness, or oversensitivity, can lead to nurses seeking a different work environment or abandoning the profession (Wakefield, 2000). Symptoms can be particularly debilitating to nurses, as the provision of quality patient care is dependent on critical thought processes and an emotionally balanced state of mind. Education may be used to help nurses recognize the signs and symptoms of compassion fatigue and mitigate its effects.

The concept of compassion fatigue was first identified by Figley (1983), who noted that nurses were particularly susceptible to it due to the manner in which their core

values are centered on the empathetic. Figley described compassion fatigue as a condition that results from caring's cumulative impact with corresponding tension and lack of empathy. Figley also described compassion fatigue as a condition encountered by caregivers who aid people in distress, and that it can lead to compromised care due to nurses' increasing indifference to their patients' suffering. It is important that nurses have a professional quality of life as this affects not only nursing caregivers but also the recipients of that care (Todaro-Franceschi, 2012). Given hospice nurses' constant exposure to patients with complex medical issues and resultant mortality, education may raise awareness of the need to monitor compassion fatigue. Compassion fatigue refers to secondary traumatic stress disorder. Post-traumatic stress disorder (PTSD) results when a person experiences a traumatic event; compassion fatigue occurs in individuals who experience emotional affectation from the trauma of another (Figley, 1983). Figley also stated that nurses have been found to respond to a patient's impending death in a manner similar to that felt by the patient's family members. Repeated exposure to this type of grief can result in a loss of compassion and empathy as a defense mechanism. Nurses experiencing the loss of essential caring traits may not be aware of the reason why, which supports the need for education regarding compassion fatigue (Sabo, 2011). An awareness of compassion fatigue may enable nurses to provide self-care when they see these signs arise.

Nurses undergo thorough training in the scientific aspects of health care but receive little guidance on how to care for themselves in the face of the stressors they confront caring for others on a regular basis (Mishler, 2008). Nursing requires being

supportive and caring of those who are sick and ill, frequently to the point of dying. Mishler also noted that the emotional investment needed to meet the demands of this role often taxes nurses to the point that they lose empathy and compassion for their patients. When left unidentified or untreated, compassion fatigue can result in nurses having increased feelings of vulnerability and losing their sense of hope (Sabo, 2011). The sequelae of compassion fatigue include nursing turnover, increased shortages of nurses, and potential negative fiscal effects on health care organizations due to the high costs of replacement and training of nurses. One approach that can be used to minimize the risks and potential damage caused by caregiver stress is the provision of education focused on compassion fatigue (Teater & Lundgate, 2014). This project included an education-based approach to reduce compassion fatigue among hospice nurses at a facility in Southeast Texas.

Problem Statement

Figley (2013) noted that the longer a caregiver works in a stressful environment, the higher the risk of compassion fatigue. When symptoms begin, nurses may experience mood swings, isolation, poor self-care, and negative behaviors or emotions (Figley, 2013). These symptoms can result in nurses avoiding certain types of patients or becoming less empathetic toward patients and their families. Symptoms can also affect nurses' physical and mental health, with some nurses experiencing depression, irritability, sleep disturbances, and gastric complaints (Figley, 2002). Figley also noted that failure to provide support and assistance to nurses experiencing these symptoms can undermine organizations' provision of care when they lose talented nurses.

One approach to reducing compassion fatigue among health care providers, such as nurses, is to recognize when these symptoms are first present and to provide access to resources that can help (Todaro-Franceschi, 2012). Awareness of compassion fatigue helps nurses prioritize themselves through strategies such as work-life balance, so they remain energized and are able to provide care in a manner that prevents them from becoming overwhelmed (Mathieu, 2012). Teater and Lundgate (2014) argued that providing nurses with information about the causes and symptoms of compassion fatigue through education has been found to be effective in reducing it among nurses. They likewise noted that awareness of compassion fatigue encourages nurses to be physically and mentally nourished so they are able to give to others without depleting themselves. The local nursing practice problem that I addressed in this project was lack of compassion fatigue awareness among nurses working in hospice care.

The signs and symptoms of compassion fatigue fall into five categories: psychological, social, physical, spiritual, and professional decline, and may slowly encroach on a caregiver over a span of many months or years (Figley, 2002). The causes of compassion fatigue include high nurse-to-patient ratios, increased documentation requirements, decreases in nurses' autonomy, and difficulty meeting elevated self-imposed standards (Lombardo & Eyre, 2011). The high risk for compassion fatigue among hospice care nurses can result in nurses leaving the profession, which could result in both a financial loss to their organizations and a loss of potential mentors to newer nurses. There has been a demonstrable reduction in recent years in the availability of seasoned hospice nurses to provide mentorship to new nurses regarding the critical

thinking skills needed to care for the terminally ill (Aycock & Boyle, 2009). Harris (2013) made the assertion that it is important to ensure that nurses working in hospice care are equipped to handle its stressors. Nurses are necessary in the hospice environment for psychological and spiritual support they provide to patients and their families. A nurse who is aware of the symptoms of compassion fatigue will be better able to circumvent its growth (Harris, 2013). Education regarding compassion fatigue may also promote the creation of healthier work environments. In this project, I examined whether the provision of education regarding compassion fatigue would result in its reduction among hospice nurses.

Purpose Statement

Lack of compassion fatigue awareness among hospice nurses was identified as the local practice problem for this doctoral project. Education focused on providing help for nurses experiencing compassion fatigue has been found to reduce stress and improve work-life balance (Lombardo & Eyre, 2011). The practice-focused question for the project addressed whether compassion fatigue can be reduced in hospice nurses through the provision of compassion fatigue awareness education. To answer this question, I developed an educational booklet focused on compassion fatigue's causes, symptoms, and prevention strategies, and I administered the provision of the educational booklet to a group of hospice nurses in Southeast Texas. The effectiveness of the educational intervention was evaluated through comparison measurement (with a standardized tool) of nurses' levels of compassion fatigue before and after the educational intervention. It

was my hope that answering the practice-focused question would improve nursing practice and address the gap in knowledge.

Although compassion fatigue is not unique to nurses practicing in hospice environments, aspects of this nursing specialty make nurses particularly susceptible to compassion fatigue. In situations in which nurses encounter death and dying in higher numbers, such as hospice, nurses' exposure to the suffering of their patients and their families can result in death overload, which is a form of traumatic stress and a contributor to compassion fatigue (Melvin, 2015). Death overload results from frequent exposure to the deaths of patients within a short timeframe. This term is also used to describe working with patients for an extended period of time prior to their dying (Todaro-Franceschi, 2012). Abendroth and Flannery (2006) made the assertion that caring for dying patients requires hospice nurses to manage stress associated with this care specialty. The patients in this population are challenging due to their complex disease states and processes. The challenge to remain psychosocially empathetic to families who are in crisis mode is stressful. Sabo (2011) found that hospice nurses reporting being in the moderate to high risk for compassion fatigue when surveyed, and they also reported that they felt that there was a lack of emotional support within their work environments. Given the multiple risk factors for compassion fatigue in hospice nursing, this doctoral project's purpose was to fill the gap in practice by examining whether a compassion fatigue educational booklet would result in reduction of compassion fatigue in hospice nurses.

Mishler (2008) noted that nursing practice requires an increasing body of scientific knowledge; however, nurses receive little to no training on how to care for

themselves as they deal with the stressors of the profession on a daily basis. As a result, compassion fatigue is experienced by these caregivers, which can be especially debilitating to nurses who are accustomed to demonstrating high levels of empathy (Mishler, 2008). It is essential that nurses become knowledgeable regarding symptoms of compassion fatigue and strategies for intervention, and lack of awareness of symptoms can contribute to the development of compassion fatigue. (Flarity, Gentry, & Mesnikoff, 2013). Melvin (2015) noted that hospice nurses, with their constant exposure to dying patients and their grieving families, are at particular risk for compassion fatigue, which can be detrimental to the empathetic and caring relationship that is a hallmark of professional nursing care.

Nurses need access to education regarding strategies for the reduction of compassion fatigue (Adams, Boscarino, & Figley, 2006). Education focused on providing help for nurses experiencing compassion fatigue has been found to reduce stress and improve work-life balance (Lombardo & Eyre, 2011). Through provision of an educational method consisting of a booklet that addresses the causes, signs, and symptoms of compassion fatigue, as well as strategies for preventing it, this project was intended to address the gap in practice that exists with hospice nurses regarding awareness of compassion fatigue. I sought to provide education regarding compassion fatigue in a manner that would reduce it among this group of caregivers.

Nature of the Doctoral Project

I used a before-and-after quality improvement design to measure whether provision of compassion fatigue awareness education resulted in a reduction of

compassion fatigue among nurses at a hospice organization in Southeast Texas. The measurement tool used to collect data to answer the project question was the Professional Quality of Life Scale (ProQOL), which measures levels of compassion fatigue. This scale was developed by Stamm (2005) and was based on the Figley's pioneering Compassion Fatigue Self-Test. Permission to use Stamm's scale was granted via standard permissions on the ProQOL website (Permission to Use ProQOL, 2018). The ProQOL comprises 30 items in which respondents are advised to indicate the frequency with which they experienced each respective event during the previous 30 days. The results from the ProQOL were analyzed to demonstrate whether the provided education reduced compassion fatigue among the nurses in the hospice facility.

Other evidence in the project included information obtained from the literature, including journals such as *Nursing Management*, *Journal of Nursing Administration*, *Journal of Professional Nursing*, and the *Journal of Hospice and Palliative Nursing*. Databases that were used included CINAHL Complete, MEDLINE Complete, Nursing Reference Center Plus, and E-books Medical Featured Collections; the Google Scholar search engine of scholarly works was also used. Searches in these databases were conducted using Boolean search strings such as *compassion fatigue* AND *hospice nurses* AND *education*, *compassion fatigue* OR *burnout*.

The educational booklet used for the nurses participating in this project was designed with the Apple Pages® software; the information provided in the booklet (Appendix C) came from the works of Figley and others whose research has contributed evidence-based methods for reducing compassion fatigue. The booklet was provided to

the nurse participants in both a printed format and an electronic version. These methods ensured that the nurses would be able to review the booklet regardless of which shift they worked. The booklet provided basic information regarding compassion fatigue and reduction/prevention strategies, and the booklet took 10 minutes or less to review. The ProQOL survey and permission forms for the nurses were also provided in a printed format. The survey responses to the ProQOL tool were collected prior to the participants being provided with either the printed or electronic versions of the educational booklet. Three weeks after the booklet was provided, the participants were asked to take the ProQOL survey a second time. This was done to assess whether there was a reduction in the respondents' level of compassion fatigue over a 30-day period after exposure to the educational offering. It was my hope in this project that education regarding compassion fatigue would reduce compassion fatigue.

Significance

Compassion fatigue in nurses can present in myriad ways, including increases in absenteeism, tardiness, and staff turnover, as well as decreases in morale. These symptoms of compassion fatigue tend to permeate the culture of a department or organization if not addressed and can diminish the quality of patient care (Wakefield, 2000). The current health care environment has resulted in the profession of nursing becoming increasingly demanding due to influences such as increased regulatory requirements and higher patient workloads (Teater & Ludgate, 2014). As a result, compassion fatigue has received increased attention as an occupational hazard of nursing. Education regarding compassion fatigue is one strategy to address this.

This project was relevant for nursing practice because many nurses affected by compassion fatigue have left their jobs or have abandoned nursing as a career. Newsom (2010) noted that compassion fatigue has negative consequences for the present nursing shortage, and also has negative effects on health care costs due to the expenses that result when organizations must replace and train nurses. Strategies for reducing compassion fatigue are important because compassion fatigue can extract a high cost from nurses in their personal and professional lives and can result in additional financial costs to health care organizations (Newsom, 2010). This project was conducted to assess whether compassion fatigue is reduced in nurses who are provided with education and are made aware of its causes, signs, and symptoms.

Awareness of the symptoms of compassion fatigue and their negative impact may help nurses achieve positive changes, personal transformation, and resiliency. Education regarding compassion fatigue's symptoms and treatment can be effective in the prevention of this phenomenon in nurses (Hooper, Craig, Janvrin, & Wetsel, 2010). All nursing specialties have challenges and stressors; however, hospice care nurses are confronted with work-related stress that results from the continual care of dying patients, as well as having to be empathetic and understanding of the psychosocial impact on their patients' families. This project addressed whether education of nurses would be effective in reducing compassion fatigue among nurses practicing in the hospice setting.

Stakeholders

The most caring and dedicated nurses are often susceptible to compassion fatigue, which can affect them professionally and personally through symptoms such as difficulty

in concentration, mental imagery that is disruptive, and hopelessness, as well as irritability and exhaustion (Figley, 2013). Stakeholders such as patients and their families are negatively impacted when nurses are afflicted with compassion fatigue, and patient care can be compromised through errors in clinical decision-making that result from nurse fatigue and lack of empathy. Nurses who are at reduced risk for compassion fatigue find interest and enjoyment in their work, and hospitals for whom these nurses work have higher rates of nurse satisfaction and retention (Sabo, 2011). Job satisfaction in nursing benefits patients through the advocacy for and provision of patient-centered care (Todaro-Franceschi, 2012). All stakeholders could benefit from this project's focus on the reduction of compassion fatigue through an educational strategy.

Contributions to Nursing Practice

This project demonstrated that education and subsequent awareness of compassion fatigue were effective in reducing it among nurses. Nurses who suffer from compassion fatigue are more likely to leave a job, and replacing them is difficult and costly (Lancaster, 2015). The IOM (2011) found that one of the primary reasons that nurses leave their job is stress. Another contribution made to nursing practice by this project was the promotion of self-care among nurses when they were educated and aware of the signs and symptoms of compassion fatigue. Nurses from all specialties are susceptible to compassion fatigue; ascertaining whether education and awareness of the condition contribute to its reduction was applicable regardless of practice area.

Transferability

Although this project was focused on nursing, findings could have implications for other caregivers. Compassion can be defined as feeling and acting with deep empathy and sorrow for those who suffer (Stamm & Figley, 2002). Compassion is necessary in helping professions, and compassion fatigue is not unique to nursing. Compassion fatigue can affect those who provide direct care to patients with complex mental health disorders, such as psychologists and psychiatrists (Ray, Wong, White, & Heaslip, 2013). Compassion fatigue is also not confined to clinical providers. Those providing social services, such as child protective services workers, or community service workers, such as first responders such as firefighters and emergency medical services, have experienced high turnover due to their respective focus on children and the stress from constantly managing life-threatening emergency situations (Cacciatore, Carlson, Michaelis, Klimek, & Steffan, 2011). Individuals working in these professions have also been shown to be susceptible to compassion fatigue to an extent that it can have adverse effects on their ability to perform their jobs. In this project, I sought to examine whether compassion fatigue could be reduced through an educational intervention using prevention strategies that are not specific to nursing. Findings from this project may be applicable to other disciplines affected by compassion fatigue.

Implications for Social Change

This project has the potential to affect social change by improving the work environments for nurses in areas such as hospice who care for patients in distress on a consistent basis. Education and awareness of compassion fatigue can lead to the initiation

of preventive interventions that provide effective methods to improve nurses' responses and resiliency in the face of the stressful and often traumatic experiences of their work environment (Flarity, Gentry, & Mesnikoff 2013). The stress-related symptoms that result from compassion fatigue can have a negative effect on job satisfaction and job turnover among nurses, which has been identified as a contributor to the shortage of nurses (Newsom, 2010). Compassion is necessary in the care of patients who are dying. Compassion fatigue results not only in professional dissatisfaction among nurses, but is also detrimental to the nurse-patient therapeutic relationship. Workplace stress has made recruitment and retention of hospice nurses difficult (Harris, 2013). The most prominent force in hospice care is nursing; although an interdisciplinary team is necessary for care, nursing is at the center of the services provided by hospice and palliative care organizations. Hospice programs depend on hospice nurses who are available and equipped to deal with this challenging patient population (Harris, 2013). This project focused on reducing compassion fatigue by educating nurses about its causes and effects. Social change may result from nurses' increased awareness of the need for self-care in the face of the stressors they face daily in their profession.

Summary

Compassion fatigue is a condition that can be encountered by nurses who provide care to those who are in distress. Hospice nurses are susceptible to compassion fatigue due to their frequent exposure to terminal patients and their families. This project addressed whether compassion fatigue would be reduced in hospice nurses who were provided with awareness education. The effectiveness of the educational intervention was

assessed using Stamm’s ProQOL survey, which was administered before and after the provision of the education booklet. Although studies had been conducted on the impact of compassion fatigue on nurses in other high-stress specialties, there was an identified gap in practice regarding effects on nurses providing care to hospice patients. At the project site, these effects were evidenced by the large numbers of nurses who had resigned from the organization, and by their comments in exit interviews that indicated that the stress of caring for dying patients daily was overwhelming. This project was conducted to provide hospice nurses at this facility with knowledge of compassion fatigue, which as noted by Flarity, Gentry, and Mesnikoff, (2013), had been demonstrated to be effective in reducing its incidence. The theories and concepts that supported this project, its context at the local level, and its relevance to nursing practice are addressed in Section 2.

Section 2: Background and Context

Hospice nurses are exposed to dying patients and grieving families on a consistent basis, which has been identified as a contributing factor to compassion fatigue within this specialty of nursing (Melvin, 2015). The practice problem identified was that frequently these nurses are unaware of the causes and symptoms of compassion fatigue, which demonstrated a need for provision of education regarding compassion fatigue. Wiklund-Gustin and Wagner (2013) posited that it is essential for nurses to show compassion for themselves to be able to provide compassion for their patients. They also noted that assisting nurses with self-compassion through a learning process that expands their need for self-care will enhance their capacity for the provision of compassion toward others. This project's purpose was to evaluate whether there was a reduction in compassion fatigue among hospice nurses after the provision of education regarding this phenomenon. This section provides a discussion of the concepts, models, and theories that informed this project, a synthesis of works by theorists and scholars related to these components, and clarification of terms used in the project.

Concepts, Models, and Theories

Theory is the foundation of research, and the selection of a theory assists in guiding processes toward the answer that a researcher is seeking (Boyd & Stinson, 2010). Nursing theories provide the principles and foundation to support professional nursing practice while assisting in generating knowledge and directing the development of future nursing practice. Theoretical frameworks form the foundation for nursing studies and research by providing structure, rationales and predictions of the relationships between

variables, and a frame of reference, while also guiding and directing a study and allowing for its meaningful interpretation (Alligood, 2013). This project, which focused on the phenomenon of compassion fatigue, was informed by the theories of Roy and Watson. The works of these two prominent theorists, which focused respectively on adaptation and caring, were well suited and highly applicable to my doctoral project's focus on reducing compassion fatigue by increasing its awareness through the provision of education.

Roy's Adaptation Model

The focus on holistic adaptation systems allowed Roy's adaptation model to be applicable to this project. Roy's adaptation model is based on the assumption that each person is a distinct psychosocial being who is in a perpetual state of interaction with an environment that is in a continuous state of change, and adaptation to those changes is necessary to respond positively to episodes of health and illness (Roy, 2009). Roy's adaptation model classifies the internal and external stimuli with which nurses are regularly inundated into three categories:

- Focal stimuli are those that are the most immediate cause of a situation.
- Contextual are all other stimuli that are present in the internal and external environment and may or may not contribute to a situation.
- Residual stimuli are those that may impact the situation but are not measurable or knowable (McEwen & Wills, 2014).

Roy (2009) posited that nurses have a responsibility to promote adaptation in a manner that has consideration and respect for a person's values and opinions. Roy delineated four concepts of adaptation:

- Adaptation is a process of being able to respond to environmental changes in a positive manner.
- Each person is an adaptive system who is continuously interacting with a constantly changing environment utilizing both inborn and learned/experienced adaptation methods.
- The environment composes both an external and internal entity with which persons are continually confronted.
- Health comprises a state and wellness and illness that is a continuous dimension of each person's existence.

With its focus on adapting to environmental stressors, Roy's model was relevant to this nursing project. Intense and prolonged contact with sick or dying patients and lack of self-care that result in the symptoms of compassion fatigue, such as anxiety, apathy, depression, and physical ailments, are both internal and external stressors with which nurses must adapt. Improving recognition and awareness of compassion fatigue is one method of adapting to prevent its debilitating effects (West et al., 2017). Following the tenets of Roy's adaptation model, I attempted to demonstrate that education regarding compassion fatigue helps nurses adapt to stressors in a manner that reduces compassion fatigue.

Watson's Caring Theory

Watson's human caring theory fosters nursing well-being while encouraging self-actualization as a compliment to Roy's theory. Staffing, regulatory, and financial issues can impact nursing caring practices in a negative manner. Watson's theory is a valuable tool whose elements and concepts can be used to promote compassion among nursing caregivers, even when they encounter arduous tasks and responsibilities (Lukose, 2011). This theory's key concepts include instillation of faith and hope, sensitivity to self and others, and promotion and acceptance of negative feelings. Watson's theory is a foundation for the enhancement of patient healing, but also promotes nurse well-being. This theory also emphasizes the importance of nurse self-actualization and well-being as a component of their self-care (West et al., 2017). Watson described the theory's main concern as being the relationships of a caring-healing nature that occur between humans who are in the midst of suffering, grief, loss, death, or other transitions and those caring for them. For these relationships to be functional, both parties must be in harmony with themselves and others (Clarke, Watson, & Brewer, 2009). According to Watson's theory, caring in nursing is more than simply emotion, concern, attitude, or the desire to do good. As it applies to nursing, *caring* refers to ensuring protection, enhancement, and preservation of human dignity of both caregivers and care receivers. A tenet of this theory is that this transpersonal caring should promote the patterns and possibilities of self-control, self-knowledge, and self-healing (Watson, 2005). Because self-care is an essential component in combating the onset and symptoms of compassion fatigue in

nurses, Watson's human caring theory was applicable to this doctoral project, which focused on reducing compassion fatigue in hospice nurses through education.

Synthesis of Literature

The term *compassion fatigue* was first used by Joinson (1992) in a study of occupational burnout in emergency room nurses. Joinson described this phenomenon as nurses losing their ability to nurture. However, through the development of training for those involved in disaster relief, Figley is widely considered to be the pioneer in the field of compassion fatigue research. Figley (2002) began using the term compassion fatigue in 1995 to lessen the accompanying stigma of the condition that had previously been referred to as secondary traumatic stress. Figley (2013) identified the concept of compassion fatigue as a negative result of working with individuals who had experienced trauma. Figley also defined compassion fatigue as a state of tension and preoccupation with the cumulative impact of caring, and Figley reasoned that because empathy and compassion are core values of the nursing profession, nurses were at risk for compassion fatigue. Figley (1999) also noted that caregivers such as nurses must be properly prepared for the hazard of compassion fatigue, but in a manner that emphasizes the rewards of their work. Figley's research was applicable to this project's focus on educating hospice nurses in a manner that promotes the reduction of compassion fatigue.

Description of Terms

Burnout is a condition of physical and emotional exhaustion resulting from exposure to excessive, prolonged stress. Harr (2013) noted a lack of clarity regarding the differences between compassion fatigue and burnout. Burnout typically includes

symptoms that are more mental than physical, and includes feelings of powerlessness, hopelessness, detachment, isolation, frustration, and difficulty in achieving personal and professional expectations (Circenis & Millere, 2014). Although burnout differs from compassion fatigue, the two conditions can coexist.

Compassion fatigue is defined as a disorder in which a nurse or other caregiver demonstrates feelings of fatigue, lack of empathy, and an accompanied depressed mood in relationship to work (Stamm, 2002). Compassion fatigue also refers to the behavioral response that results from the physical and emotional effects that accumulate over an extended period of time from assisting or caring for another who is experiencing illness, pain, or trauma. Compassion fatigue differs from burnout in that it is a specific disorder of persons working in caring occupations, including nurses (Gilmore, 2012).

Compassion satisfaction is a component of caring in which the negative aspects of caring for patients experiencing acute illness or trauma are balanced in a positive and productive manner. Compassion satisfaction has also been described as the ability to derive gratification from providing care (Hooper et al., 2010). Compassion satisfaction can alleviate the negative symptoms associated with compassion fatigue.

Resilience is defined as the ability to cope with change and adversity. Resilience can also denote a person's ability to adapt positively or rebound from adversity, distress, and stress (Burnett & Wahl, 2015). Another definition of resilience is the ability to maintain stable psychological and physical functioning in the face of trauma and loss in a way that promotes new experiences and emotions that are positive (Bonanno, 2008).

Relevance to Nursing Practice

Compassion fatigue is a relevant problem in nursing practice because of its effect on nursing retention, patient and family satisfaction, and patient safety. Compassion fatigue also exacts a high price from nurses and their workplaces through diminished productivity, excessive use of sick days, and increases in nurse turnover (Potter et al., 2010). In most developed countries, the number of older adults is projected to increase substantially in the next decade, indicating the need for nurses who are skilled in the provision of end-of-life care (Melvin, 2012). Sabo (2011) posited that end-of-life care requires extensive management of complex patient symptoms, and this level of care also places extreme burdens on individuals providing it, placing hospice nurses at moderate to high risk for compassion fatigue. Hospice nurses have reported high rates of PTSD and have experienced a lack of emotional support within their work environment. The longer that health care professionals work in stressful environments such as this, the more they are at risk for compassion fatigue (Figley, 2013).

Lancaster (2015) noted that when symptoms begin, providers may experience mood swings, isolation, poor self-care, negative behaviors or emotions, and legal issues, and that the key is for them to recognize when these symptoms are present and access resources that can help. Failure to get help may lead to more negative results including absenteeism or aggression. The psychological cost of caring can also result in provider turnover, which can have a substantial fiscal impact on health care organizations: the financial cost of replacing one nurse can be twice the amount of a nurse’s annual salary (Lancaster, 2015). Caregivers such as nurses who develop a declination in their ability to

provide the empathetic care necessary for a therapeutic relationship are at high risk for compassion fatigue (Ray, Wong, White, & Heaslip, 2013). The symptoms of this phenomenon have high potential for creating long-term mental and physical health problems in those who are affected by it (Sabo, 2011). Patients may suffer when compassion is impeded in nurses, as the quality of care provided to patients declines; compassion fatigue has been demonstrated to result in a reduction in quality of care and safety (Laschinger & Leiter, 2006).

Although first responders witness the trauma and illness of others, their contact with patients is abbreviated. Nurses, in contrast, could be described as sustained responders based on the manner in which their contact and relationships with their patients are maintained over a period of time (Boyle, 2011). Boyle also noted that there is little in the way of support to assist nurses in dealing with the emotional cost that is exacted from continuously being exposed to others' trauma, illness, sadness, or grieving. However, existing scholarship has raised awareness in the profession of nursing regarding the emotional disturbances that can result when nurses are continuously confronted with the pain and suffering of their patients. Research has demonstrated that the development of programs focused on prevention and early recognition of compassion fatigue may be effective (Circenis and Millere, 2011). Approaches to compassion fatigue prevention in nurses include self-care, self-reflection, meditation, and mindfulness activities. Other elements that have been determined from research in combating compassion fatigue in oncology and emergency department nurses include self-regulation of the autonomic nervous system during stressful situations, having an attitude of

intentionality and purpose toward work activities, focusing on nursing as a serving profession and reducing the internalization of negative work environments, strong and positive peer-support systems, and participation in regular and rejuvenating exercise and activities (Flarity, Gentry, & Mesinkoff, 2013; Potter, et al., 2013). There exists a large body of research focused on the effects of compassion fatigue and burnout in nurses and other healthcare workers. However, there is comparatively not much focus on compassion fatigue awareness and reduction through the promotion of self-care and preventative interventions (Duarte & Pinto-Gouveia, 2016). This doctoral project aimed to demonstrate the effectiveness of an educational approach in reducing compassion fatigue through awareness among hospice care nurses.

While hospice nurses receive training in how to assist the bereaved, they are frequently neglectful of their own chronic bereavement, making them vulnerable to the development of compassion fatigue. A study by Melvin (2012) of hospice care nurses demonstrated that the lack of adequate coping mechanisms places individuals working in this field at high risk for compassion fatigue. Melvin's study determined that the compassion fatigue in hospice nurses was a particular concern because of their repeated exposure to death over extended time periods, difficulty in setting boundaries with dying patients and their families, and the overall emotional and physical stress of providing nursing care in general in hospice and palliative care environments. Hospice nurses in Melvin's study related that they felt responsibility for their patients to the point that they would worry about them in their off-duty time at home, and Melvin posited that these nurses must be provided with support strategies (Melvin, 2012). Hospice nurses have,

however, been noted to have defense mechanisms that are highly structured in order to cope with the environment in which they work. These defense mechanisms of hospice nurses include balancing the stressors inherent in hospice care, as well as being able to distance themselves, and providing self-care through taking time off from work when they notice increasing stress. These mechanisms were more often seen in seasoned and experienced nurses, and those who had not developed them were noted to be at a higher risk for compassion fatigue (Abendroth & Flannery, 2006). Proactive coping strategies such as these have been noted to be an approach to addressing the gap-in-practice regarding the negative impact of compassion fatigue. Examples of these proactive coping behaviors include removing oneself from a stressful situation for a short time, participation in critical incident stress debriefings, emphasis on positive thinking, and training on preparation for negative stress (Gillespie & Gates, 2013). When nurses have been prepared for negative stress and provided with proven emotional support mechanisms, their work-life balance correspondingly improves. One manner of doing this is to offer peer coaches and provide reflective supervision, in which staff nurses are encouraged to share their concerns with each other and their leadership (Kinman & Leggetter, 2014). These support mechanisms, when promoted by nurse leaders, will assist the nurses in their employ in finding methods to establish emotional boundaries between the people for whom they provide care and themselves. Nurses with positive, supportive managers are more likely to have accompanying higher levels of compassion satisfaction than those with managers who are unsupportive (Hunsaker et al., 2015).

Local Background and Context

The nature of their work places hospice nurses at substantial risk for compassion fatigue. In the healthcare continuum, the end-of-life care that these nurses provide to patients and their grieving families throughout the dying process requires skill, empathy, and compassion to be delivered in a manner that exacts a toll from those who are not prepared (Melvin, 2015). This project has relevance because when nurses suffer from compassion fatigue, they tend to eventually leave a job. Losing nurses is even more detrimental to hospice organizations, as these nurses have, on average, more than 20 years of nursing experience. This results in not only a financial burden to these organizations, but also the loss of crucial mentors for newer nurses, as well as a loss of nurses who have established trusting relationships with physicians (Abendroth & Flannery, 2006).

The retention of satisfied staff is vital to the mission of healthcare organizations, and replacement of staff lost due to compassion fatigue has negative implications for them on multiple fronts. During the time spent with the hospice organization at which this author's practicum was completed, it was noted that this was a concern among their senior leadership. Statistics provided by the organization's human resources (HR) director that encompassed the years 2015 and 2016, the most recent full years for which there is complete data, demonstrated that there was substantial turnover of nurses in their facility. Forty-five percent of the nurses (28 of 62) in the organization resigned during this timeframe. The HR Director also stated that of this number, eighteen stated during exit interviews that they attributed the stress involved with caring for dying patients on a

daily basis as influential on their decision to leave the organization. This resulted in a substantial financial cost to the organization (D. Wheaton, personal communication, February 1, 2017). This doctoral project advanced nursing practice by providing education that promoted awareness among hospice nurses in a manner that resulted in its reduction, which hopefully had the tertiary effect of improving retention and job satisfaction among nurses practicing their profession in this environment.

Implementation

A before and after quality improvement project was the methodology chosen for this doctoral project because of the manner in which it allowed for analysis of the impact of the educational offering that provided awareness regarding compassion fatigue. These studies utilize measurement of variables of interest before and after an intervention. The operational assumption of these studies is that the intervention was responsible for any changes noted after it was implemented (Portela et al., 2015).

Institutional Context

This project was administered in a large hospice facility that is part of a healthcare organization headquartered in the city of Beaumont, Texas. This allowed for a substantive sample size of nurses. The compassion fatigue training and strategies for reducing it were presented to nurses working both night and day shifts. This is a for-profit organization with hospices, home health services, medical clinics, and management services in multiple states, including Texas, Louisiana, Nevada, and Michigan. Their hospice facilities were the first in the nation to be certified by The Joint Commission in Community-Based Palliative Care. One of the core values of this organization is the

value that they place on their employees, which coincided with the focus of this doctoral project.

Clarification of Terms

The term compassion fatigue is used to describe the severe physical and emotional exhaustion that those in helping professions can develop over the course of their careers. Compassion fatigue can be designated as an occupational hazard, and as such, most persons in these professions will eventually manifest some of its symptoms, although the severity may vary (Mathieu, 2012). Vicarious traumatization is a term that is used to describe the alteration in their world view that develops in nurses and others who care for patients and clients that have experienced trauma. It occurs over long periods of time and from multiple encounters with traumatized patients (Figley, 2002). These terms have a lot in common with secondary traumatic stress, however, that term is used to denote conditions that are much more similar to post-traumatic stress disorder (PTSD), in which those who care for others become so preoccupied with another's traumatization experience that they likewise become traumatized. This can result from death overload, which is a form of traumatic stress in which a caregiver has been exposed to the deaths of an excessive number of patients in a short amount of time, or from caring for a dying patient for a long time prior to their expiration (Todaro-Franceschi, 2012). While these terms are commonly used to describe burnout, that term is actually applied to frustration and stress that results from workplace issues, such as those involving pay, workloads, poor management, and other negative concerns that can occur in any occupation, not just those related to caring.

Role of the DNP Student

In 2008, I had the privilege to assist the hospital chaplain at my hospital in California with his doctoral research project on pastoral care's impact in regard to compassion fatigue. Over the course of his research involving physicians, nurses, and other caregivers, it became increasingly apparent that compassion fatigue affects our profession in ways that many of us do not fully comprehend. Nursing is such a demanding profession in a multitude of ways, and at some juncture in time, most nurses have had coworkers who exhibited signs of compassion fatigue. With the particular vulnerability that hospice nurses have toward compassion fatigue, it was a goal that this project was purposeful in helping determine strategies that these caregivers could utilize to guard them against it.

My role in this doctoral project was that of its overall coordinator. I designed the educational booklet on compassion fatigue, around which the project is centered, using Apple Pages® software. I also provided analysis of all data obtained from this project. I facilitated all communication with the leadership of the hospice organization where the project was conducted. I was the interim CNO for the long-term acute care hospital (LTACH) for this organization in 2015 and have provided consultant services for them in the time since.

As a nurse leader, I am concerned with fiscal responsibility and the safety of patient care. Accordingly, I am interested in compassion fatigue reduction strategies to ensure that the nurses in my organizations are equipped and knowledgeable regarding compassion fatigue so that we can ensure the provision of high-quality patient care, and

also improve retention of nursing staff. However, as a nurse, I have an inherent interest and motivation concerning this project. In general, those who chose to be in the nursing profession did so because of the satisfaction and fulfillment that is achieved by helping those who are sick or injured. Nurses who are experiencing compassion fatigue are frequently unable to derive this satisfaction from their work. It was my hope that a primary outcome of my project would be to demonstrate that compassion fatigue among nurses can be reduced through the provision of education and awareness.

One of the goals of mindful practice is to recognize one's own bias and judgment in a manner that facilitates an approach that is principled and compassionate (Epstein, 1999). A potential bias that I may possess is an opinion that, due to limitations of their education level, many Licensed Vocational Nurses (LVNs) may not have the experience or critical thought processes necessary for self-reflection to participate in a project such as this. This is admittedly somewhat of a hypocrisy on my part, as I began my career in nursing in 1990 as an LVN. To have a substantive sample size, it was necessary to have LVNs participate in the education and subsequent survey. The booklet regarding compassion fatigue that comprised the educational component of this doctoral project provided introductory information regarding the topic in a manner that was accessible to nurses of all educational and skill levels. Additionally, the survey that was administered was provided in a manner that allowed for anonymity from the hospice nurse respondents. Accordingly, the results were collated into a whole so that individual responses were not identifiable. This addressed any bias that I may have had and

appropriately provided results that were reflective of nursing in general from the hospice nurses who participated.

Summary

The focus of this doctoral project was reducing compassion fatigue among hospice nurses through the provision of an educational offering. As aforementioned, this project has relevance to nursing because of the influence that compassion fatigue has in many nurses' decisions to leave positions, or even the profession, which worsens the nursing shortage. The theories that informed and provided the foundation for this project were Roy's Adaptation Model and Watson's Caring Theory. The role of this DNP student in this project was shared: I directed and coordinated all aspects of this project, including its conception, implementation, analysis, and dissemination. In Section 3, the search strategy and sources of evidence that were reviewed for this project are presented, as well as an analysis and synthesis of generated evidence. Details regarding the project's research design, data collection, and data analysis methods are discussed as well.

Section 3: Collection and Analysis of Evidence

The susceptibility among hospice nurses for developing compassion fatigue was identified as the local nursing practice problem for this doctoral project. Nurses are faced with an ever-changing landscape that requires an increasing body of scientific knowledge; however, Mishler (2008) asserted that nurses receive little to no training on how to care for themselves as they deal with the stressors of the profession on a daily basis. This project's practice-focused question addressed whether the administration of education regarding compassion fatigue to hospice nurses resulted in a subsequent reduction in their levels of this condition. Compassion fatigue has a high potential for negative impact on those affected by it, and may manifest in different ways, including depression, loss of empathy for those who are suffering, and poor self-care. Compassion fatigue may affect the quality of nurses' work and the provision of patient care. The background and context of this problem were supported by Roy's adaptation model and Watson's caring theory. In this section, I describe the sources of evidence, the published research, and the data collection procedures and evidence that were used for this doctoral project.

The local nursing practice problem that the focus of this project was the lack of compassion fatigue awareness among hospice care nurses. The gap in practice was a lack of education regarding compassion fatigue among hospice nurses. The practice-focused question addressed whether compassion fatigue was diminished in hospices nurses after they had been provided with education regarding it. This project was a quality improvement project. Quality improvement projects provide outcome indicators that

demonstrate characteristics of change that are specific, measurable, and observable (White & Dudley-Brown, 2012). This project's findings were used to measure whether the educational component resulted in a reduction in compassion fatigue in hospice nurses and through data collected from the Professional Quality of Life scale prior to and after the administration of the educational component.

Operational Definitions

Hospice nursing: A specialty area of nursing concentrated on the provision of end-of-life care. This specialized care focuses on keeping patients comfortable both on a physical level through pain management and on an emotional level by ensuring that patients and families have the support they need (Abendroth, 2005).

Professional Quality of Life (ProQOL) Scale: A tool developed by Stamm (2010) that comprises 30 questions scored by respondents to measure the three subcategories of compassion fatigue, compassion satisfaction, and burnout.

Quality improvement (QI) project: The use of formal and systematic methods to analyze and improve an element of practice (American Academy of Family Physicians, 2018). QI is a term that is used to describe efforts that contribute to improvements in patient outcomes, system performance, and professional development (Adams, 2018).

Sources of Evidence

This doctoral project had a quality improvement focus and a design based on the before-and-after methodology to assess the impact of the provision of awareness training to hospice nurses. Portela, Pronovost, Woodcock, Carter and Dixon-Woods (2015) posited that quality improvement projects' defining trait is that they are focused on

improving an issue of concern more than on the generation of new evidence. Before-and-after studies are used to identify the consequences of an intervention based on the supposition that the differentiation in a measurement before and after an intervention is introduced is due to the intervention's impact (Portela et al., 2015). The intervention used in this project was an educational booklet on compassion fatigue that was presented to a group of hospice nurses in Southeast Texas. The measurement tool was the *ProQOL* scale, which is used to measure levels of compassion fatigue and burnout, and which has been shown to have a high level of reliability in independent testing (Stamm, 2005). The hospice nurses who participated in this project scored their responses on the ProQOL scale before exposure to a short educational booklet on compassion fatigue. Participants then provided their scores a second time 20 days after reviewing the educational booklet. Comparison of the scores was used to determine whether the educational booklet resulted in a decrease in compassion fatigue among these nurses.

The relationship of this evidence to the purpose of this doctoral project was expressed through the assumption that the participating hospice nurses' scores on the ProQOL conveyed a decrease in compassion fatigue after the provision of an educational booklet in comparison to the scores that were provided before its provision. Collection and analysis of this data allowed for a process of addressing the practice-focused question that guided this doctoral project by establishing whether providing education concerning compassion fatigue to nurses working in this specialty would result in its reduction. A review of the literature demonstrated that education regarding compassion fatigue has resulted in a reduction in compassion fatigue among nurses working in specialties such as

oncology and emergency care (Campbell, 2007; Flannelly, Roberts, & Weaver, 2005; Gillespie & Gates, 2013; Hooper et al., 2010; Lombardo & Eyre, 2011). This project addressed whether this approach would have a similar effect for nurses working in hospice organizations.

Literature Review

In the process of performing the review of literature for this doctoral project, I observed that the topic of interventions to reduce or prevent compassion fatigue had been addressed in the published works of many researchers and scholars. Evidence included information obtained from the literature, including journals such as *Nursing Management*, *Journal of Nursing Administration*, *Journal of Professional Nursing*, and the *Journal of Hospice and Palliative Nursing*. Published information from nursing organizations was reviewed as well, such as the *Online Journal of Issues in Nursing*, which is the scholarly journal of the American Nurses Association. Information from books that had been published with scholarly examinations of compassion fatigue was also reviewed. Databases used included CINAHL Complete, MEDLINE Complete, PubMed, Nursing Reference Center Plus, and E-books Medical Featured Collections. The Google Scholar search engine of scholarly works was used as well.

An extensive search strategy was followed for the purposes of this review of literature. Search terms that were used included *compassion fatigue*, *compassion satisfaction*, *burnout*, *stress*, *secondary traumatic stress*, *awareness education*, *mindfulness*, *resiliency*, *hospice nurses*, *self-care*, *pastoral care*, *relaxation techniques*, *work setting improvements*, and *communication skills*. Searches were also performed

regarding Roy’s adaptation model and Watson’s caring theory. These key terms all contributed to the selection of works examined in this literature review.

The scope of this literature review included scholarly works published from 1992 to 2018. The sources of these works included books, articles from academic journals, and white papers on the topic of compassion fatigue. An initial search generated 141 articles that focused on compassion fatigue and strategies for countering it. Many articles addressed the impact of compassion fatigue on nurses working in critical care areas and emergency departments. After an assessment of the abstracts of these articles, I selected 38 articles and books for inclusion in this review based on their relevance to this doctoral project.

A review of extant literature was conducted for this project using multiple published works from other scholars and researchers regarding compassion fatigue and its impact on caregivers in several specialties, with an emphasis on nurses working in the field of hospice care. Literature was also reviewed that provided approaches to reducing compassion fatigue among caregivers and nurses, with an emphasis on education. The purpose of this literature review was to examine effective methods of reducing compassion fatigue among caregivers to support this project’s purpose in reducing compassion fatigue among hospice nurses through education.

According to Figley (2002), the concept of compassion fatigue was first identified but not named by Hilfiker in a 1985 study of Harvard-trained physicians who reported feeling socially and psychologically isolated by the toll that was being exacted by the emotional stress of being a physician. Compassion fatigue was first named by Joinson

(1992) in a study of nurses who were experiencing these same symptoms from their daily work in an emergency department. Joinson also compared compassion fatigue with burnout without explaining how the two overlap. Figley (1995) used compassion fatigue to describe the cost of caring that was experienced by mental health clinicians whose work was focused on clients who had endured physical and emotional trauma. Figley (2002) provided the definition of compassion fatigue that is most commonly used to today, in which a caregiver's capacity for empathy is reduced due to exposure to the suffering of her patients. Another pioneering researcher in the field of compassion fatigue study was Stamm, whose Professional Quality of Life (ProQOL) scale is used to measure compassion fatigue. Stamm (Stamm & Figley, 2002) posited that compassion fatigue manifests in feelings related to lack of connection, happiness, and sensitivity to patients and work environment. Stamm stated that compassion fatigue is different from burnout, which includes symptoms such as exhaustion, frustration, anger, and depression, and is different from from secondary traumatic stress, in which a person exhibits negative feelings related to fear from work-related trauma (Stamm & Figley, 2002).

The literature indicated many causes for compassion fatigue in the modern nursing workplace, and also different approaches that can be taken to reduce its prevalence. Holland, Allen, and Cooper (2013) stated that decreased morale is both a contributing factor and a symptom of compassion fatigue, which occurs in helping professions in which individuals work closely with others in emotionally charged environments. There are many variables that come into play that affect nursing morale. Holland et al. demonstrated that ensuring that employees are given a voice regarding

nursing practice concerns significantly reduced levels of compassion fatigue. Holland et al.'s research showed that this intervention facilitated two-way dialogue between management and employees, which had a drastic impact on nursing morale by creating opportunities for employees to have input on decision-making for their units. This improved morale and contributed to a reduction in compassion fatigue by providing staff nurses with a feeling of influence and control (Holland et al., 2013).

Holland et al.'s (2013) research was tangentially related to another approach presented by Henry (2014), who found that unit retreats resulted in increased morale and job satisfaction among nurses through enhanced communication. When arranged properly, retreats focusing on shared goals strengthened and reenergized patient care teams through the clarification of roles and expectations and through the identification of the unique contributions each staff member brings to the team. Henry also asserted that the implementation of clinical ladder programs to provide salary increases had a positive effect on morale and compassion satisfaction; however, nurses reported that monetary rewards had the least effect on morale. Fairness from management was the primary motivator that contributed to job satisfaction and subsequent reductions in compassion fatigue (Henry, 2014). Holland et al.'s and Henry's assertions were supported by a study of New Zealand nurses, which indicated that most nurses are passionate and enthusiastic about their jobs; however, increasingly unsafe practice environments, leaders' unresponsiveness to nursing concerns, and rigid management resulted in compassion fatigue and dissatisfaction among nurses ("Nursing morale," 2017). Vargas et al. (2013) also noted that decreased morale results in emotional exhaustion, depersonalization, and

reduced job satisfaction, all of which are identified contributors to compassion fatigue. Vargas et al. further described how compassion fatigue has a negative impact on the physical and emotional health of nurses, and also affects patient satisfaction, health outcomes, and mortality.

Caregivers from myriad fields can be afflicted by compassion fatigue. A study by Ray et al. (2013) demonstrated how compassion fatigue affects frontline mental health professionals through personally and professionally. They found that frontline mental health professionals with multiple years of experience in the profession were less likely to be affected by compassion fatigue than those with less tenure. Accordingly, they argued that the establishment of supportive mentoring relationships with more seasoned colleagues can contribute to lower levels of compassion fatigue in those who are newer to mental health professions. This is similar to what has been found in regard to compassion fatigue's impact on social workers (Bride, Radey, & Figley, 2007; Adams, Boscarino, & Figley, 2006). Likewise, clergy and those who provide spiritual care to others can be affected by compassion fatigue as well. Flannelly, Roberts, and Weaver (2005) described compassion fatigue's effect on 149 chaplains and other clergy who responded to the attacks on September 11, 2001 in New York City. Their study demonstrated that compassion fatigue among these members of the clergy was directly correlated to the number of hours that they worked with the victims of this tragedy. They also found that the clergy involved in this study had high levels of both compassion fatigue and compassion satisfaction, demonstrating that they found helping the victims of 9/11 simultaneously draining and rewarding. There are other studies demonstrating that

compassion fatigue has similar effects on those working in such varied occupations as child protection workers, police officers, fire fighters, and special education teachers (Conrad & Kellar-Guenther, 2006; Turgoose, et al., 2017; Cocker & Joss, 2016; Sharp-Donahoo, Siegrist, & Garret-Wright, 2017).

While compassion fatigue can affect workers in many different settings, it is particularly impactful in the profession of nursing. Lombardo and Eyre (2011) posited that any nurse could be affected by compassion fatigue, since nurses of all specialties are confronted with the pain and suffering of patients and their families. One specialty of nursing that has a high prevalence of compassion fatigue is that of cardiovascular nursing. A study by Young et al. (2011) provided evidence that nurses that work in cardiac and vascular intermediate care units demonstrated high levels of compassion fatigue. They related these findings to the complex technology that nurses in this setting use on a daily basis, as well as the continual changing of patient assignments of these high-acuity patients, and that the severity of the illnesses of patients who are admitted into critical care areas such as this can be a major stressor for nurses who work in these units. Likewise, nurses who work in emergency departments are at high risk for development of compassion fatigue as well. The emergency department has its own inherent stressors that contribute to compassion fatigue, due to the traumatic occurrences that result in patients seeking care. Likewise, crowded hallways and waiting rooms, pressure to improve patient throughput, and delays in admission bed assignments also contribute to an environment that is rife with potential for the development of compassion fatigue in nurses working in emergency departments (Emergency Nurses

Association, 2014). Another specialty that is prone to developing compassion fatigue is oncology nursing. In their study of 96 oncology nurses, Duarte and Pinto-Gouveia (2016) found that these nurses were very susceptible to compassion fatigue due to their constant exposure to the pain and suffering that patients with cancer are enduring. They argued that this is a primary reason why there is such a global shortage of oncology nurses. These findings parallel those found in the literature regarding hospice nurses as well.

Compassion fatigue can be especially debilitating to those nurses who are accustomed to the demonstration of high levels of empathy. A review of the literature demonstrates that hospice nurses, with their constant exposure to death and grieving families, are at particularly high risk for the development of compassion fatigue. This can ultimately lead to nursing turnover and shortage, with subsequent negative effects on an organization's fiscal health due to the expenses that accompany replacing and training nurses (Newsom, 2010). A study by Young et al. (2011), found that hospice nurses had higher levels of secondary traumatic stress and compassion fatigue than their counterparts in cardiovascular nursing, in large part due to the higher number of deaths that they witness, which may result in impaired coping mechanisms on the part of hospice nurses. Carter, Dyer, and Mikan (2013) stated that the constant exposure to bereavement by hospice nurses results in sleep disturbances, which lead to subsequent health issues such as depression and chronic stress. Melvin (2012) likewise noted that a prevalence of compassion fatigue among hospice nurses, and that there are distinct consequences for the mental and physical health for these nurses who work in this specialty for an extended period of time. These studies are also supported by the findings of a study of 90 hospice

nurses by Barnett and Ruiz (2018), who found a correlation between the psychological stress to which nurses in this specialty are constantly exposed and high levels of compassion fatigue. They also noted that nurses working in hospice organizations had low levels of self-esteem that seemingly contributed to this as well.

Flannelly, Roberts, and Weaver (2005) discovered in their study that training regarding compassion fatigue could significantly reduce its effect on caregivers and posited that awareness of compassion fatigue acts as a buffer against its negative impact. Lombardo and Eyre (2011) stated that the focus of Watson's theory of human caring on relationship-based nursing makes it especially well-suited as the foundation for an approach to countering compassion fatigue in nurses, since the empathic relationship between nurse and patient is at the core of the profession of nursing. Wiklund-Gustin and Wagner (2013) likewise used Watson's theory as a framework for their study, which found that clinical nursing teachers could lessen compassion fatigue among their students by educating them on self-compassion and self-care. Their study was focused on reducing compassion fatigue by increasing participants' awareness of compassionate caring and self-compassion. In doing so, they used Watson's first Caritas Process, which promotes the cultivation of kindness and equanimity towards both others and one's own self as a basis for the education that they promoted among clinical nursing teachers and their students. The finding of their study demonstrated that nursing students who were taught and had increased awareness of self-compassion provided higher levels of compassion toward their patients.

Mishler (2008) posited that one manner of ameliorating the effects of compassion fatigue in nurses is through education. He shared how multiple studies have indicated that nurses have been successful in overcoming compassion fatigue when they have been educated on creating a personal plan that emphasizes spending time alone recharging themselves through exercise and nutrition, as well as ensuring that they have at least one focused, meaningful, and connected conversation each day. His study of nurses working in an intermediate critical care unit in hospital in Visalia, California, validated that providing education with a focus on raising awareness and skills for self-care was effective in helping them combat compassion fatigue. Gillespie and Gates (2013) performed a study with similar findings in regard to nurses working with trauma patients in emergency departments. They found that nurses who had been educated regarding secondary traumatic stress and compassion fatigue developed coping strategies that were proactive and were effective at mitigating the symptoms related to both conditions. Two additional studies were reviewed that corroborated this finding. The conclusions noted by Hooper et al. (2010) in their study compared compassion fatigue levels among emergency department nurses with those in other nursing specialties and determined that education regarding compassion fatigue is indispensable among all nursing specialties if it is to be prevented. They discovered that the high incidence of compassion fatigue among emergency department nurses could be reduced if they were afforded education on beneficial methods of dealing with the stress that is a characteristic component of their workplace.

Likewise, Campbell (2007) related the results of her findings regarding social workers assisting affected residents in the aftermath of Hurricanes Ivan and Katrina. She found that providing education to these social workers helped to stem the effects of compassion fatigue. The training provided covered the history and concept of compassion fatigue and compassion, as well as techniques that assist in reducing its symptoms. Campbell (2007) posited that without awareness the problem of compassion fatigue among medical and social service workers will not be resolved, but with education, compassion fatigue does not need to be an accepted facet of working in these fields. She also argued that competency in self-care is a necessary component of those for whom the provision of compassion is a necessary aspect of their profession. Melvin (2015) likewise contended that education regarding compassion fatigue is necessary for hospice nurses in order for them to learn methods of prevention as well as resiliency strategies. There are many educational approaches that have been used to promote knowledge and awareness of compassion fatigue. Sinclair et al. (2017) cited an education module that focused on healthcare worker self-care, which was found to raise awareness of compassion fatigue while simultaneously providing a reduction in work-related stress among pediatric critical care nurses. This project sought to replicate the findings of these studies among nurses working for a hospice facility in southeast Texas. While there are many studies regarding compassion fatigue’s effect on nurses, and on using education to reduce its impact, there was an identified gap noted in the application of this approach toward nurses working in palliative care and hospice organizations.

Analysis and Synthesis

Participants

The participants for this project were nurses working for a hospice organization in Beaumont, Texas. As aforementioned, the educational booklet and ProQOL survey were made available to nurses working on both the day and night shifts. These nurses work for the largest hospice organization in southeast Texas in a facility that typically has a very high census of patients. These nurses were not identified by their participation in the project, and all nurses were afforded the opportunity to take part regardless of tenure with the organization, or length of service as a nurse. Licensure status was not be utilized as a consideration either; both Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) were asked to participate. Accordingly, hourly status was not used as a criterion either; nurses employed full-time and part-time from this organization were solicited to participate in this doctoral project. As they work in a standalone hospice facility, these nurses were optimally relevant to this project's practice-focused question regarding whether education regarding compassion fatigue resulted in its reduction among nurses working in this specialty.

Procedures

The Professional Quality of Life (ProQOL) scale was used to collect data measuring compassion fatigue in the hospice nurses participating in this doctoral project, both before the administration of a brief educational offering on compassion fatigue, and 20 days afterward. This scale utilizes multiple questions that measure the intensity of compassion fatigue's various symptoms, which fall into three domains:

- Re-experience of the traumatic occurrence;
- Avoidance and indifference to the event; and
- A persistent state of arousal in which one may manifest itself through insomnia, anger, inability to concentrate, and autonomic nervous system responses such as tachypnea and tachycardia (Stamm, 2010).

The Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL R-IV*)* uses a 6-point Likert scale that ranges from “0” for “Never”, to “5” for “Very Often” for the scoring of 30 individual questions. The composite scores from this tool are also separated into 3 subscale categories that rate compassion fatigue, burnout, and compassion satisfaction (Stamm, 2010). The ProQOL scale also establishes overall risk for compassion fatigue, as well as for the three measured subscales, along a quartile method, with the top 25% of scores representing high risk, 50% percent scores representing middle risk, and the lowest 25% scores representing low risk. In collation of responses from 2000 studies that used the ProQOL for measurement, the average scores for each subscale were found to be the following:

- The compassion satisfaction scores ranged from 33 to 42 for an average of 37, and a standard deviation of 7.
- The compassion fatigue scores ranged from 8 to 17, for an average of 13, and had a standard deviation of 6.
- The burnout scores ranged from 18 to 27, for an average of 22, with a standard deviation of 6.

The ProQOL scale has been extensively tested over many years, and has demonstrated validity through α subscale reliabilities, respectively, of 0.80 for compassion fatigue, 0.87 for compassion satisfaction, and 0.72 for burnout (Stamm, 2010).

A booklet regarding compassion fatigue, its effects, and strategies for mitigating it and increasing resiliency was built using Apple Pages® software (Appendix C). This booklet was formatted using graphics and information that relayed the information in a concise, interesting, and easy-to-read manner, and was professionally printed and bound. The ProQOL was provided to them before and after they had reviewed the educational material and was administered via a paper form with no modifications made to Stamm's tool.

Protections

This proposal was used as the foundation for receiving approval from both the organization and the Walden University Institutional Review Board (IRB). The Standard Application for Research Ethics Review form was submitted to the Walden University IRB, which has the responsibility of assuring that all studies and research meet the University's standards of ethics and that they do not violate any regulatory standards. Data collection for this DNP project began after IRB review and approval was granted; the IRB approval number assigned to this project was 10-19-18-0054886. Likewise, review and approval of this proposal by the hospice organization's Administrator was completed prior to any staff interaction or data collection. I offered the educational booklet used as the intervention in this project to the organization at its conclusion for their use in future training or orientation sessions.

To maximize participation among the nurses working in this hospice organization, a request was submitted asking to be allowed to briefly speak with them during a staff meeting or when they have downtime on the unit. At that time, a description of the project and its value was shared with these nurses. The incentive for participation was an awareness of compassion fatigue and the coping skills needed to prevent it, and it was emphasized that the time expenditure for their participation will be minimal. In order to ensure that the privacy of the nurses participating in this project is safeguarded, no identifying information of any kind was solicited or obtained. They were provided with a consent form prior to the start of the project that outlined its goals and aims, and they were also be advised that they could withdraw their participation at any time.

Assurance of Integrity

To ensure that the integrity of the evidence collected was assured, safeguards were put into place. The completed scored ProQOL tools that were received from the hospice nurses participating in this project were scanned and converted into the Portable Document Format (PDF). This format allowed for the electronic storage of the completed ProQOL tools and also prevents alteration of the forms as well. The scans of the tools in PDF format were secured by saving them to an encrypted, password-protected cloud drive. Once the completed ProQOL tools were collected from each nurse participant, and after scanning and conversion to PDF was completed, all paper forms were shredded. The results from the completed ProQOL tools were transcribed into a password-protected Microsoft Excel ® spreadsheet for analysis. This reviewer is the only person with access to the scans or the spreadsheet, which will be stored for a minimum of 5 years.

As noted by Grove, Burns, and Gray (2013), another consideration for preserving the integrity of collected data is to also ensure consistency in order to maintain the validity of the project. They advised that the collection of data should be done at the same time of day for all participants. They asserted that this is necessary to minimize any variations in care that may occur based on the time of day. For example, at 0900 a.m., nurses typically may be burdened with multiple medications that must be administered, or with procedures such as dressing changes that must be completed. As the data collection instrument for this project measures compassion fatigue, the results could be skewed should a nurse be presented with the ProQOL tool at a busy and stressful point in their workday. With both night and day shift nurses from the hospice facility participating, every effort was made to collect the data at the same time during their shifts (for example, during downtime, such as lunch breaks) for all nurse participants.

There was always the potential that responses were mismarked or missing from a returned ProQOL tool. In regard to missing information, Grove, Burns, and Gray (2013) advised that efforts should be made to retrieve the missing data. If this is not possible, they stated that the missing data should be evaluated for its impact, and that if it is considered essential, a participant's responses may need to be excluded. This process was followed during the data collection phase of the project.

Systems

Omniplan® project planning software for the macOS computing platform was used for planning and tracking of the project's progress. This application allowed for the creation of timelines and due dates and was invaluable in ensuring that progress points in

the data collection process were achieved. The Microsoft Excel® and Apple Numbers® spreadsheet applications were used for recording the data that was obtained from the submitted ProQOL surveys that were completed by the hospice nurses who participated in this project. Both of these applications allow for entry of data in a manner that can be sorted and analyzed through methods such as pivot tables and graphing.

Analysis of the collected data was performed using Microsoft Excel®. The hospice nurse participants' responses were measured for averages across each of the 30 items on the ProQOL tool. This provided for an assessment of the impact of the compassion fatigue educational booklet on the nurses in aggregate across the three subscales of the ProQOL: compassion fatigue, compassion satisfaction, and burnout. The results from these three subscales were compared both before and after the provided educational component using a percentage scale. This provided a means to statistically analyze any resultant changes in the three subscale scores after the nurses had received education regarding compassion fatigue. Comparison of these results answered the practice-focused question that is the purpose of this project, which was to discern whether the provision of education regarding compassion fatigue resulted in its decrease among hospice nurses. Additionally, licensure status (RN or LVN) was collected with no identifying information. This data was used to ascertain if any differentiation in compassion fatigue as scored on the ProQOL exists between these different licensure levels.

Summary

This DNP project addressed the problem of compassion fatigue in hospice care nurses and attempted to demonstrate that levels of this condition decrease when nurses are offered education regarding it. A before-and-after quality improvement methodology was used, with the nurses' scores from Stamm's ProQOL measurement tool as the evidence collected. This data was evaluated and analyzed to determine the effectiveness of the educational booklet that was provided to the nurses in this hospice facility. In Sections 4 and 5 that follow, the project's findings are discussed alongside recommendations and a plan for dissemination of the results.

Section 4: Findings and Recommendations

This section provides the findings of the doctoral project and recommendations generated by those findings. The local nursing practice problem that was the focus of this project was hospice nurses' high risk for compassion fatigue, and the identified gap in practice was the lack of education among these nurses regarding compassion fatigue and its effect on those providing end-of-life care. The practice-focused question for this project addressed whether a reduction in compassion fatigue among hospice nurses could be achieved by providing them with educational material focused on compassion fatigue. A before-and-after quality improvement project was used to evaluate compassion fatigue in a group of hospice nurses in Southeast Texas through the provision of educational materials regarding causes, symptoms, and preventative methods of compassion fatigue.

The Professional Quality of Life (ProQOL) scale was used as the source of evidence for this project. The data generated by the participants were analyzed using Microsoft Excel® and IBM SPSS® to determine whether compassion fatigue scores decreased over a 3-week period after participants were given educational materials. The initial ProQOL survey was administered to the hospice nurses at three staff meetings over two days in November 2018. At these meetings, nurses were also provided with a booklet that I designed to be easy to read and accessible by staff nurses (Appendix C). This booklet contained information on compassion fatigue and how it can affect hospice nurses, as well as strategies that the nurses could use to prevent it from occurring. The booklet contained a second copy of the ProQOL that the nurses were asked to complete and submitted 18 to 20 days later. The scores from the initial and subsequent

administration of the ProQOL survey were compared to assess the educational booklet's effectiveness in reducing compassion fatigue among the nurses.

Findings and Implications

The literature researched for this project revealed that education regarding compassion fatigue had been effective in reducing it among caregivers such as registered nurses in critical care or emergency departments, as well as mental health professionals. The purpose of this project was to determine whether this approach would have a similar result among hospice care nurses. Twenty-three nurses from a hospice organization located in Southeast Texas participated in this project. To encourage participation and provide assurance of confidentiality, I did not collect demographic information regarding age, gender, ethnicity, or education level. However, the nurse participants were asked to indicate whether they were a registered nurse (RN) or a licensed vocational nurse (LVN.

According to the initial administration of the ProQOL survey, the licensure status for the 23 participants was as follows:

- 14 (60.9%) participants were RNs;
- Eight (34.8%) were LVNs;
- One participant (4.3%) did not indicate her licensure status.

Eighteen of the initial 23 participants returned the second survey form. The licensure status of those who returned the second ProQOL survey was the following:

- 13 (72.2%) RNs;
- Five respondents (27.8%) did not denote their licensure status on the second survey.

Data indicated that 78.3% of the initial participants completed the process for this project. Comparison of the compassion fatigue scores in aggregate between the first and second ProQOL surveys was performed.

The ProQOL includes 30 questions to measure compassion satisfaction, burnout, and secondary traumatic stress or compassion fatigue (Appendix C). The responses to questions were on a Likert scale of 1 (“Never”) to 5 (“Very Often”). The 30 questions were randomized with 10 questions assigned to each of the three components measured. Questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 addressed compassion satisfaction; Questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 addressed burnout; and Questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 addressed secondary traumatic stress (compassion fatigue). The scoring methodology for each of the three components of the ProQOL was similar (Stamm, 2010). If the total score of the compassion satisfaction, burnout, or secondary traumatic stress/compassion fatigue was 22 or less, the respondent’s compassion level was rated as “Low”; if the score was between 23 and 41, the level was “Average”; and if the score was 42 or above, the level was “High.” The hospice nurse participants’ aggregate scores for the initial ProQOL survey administration are listed in Table 1.

Table 1

Hospice Nurses' Scores for Initial ProQOL Survey

	n	Mean score	Standard deviation	ProQOL level
Compassion satisfaction	23	42.09	4.95354	High compassion level
Burnout	23	23.39	4.88727	Average burnout level
Compassion fatigue / STS	23	25.09	5.38443	Average CF/STS level

Table 2 displays the scores from the respondents 3 weeks after the initial ProQOL and after being provided with the educational booklet (Appendix C).

Table 2

Hospice Nurses' Scores for Second ProQOL Survey

	n	Mean Score	Standard Deviation	ProQOL Level
Compassion Satisfaction	18	42.11	4.02768	High Compassion Level
Burnout	18	24.22	4.03741	Average Burnout Level
Compassion Fatigue / STS	18	22.94	6.03395	Average CF/STS Level

The changes in the scores between the first and second administration of the ProQOL survey are shown in Table 3.

Table 3

Comparison of ProQOL Scores

	1st ProQOL Average Score	*2nd ProQOL Average Score*	*Percentage Change*	ProQOL Level
Compassion Satisfaction	42.09	42.11	+.01%	High - Unchanged
Burnout	23.39	24.22	+.01%	Average - Unchanged
Secondary Traumatic Stress / Compassion Fatigue	25.09	22.94	-8.6%	Average - Unchanged

As noted in Table 3, the scores for compassion satisfaction and burnout increased by only .01% after the educational intervention. However, the secondary traumatic stress/compassion fatigue score decreased by 2.15 points on average, for an overall decrease of 8.6%. This indicated a positive measurable change in the compassion fatigue levels for these nurses after they were provided with the educational tool regarding compassion fatigue. This suggests that the intervention had some impact on the levels of compassion fatigue in the nurses who participated in the project.

When the RN scores were compared pre- and post-intervention, only minimal changes were noted in the levels of compassion satisfaction, burnout, or secondary traumatic stress/compassion fatigue, as shown in Table 4. This would seem to indicate that the improvement that resulted in the overall compassion fatigue scores may have been due to increases in the scores of those who identified as LVNs or those who did not indicate their licensure status on the survey form.

Table 4

Comparison of RN Respondent Scores

	RNs: 1st ProQOL Average Score (n=*14)*	*RNs: 2nd ProQOL Average Score* (n=13)	*Percentage Change*	ProQOL Level
Compassion Satisfaction	42.43	42.1	-.01%	High - Unchanged
Burnout	24.14	24.23	+.01%	Average - Unchanged
Compassion Fatigue / STS	22.94	22.95	+.01%	Average - Unchanged

Unanticipated Limitations of the Study

Although a demonstrable improvement resulted in overall secondary traumatic stress/compassion fatigue scores after the educational intervention, it would have been preferable to also measure the improvement in the scores across licensure levels of the participants. Although eight of the 23 participants in the initial ProQOL identified as LVNs, none of the 18 participants in the post-intervention did so; 13 of these 18 respondents identified as RNs. Although it was possible to measure RN scores, which showed minimal change, the inability to discern which respondents in the post-intervention ProQOL were LVNs made it impossible to measure the scores of that subset of nurses.

Likewise, only 18 of the 23 pre-intervention participants submitted their post-intervention ProQOL. The manner in which these five missing surveys would have

impacted the results was indiscernible. However, given the small sample of 23, these missing data could have resulted in a profound change in the scores. One method that could have been used to improve the number of respondents of the second ProQOL survey would have been for me to attend their staff meetings, which are mandatory, in the month following the initial ProQOL administration and provision of the educational material. This would have allowed me to collect the individual surveys personally, and I could have impressed upon the participants the importance of denoting their licensure level on the second ProQOL form.

Implications of the Findings

According to Melvin (2012), hospice nurses are particularly susceptible to compassion fatigue due to their work with end-of-life patients and their families. The results of this project demonstrated that education regarding compassion fatigue has potential in decreasing it among hospice nurses. Findings were consistent with those from Flannelly et al. (2005), who noted that education and awareness of compassion fatigue can reduce its impact on caregivers. The project's results were also aligned with research by Gillespie and Gates (2013), who found that emergency department nurses who worked with trauma patients and who were provided education on compassion fatigue and secondary traumatic stress had improvements in their compassion satisfaction scores. The decrease in compassion fatigue scores among hospice nurses who participated in the current project indicated that education may be an effective strategy for reducing compassion fatigue among nurses in this specialty.

Implications for Positive Social Change

This doctoral project may affect positive social change through increased retention and job satisfaction among nurses working in hospice. Hospice is a difficult specialty in which to recruit nurses, and improved job satisfaction among nurses in this specialty may result in a tangential benefit of improving recruitment efforts. Demonstrating that nurses working in a hospice organization are happy and satisfied with their jobs may be effective in encouraging nursing students to consider working in hospice after graduation. The project may also affect social change by increasing hospice nurses' awareness of compassion fatigue so they can make lifestyle changes or seek help to overcome it. This project may also impact social change through the improvement of patient outcomes that would result from the provision of care from experienced hospice nurses with high levels of compassion satisfaction.

Recommendations

Findings from this doctoral project indicated a decrease in secondary traumatic stress/compassion fatigue scores among the nurses at the hospice at which the project was performed. However, no substantive change in the scores of the registered nurses who participated was observed. Recommendations for educating the organization's nurses concerning compassion fatigue could be made based on the findings of this project.

One recommendation would be to integrate training on compassion fatigue into new hire orientation for nursing. I am providing the educational booklet that was created and used during this project (Appendix D) to the organization to use as they wish for any training purposes in which they feel it would be of use. This would provide an initial

exposure to compassion fatigue to these nurses who are new to the specialty of hospice care so that they can be aware of its hazards from the outset of their employment. This would also allow for these nurses to have awareness of compassion fatigue prevention strategies as well. I would also recommend having tenured hospice nurse from the organization who have fought compassion fatigue speak of their experiences with it regarding how it affected them and how they overcame it. This would help personalize the concept of compassion fatigue and how it has impacted nurses in the organization.

I would also recommend that the ProQOL be administered to the nurses in the hospice organization on an annual basis as well. The ProQOL is free to license and requires only an email to obtain permission to use it, requiring no fiscal outlay from the organization. This would provide the organization with metrics of their nurses' compassion fatigue levels for comparison across time to evaluate how well they are coping with the stresses inherent with hospice nursing. When the compassion fatigue scores are low, the organization could gauge and make note of what the nurses are doing successfully to prevent compassion fatigue. If the scores should escalate, then the organization could work with the nurses to find the root cause(s) and provide them with resources to manage and reduce their levels of compassion fatigue.

Project Strengths and Limitations

As can be expected with a project of this nature, there were strengths and limitations identified in the period after it has been completed. A strength of the project was the manner in which it demonstrated that compassion fatigue was improved among the hospice nurses who participated after they had been provided with rudimentary

education regarding it. The nurse leaders and their staff RNs and LVNs were quite receptive to completing the ProQOL and seemed genuinely interested in the material in the educational booklet that was provided. I have even been contacted regarding questions that have arisen regarding compassion fatigue in the interim since the data collection was completed. This demonstrated that nurses are eager and open to learning about the topic of compassion fatigue, which many stated they had experienced during their careers but did not realize that there was actually a term for it.

A limitation of this project was the short time frame involved, as well as the manner in which the booklet was the only education that the nurses received regarding compassion fatigue. It would be interesting to measure the ProQOL scores over a longer period of time, and after having been able to provide the hospice nurses at the organization with more formal training regarding compassion fatigue. This could include sessions with presentations, videos, open discussion, and other methods focused on compassion fatigue causes and prevention. Additional study could provide clarity as to whether the nurses' compassion fatigue scores improved given more time and education regarding it. Another limitation was the limited sample size of hospice nurses and that they all were staff members of one hospice organization. It would be interesting to assess the ProQOL scores of hospice nurses from multiple organizations before and after provision of compassion fatigue education to identify any trends across a larger and more diverse group.

Summary

This doctoral project measured the levels of compassion fatigue among a group of hospice nurses before and after providing them with an educational booklet on the topic. The overall compassion fatigue scores of all nurse participants improved by 8.6% after the educational intervention. However, analysis of the scores of just the registered nurse (RN) participants did not present any substantive changes. This project demonstrated that there was a change in the compassion fatigue scores among all hospice nurses who participated. However, there are also opportunities noted for expanded study using this framework by measuring compassion fatigue scores over a longer timeframe across multiple organizations after the delivery of more extensive compassion fatigue education and training.

Section 5: Dissemination Plan

This doctoral project's purpose was to demonstrate whether education focused on compassion fatigue would provide a measurable decrease in levels of this condition among nurses working in a hospice organization in Southeast Texas. The findings will be disseminated with the intent of facilitating change. I have provided the nurse leaders of the organization with the master file of the educational booklet for their use in training, orientation, or other staff education. Also, at the request of the organization's nurse leaders, I will attend their staff meetings to share the results from the project and share additional compassion fatigue prevention methods. I will also provide the organization's leadership with printed and bound copies of this doctoral project for their review and as an expression of gratitude for accommodating the activities of my project. I also plan to adapt this project for submission to a scholarly journal for publication.

This project's findings may be appropriate for other audiences of nurses including staff meeting discussions at other organizations as well as conference presentations. I am one of four regional correctional nursing directors for the state of Texas, and my organization holds a conference annually for which I have already volunteered to speak on compassion fatigue. The audience for this conference would include not only nurses but also mental health workers who are susceptible to compassion fatigue. My organization's accrediting agency, the American Corrections Association, solicits speakers for its biannual conferences, and I am planning to submit a proposal to present on compassion fatigue at some point in the coming year.

Analysis of Self

I have been a nurse since 1990. I began my journey in this profession as a licensed vocational nurse, and progressed through associate's, bachelor's, and master's degree programs as a registered nurse over an 18-year period. I have been in nurse leadership roles, primarily in critical care areas, since 1998. These roles provided me with a valuable perspective as a practitioner regarding the impact that compassion fatigue can have on nurses who work in these areas. This doctoral project afforded me the opportunity as a scholar to analyze compassion fatigue's impact on hospice nurses, a specialty with which I did not have any prior experience. It was interesting to approach these nurses as an outsider rather than as a coworker or manager.

In 2007, I was the nurse manager of a large intermediate critical care unit in Central California. My staff assisted the chaplain with a doctoral study, which focused on compassion fatigue in critical care nurses. At this time, I had a fellow nurse manager at this hospital who wrote an article on compassion fatigue that was published in *Nursing Management*. Through these two colleagues, my interest in this phenomenon was initiated. In the years since, I have strived to share information about compassion fatigue with the staff nurses whom I have overseen. This project allowed expansion of my interest in this topic by providing me the opportunity as a scholar to explore a hypothesis that I have contemplated for some time: compassion fatigue's impact can be mitigated if nurses are made aware of it.

I have also learned much as the manager of this project. I was responsible for creating the project tracking tools, timelines, educational materials, and self-imposed

deadlines, and for demonstrating the value of the project with the nurse leaders of the hospice organization. This contrasted with the professional roles that I had held as a nurse leader in which I could delegate aspects of projects to others. Although I did not have a project team, I received valuable encouragement from the administration of the hospice organization, as well as access to their staff nurses. The completion of this project provided insight into how a scholarly endeavor requires assistance from multiple sources.

The Doctor of Nursing Practice program at Walden University increased my knowledge regarding the identification of problems and how to approach them from a scholarly perspective, and how to conduct research based on evidence-based practice. This project provided the foundation for further study that I would like to do regarding compassion fatigue and its impact on my colleagues in the profession of nursing. I am currently exploring a study that would involve the use of methods from this doctoral project to measure the impact of compassion fatigue education provided to correctional care nurses. There is scant literature on this specialty, and I am in the beginning phase of examining how the framework for this project could be implemented for a large group study involving corrections nurses from across the state of Texas.

Summary

Compassion fatigue is an insidious condition that affects nurses in various specialties. Due to the nature of their patient population, which includes dying patients, hospice nurses are vulnerable to compassion fatigue. Using Roy's adaptation model and Watson's caring theory as frameworks, I conducted a before-and-after quality improvement project to determine whether the provision of educational materials could

decrease compassion fatigue levels among hospice nurses. There was an 8.6% decrease observed in the overall compassion fatigue scores of all nurses in the hospice organization at which the project was held. This suggests that education to improve awareness of compassion fatigue among nurses may be effective in diminishing its deleterious effects.

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Appendix A: Professional Quality of Life (ProQOL) 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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YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

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

Compassion Satisfaction ____________

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

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout____________

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

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

Secondary Traumatic Stress____________

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

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

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

From: **ProQol** proqol@CVT.ORG
Subject: RE: Request Permission to Use the ProQOL
Date: August 7, 2018 at 10:43 PM
To: ProQol proqol@CVT.ORG

Hello,

The request you sent and the document attached here together comprise your permission to use the ProQOL. Please consider donating your de-identified baseline data to the ProQOL office if possible, as this helps us maintain the measure.

Please let me know if you have any questions,

Alyce

ProQOL Office

The Center for Victims of Torture

2356 University Ave W., Suite 430 / St. Paul, MN 55114

http://proqol.org / www.cvt.org

CVT: Restoring the Dignity of the Human Spirit

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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.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

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

Permission granted by
Beth Hudnall Stamm, PhD
Author, ProQOL
ProQOL.org
info@proqol.org

Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at www.proqol.org and www.proqol.org/Donate_Data.html. Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.

Appendix C: Compassion Fatigue Education Booklet

PREFACE

This workbook is a component of my doctoral project, which is focused on reducing compassion fatigue in hospice nurses by providing education on what compassion fatigue is, its warning signs, and strategies to prevent it. I chose this topic because in the nearly 30 years that I have been in nursing, I have seen many of my friends and colleagues become exhausted from expending the care required of being a nurse to the point that they no longer have anything to give their patients.

While I was working in California, I assisted a friend of mine, Dr. Kent Mishler, with his doctoral project, which was focused on reducing compassion fatigue in critical care nurses, and I saw the impact that it had on the nurses who participated in his study. As I was working on the early part of my doctoral studies, I made the decision that I wanted to use this important topic for my project as well. As I studied it more, it became increasingly evident that there was a lack of research in regard to compassion fatigue reduction strategies for hospice nurses.

The daily exposure that hospice nurses have to dying patients and grieving families makes them an extremely high risk group for development of compassion fatigue. My goal with this project is to demonstrate that education about compassion fatigue is the best method for combating its devastating effects, and I am very appreciative of your assistance in this process.

My mother passed away in this very hospice facility on July 1, 2017, and I was so impressed with the care and compassion that the nurses at Harbor provided, not only to her, but to me and my family as well. This only confirmed even more to me that I had chosen the right specialty of nursing on which to focus my project.

It is my hope that you find this booklet helpful and informative. I also want to express my sincerest gratitude for your participation in my project as well - I could not do this without you.

Thank you,

WHAT IS COMPASSION FATIGUE?

Compassion fatigue is characterized by physical and emotional exhaustion and a profound decrease in the ability to empathize. It is a form of secondary traumatic stress, as the stress occurs as a result of helping or wanting to help those who are in need.

Compassion fatigue is a secondary stress reaction resulting from providing care to those undergoing traumatic life events. It is often referred to as "the cost of caring" for others who are in physical or emotional pain. If left untreated, compassion fatigue can not only affect mental and physical health, but it can also have serious legal and ethical implications when providing therapeutic services to people.

The expression of compassion for patients and their families is a hallmark of nursing as a profession. Unfortunately, over time, this can become psychologically and emotionally taxing upon nurses.

What Is Compassion Fatigue?

First, let's discuss what it is *not*!

Compassion fatigue is not "burnout". While it is not uncommon to hear compassion fatigue referred to as burnout, the conditions are not the same.

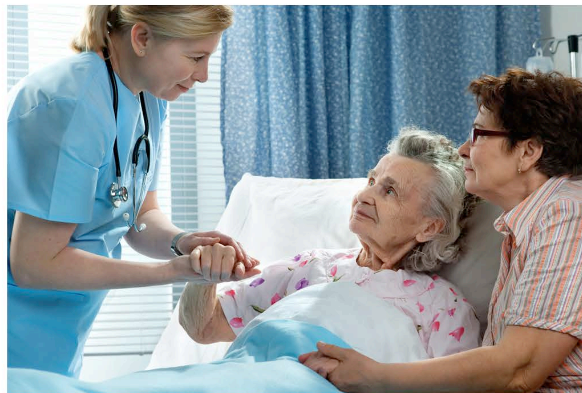
Compassion fatigue is more treatable than burnout, but it can be less predictable and may come on suddenly or without much warning, whereas burnout usually develops over time.

What Is Compassion Fatigue?

It is characterized by deep emotional and physical exhaustion, symptoms resembling depression and PTSD, and by a shift in the helper's sense of hope and optimism about the future and the value of their work.

The level of compassion fatigue a nurse experiences can ebb and flow from one day to the next. Even very healthy nurses with optimal life/work balance and self care strategies can experience a higher than normal level of compassion fatigue when they are overloaded or have a heavy load of patients who are all chronically in crisis.

With their constant exposure to dying patients and grieving families, hospice nurses are particularly susceptible to compassion fatigue.



What Are Symptoms of Compassion Fatigue?

Compassion fatigue has received increased attention as an occupational hazard of nursing.

The symptoms of compassion fatigue can impact nurses' daily work lives in many ways:

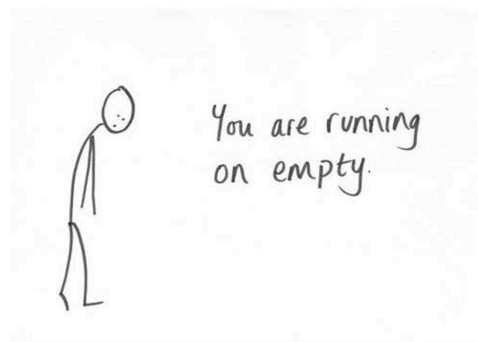
- Avoidance of certain types of patients;
- Diminished empathy toward patients and their families;
- Increased symptoms of depression, such as irritability (Figley, 2015).
- When unaddressed, compassion fatigue can lead to increases in nursing turnover and resultant shortages of nurses.

- All of this this ultimately has a negative affect on the provision of care and patient outcomes (Teater & Lundgate, 2014).

Behavioral Signs and Symptoms

- Increased use of alcohol and drugs
- Anger and irritability
- Dreading going to work - and feeling guilty as a result
- Avoidance of patients
- Absenteeism
- Difficulty with decision-making
- Physical symptoms such as headaches, insomnia, and weight loss/gain
- Problems in personal relationships
- Compromised care for patients
- Reduced feelings of sympathy or empathy for others

These signs have a tendency to slowly creep up over time; it has also been noted that people with fewer relationships / friendships tend to exhibit more symptoms. (Mishler, 2008).



Compassion Fatigue and Hospice Nurses

- Compassion is necessary in the care of patients who are dying, and compassion fatigue not only results in professional dissatisfaction among nurses, but is also a detriment to the nurse-patient therapeutic relationship.

- For hospice programs to remain viable, they are dependent upon hospice nurses who are available and equipped to deal with this challenging patient population.

- Constant exposure to dying patients with complex medical concerns has been identified as a contributing factor to compassion fatigue and decreased nurse retention among hospice nurses.

- Nurses in the hospice environment are necessary for the support, both psychologically and spiritually, that they provide to both patients and their families. As such, they fulfill a very pivotal role in the healthcare continuum.

- As such, it is important to ensure that nurses working in hospice care are equipped to handle its stressors.

Strategies for Preventing Compassion Fatigue

Develop an "Early Warning" System for Yourself!

- Take stock - is your plate too full? Make a list of what is making demands on your time and energy, such as work, family, home, or other. What stands out on your list? Consider what you would most like to change.
- Find time for yourself every day to rebalance your workload - even if it means just taking 10 minutes during a quiet time to sit and relax.
- Delegate! Learn to ask for help at home and work. Don't expect others to read your mind - ask for assistance when you need it.
- Learn to say "no" more often. Saying "yes" to everything, such as committees and extra shifts can end up leaving you feeling depleted when it is overdone.
- Exercise - think of even small ways to increase your physical activity.
- Learn more about compassion fatigue. Educating yourself about its signs, symptoms, and strategies is the best way to combat it. A great start is the following website: www.compassionfatigue.ca

Follow the Chinese proverb, "Dig where the ground is soft": instead of finding the hardest area to work on, pick an issue that you can most easily visualize improving.

Strategies for Preventing Compassion Fatigue

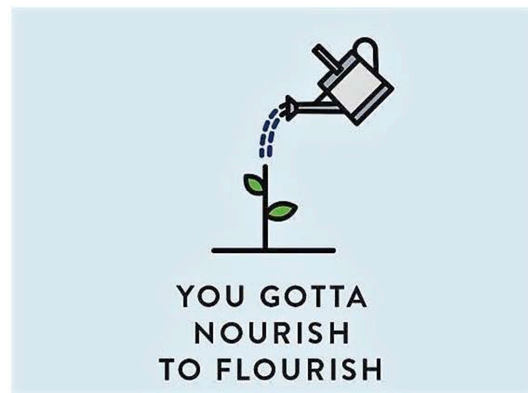
Practice Effective Self-Care

Those who practice good self-care are much less prone to stress and compassion fatigue than those who do not.

A good self-care regimen may be different from person to person, but it should generally include:

- A balanced and nutritious diet
- Regular exercise
- A routine schedule of restful sleep
- Balance between work and leisure
- Addressing any emotional needs

When you make time for these self-self-care activities, you are leaving less room for overworking, which is one of the major contributors to compassion fatigue.



Strategies for Preventing Compassion Fatigue

Other Strategies

- *Relaxation* - which is more than just not working; it is doing activities that you find enjoyable.
- *Engage in outside hobbies* - this is an effective way of getting your mind off of work.
- *Connect and cultivate healthy friendships outside of work.* While it is important to have healthy friendships with co-workers, it is equally important to maintain relationships outside of the work environment as well.
- *Identify workplace strategies* - some that have been found to be beneficial include:
    - Regular breaks
    - Routine check-ins on co-workers who are struggling
    - Mental health days
    - Taking advantage of Employee Assistance Programs
- *Keep a journal* - this is a great way to process and release any negative feelings that have arisen due to work.

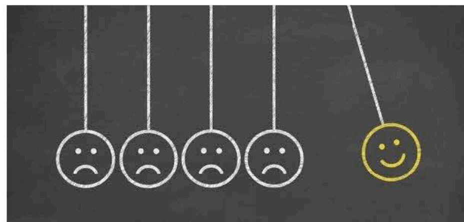
Strategies for Preventing Compassion Fatigue

Awareness of Negative Thoughts

When we are experiencing distress, our minds may be on the lookout for potential dangers or threats. This can lead to a cycle of negative thinking patterns that can result in frustration, anger, and blaming. The following strategy can help you prevent this cycle of negative thought patterns and reduce stress:

Questions to assess your current thoughts?

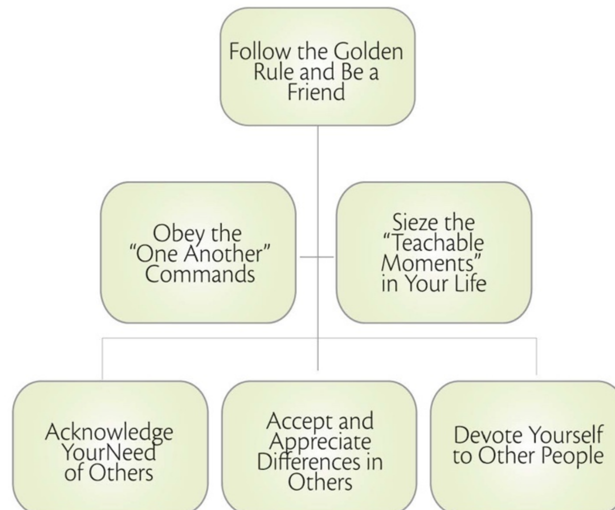
- Am I expecting perfection from myself and others?
- Am I overestimating setbacks, obstacles or tragedy?
- Am I blaming or criticizing myself or someone else for something that isn't entirely my fault or his or her fault?
- Am I concentrating on my shortcomings and neglecting to celebrate all of my strengths and accomplishments?
- Am I setting unrealistically high standards for myself and others?
- Am I jumping to conclusions and assuming I know how something is going to turn out?
- Am I getting stuck in "all good or all bad" thinking without checking for other possibilities?



Strategies for Preventing Compassion Fatigue

Connect with Others

- Do not isolate yourself.
- Engage in meaningful conversation with someone on a regular basis.
- Maintain connections with others.
- Seek and receive support from peers, family, and friends.
- Teach people how to support you.
- Take a class focused on something that interests you.
- Participated in social activities
- Provide volunteer services.
- Develop strong peer relationships - here are the six steps to this:



(Courtesy K. Mishler, 2008)

In closing, always remember:

You are not alone when it comes to experiencing the range of emotions that accompany working as a hospice nurse, and the work that you do touches your patients and families in ways that you will never know.

Maintaining compassion satisfaction is an ongoing process that requires patience with yourself as well as being intentional about working toward healthy self-care practices.

To quote the author Jack Kornfield, "If your compassion does not include yourself, it is incomplete".

"Helping patients all day has made me totally exhausted, both mentally and physically. It may sound strange, but I love it."

...AND THANK YOU SO MUCH FOR YOUR HELP WITH MY DNP PROJECT!

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RN / LVN (circle one)

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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