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Compassion Fatigue in Emergency Department Nurses

Michelle Candice Lawrence
Walden University

Walden University

College of Health Sciences

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Michelle Lawrence

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Review Committee
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Dr. Joan Moon, Committee Member, Nursing Faculty
Dr. Janice Long, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2019

Abstract

Compassion Fatigue in Emergency Department Nurses

by

Michelle C. Lawrence

MS, University of Phoenix, 2014

BS, University of Missouri-St. Louis, 2004

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Compassion fatigue (CF) is defined as a sudden onset of the inability to experience feelings or compassion for others that is triggered by a nurse's inability to separate his/her feelings of stress and anxiety associated with caring for patients who have suffered from a traumatic event. The practice problem addressed in this doctoral project was the lack of knowledge of emergency department nurses (EDNs) related to CF in the work setting, resulting in a negative impact on a nurse's ability to provide quality care to patients. The purpose of the project was to present an educational program on how to recognize, prevent, and manage CF. Framed within Stamm's theoretical model of compassion satisfaction and CF, the project was guided by the steps within the *Walden University Manual for Staff Education Project* and the practice question addressed whether the literature would support an evidence-based educational program on CF for EDNs. The evaluation/validation for the project included an evaluation of the curriculum by the three content experts (in which learning objectives were deemed met), content validation of the pre-/post-test items by the content experts (all test items were deemed relevant to the learning objectives, with the validity index scale analysis at 1.00), and finally, a paired *t* test to determine knowledge gained from pre- to post-test that resulted in a significant ($p < 0.0001$) improvement in knowledge. A potential positive social change resulting from the project is a healthy work environment where EDNs understand and reduce their risks for CF, which may ultimately promote optimal patient care and improved health outcomes.

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I would like to say thank you to my husband, David; my children, Kennedy and Karnell, Jr.; and my family and friends for encouraging me and helping me on this journey to obtaining my DNP. I would like to thank all the faculty who have helped me along the way as well. I am truly blessed; thankful; and grateful for God, my family, and my friends.

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Section 1: Nature of the Project

Introduction

Compassion fatigue (CF) is defined as a sudden onset of the inability to experience feelings or compassion for others that is triggered by a nurse's ineffectiveness to separate feelings of stress and anxiety associated with caring for patients who have suffered from a traumatic event (Henson, 2017). Nurses suffering from CF show signs and symptoms of increased call outs, decreased ability to express empathy/compassion to patients, disturbed sleep patterns, headaches, mood swings, anxiety, lack of attention, depression, and substance abuse (Weinstein, 2015). Compassion fatigue in emergency department nurses (CFEDN) negatively impacts nurses who regularly witness secondary trauma from the patient for whom they provide care (Wijdenes, Badger, & Sheppard, 2019). Yoder (2010) reported that 15% of nurses reported signs of CF. Although this statistic appears to be low, the reported number of nurses suffering from CF is significant even if there was only one nurse.

The nature of this CFEDN doctoral project was to assist emergency department nurses (EDNs) in recognizing, preventing, and managing CF in an effort to provide high quality care to patients. The purpose of this CFEDN doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF. By administering a pre-test, then providing education on CF followed by a post-test, I assessed the change in nurses' knowledge of CF. A potential positive social change resulting from the project is a healthier work environment facilitating the well-being of the nurse and leading to optimal patient care and improved health outcomes.

Problem Statement

The local nursing practice problem that was the focus of this doctoral project was EDNs' lack of knowledge related to CF while providing care to patients suffering from traumatic events. EDNs are at an increased risk of suffering from CF due to the significant emotional disturbance that comes along with working long hours while providing direct patient care and their empathetic relationships with patients during acute distress from pain, suffering, trauma, and dying or death (Lachman, 2016). In this 900-bed facility located in an inner city in the southeast United States that serves an underrepresented and uninsured population, I identified this problem through personal communication with the EDNs. This hospital consistently has an overcrowded emergency department (ED) with patients overflowing into hallway areas. According to the bed management staff, due to the overcrowding, patients' length of stay in the ED was 24–48 hours during peak times of the year. One EDN reported that the EDNs had verbalized their concerns about the number of patients they provide care to, insufficient staff due to high turnover and nurses calling out, and working long hours. The ED director stated that for the month of December 2018, there had been 16 nurses who resigned due to the stressful environment of the ED. The ED charge nurse reported that there are about two to five nurse call outs daily, which makes staffing a challenge and leads to a higher nurse-to-patient ratio.

Hunsaker, Chen, Maughan, and Heaston (2015) described stressors for EDNs as complex patient loads, long shifts, demanding physicians, a fast-paced environment, and working in an emotionally and physically challenging area. CF may also cause a nurse to become ineffective, depressed, apathetic, and detached with long-term results of low morale in the workplace, absenteeism, nurse turnover, and apathy (Hunsaker et al., 2015). Ermak (2014) reported nurses

are burned out from CF, which affects the healthcare system negatively because of the high rates of turnover in the nursing field. These consequences have a negative impact on patient care, which leads to patient dissatisfaction (Hunsaker et al., 2015). The results of this CFEDN doctoral project hold significance for the field of nursing practice by increasing nurses' awareness of their own needs while providing patient care during stressful times through providing education to nurses related to CF.

Purpose Statement

The purpose of this CFEDN doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF. The practice question for this CFEDN doctoral project was: What evidence from the literature supports an educational program on CF for ED staff nurses?

When nurses suffer from CF, they experience emotional, physical, social, and spiritual exhaustion that leads to the nurse's inability to care for or feel compassion for others (Henson, 2017). In this CFEDN doctoral project, I focused on assisting EDNs gain knowledge related to CFEDN and learn how to recognize, prevent, and manage CF to improve their ability to provide high-quality care to patients during traumatic events. Van Mol, Kompanje, Benoit, Bakker, and Nijkamp (2015) stated the high-stress work environment of the ED was demanding with increasingly technical skills needed in advanced life sustaining medical therapies. These stressors nurses face can be overwhelming and lead a nurse to suffer from CF. The findings of this CFEDN doctoral project have the potential to address the gap in practice by increasing nurses' knowledge of CF and helping them to be better prepared to effectively deal with the signs and symptoms of CF.

Nature of the Doctoral Project

Sources of Evidence

The sources of evidence that I collected for this CFEDN doctoral project provided evidence-based practices and interventions on how to recognize, prevent, and manage CF to assist in developing an educational program framed within *Walden University's Manual for Staff Education Project* (Walden University, 2017) and were used in the planning, implementing, and evaluating steps of the project. These sources were identified and obtained from online databases accessible through the Walden University Library. Keyword search terms included, but were not limited to *CF, CF AND nurses, CF AND ED, CF AND EN, CF AND measuring, CF AND scale, CF AND treatment, CF AND detection,* and *CF AND identification*. Evidence published from 2013 to current was explored and graded using the *Hierarchy of Evidence for Intervention Studies* by Fineout-Overholt, Melnyk, Stillwell, and Williamson (2010; see Table 1). I analyzed results from the pre- and post-tests by comparing the two tests for knowledge gained. Additional evidence included the content expert evaluations of the curriculum plan (see Appendix C), the pre-/post-test expert content validation (see Appendix F), and the summative evaluations (see Appendix I).

The purpose of this CFEDN doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF based on the findings from my analysis of the sources of evidence. I expected this educational program to increase nurses' knowledge of CF and, therefore, increase the likelihood of them being prepared to prevent or effectively deal with the signs and symptoms of CF.

Table 1

Hierarchy of Evidence for Intervention Studies

Type of evidence	Level of evidence	Number of articles
Quantitative or qualitative	I	2
Systematic review	II	1
Integrative review	III	1
Cross-sectional comparative	IV	1
Mixed method	V	1
Prospective quasi-experimental	VI	1
Nonexperimental descriptive	VII	13

Note. I = 1, II = 2, III = 3, IV = 4, V = 5, VI = 6, VII = 7, Adapted from: "Evidence-based practice step by step. Critical appraisal of the evidence: Part I: An introduction to gathering, evaluating, and recording the evidence...fifth in a series," by E. Fineout-Overholt, B. M. Melnyk, S. B. Stillwell, & K. M. Williamson, 2010, *AJN American Journal of Nursing*, *110*, 48. Copyright 2010 by Lippincott, Williams, and Wilkins Inc.

Approach

In this CFEDN doctoral project, I followed the *Walden University Manual for Staff Education Project* (Walden University, 2017) and was guided by the theoretical model of compassion satisfaction and compassion fatigue (CS-CF; see Stamm, 2010). The steps taken in this education project included planning, implementation, and evaluation. The planning phase included identifying the problem, gathering supportive evidence as shown on the literature review matrix (see Appendix A), and developing the project question and a brief overview of the approach. The steps for developing the staff education project were as follows:

1. Analyzed the need and established the criteria for the staff education program using available existing data from the site, literature, and theoretical support.
2. Discussed needs and staff education program goals with organizational leadership.
3. Secured the hospital site to implement the staff education program.

4. Obtained a commitment of support from the organizational leadership.
5. Gained appropriate ethics approval at the site and through Walden University Institutional Review Board (IRB; Walden University, 2017, p. 4).
6. Developed a practice-focused question.
7. Researched the literature for relevant teaching materials and content that supported the practice-focused question.
8. Developed a literature review matrix (see Appendix A).
9. Formulated specific learning objectives.
10. Developed a plan for the development of the education plan, which included the curriculum plan (see Appendix B), educational program (see Appendix D), and pre-/post-test (see Appendix E) to compare and assess nurses' knowledge gained.
11. The pre-/post-test was validated by the content experts (see Appendix F).
12. Revised the staff education plan per the team recommendations.
13. Finalized development of the staff education program per the doctoral project team.

Once I received approval from the hospital, from the Nursing Research Council (NRC) and Research Oversight Committee (ROC), the staff education program continued on to the implementation and evaluation phases as outlined in the Procedures subsection in Section 3.

Significance

The stakeholders of this CFEDN doctoral project were nurses, patients, unit managers, unit directors, and the executive leadership team at the hospital. Regardless of if the nurse had experienced CF, all knowledge gained from the educational program was beneficial to nurses because the project educated them on recognizing, preventing, and managing the signs and

symptoms of CF. Nurses who become better prepared to recognize the signs and symptoms of CF and ways to prevent and manage CF, lead to nurses being more able to provide compassionate care to patients. Patients would benefit by receiving quality care from nurses who are not suffering from CF. This CFEDN doctoral project was significant to unit managers, unit directors, and the executive leadership team because the nursing staff continues to provide quality care and there is a decreased chance of high turnover in the hospital setting, resulting in the unit managers, unit directors, and executive leadership team being able to focus on the daily operations of the hospital opposed to nursing staff providing inadequate care due to suffering from CF. Although not an outcome that was measured in this project, one contribution of this doctoral project to nursing practice was to decrease the number of nurses who quit working on the unit and call offs. This is a positive contribution to nursing practice because by being more able to recognize, prevent, and manage CF, the quality of care provided is likely to be impacted.

There is a potential of transferability of this CFEDN doctoral project to any area that deals with stressful situations related to providing care to ill patients. Transferability is possible because nurses respond in similar ways in all settings. One example of this would be a nurse working in a hospice setting who deals with dying patients daily; over time, that individual could lose sight of how to provide quality care to patients due to the traumatic event of death, leading to the nurse handling situations in a negative manner. Melvin (2018) presented an example of this as a case study: A nurse who provided care to an ill patient for 2 years found out the patient had passed away, and the nurse was noticed to be in distress. When counseling was offered to her, she realized she could not allow herself to feel sadness as she had other patients to care for. In the upcoming weeks, the nurse was overwhelmed with the death of the patient she had grown

to love, which led to her making medication errors and being late for work on several occasions due to CF. Melvin stated that nurses should be educated on the signs and symptoms of CF as well as about their vulnerability when working with dying patients. Nurses compromise their ability to provide quality patient care if they neglect themselves and fail to recognize symptoms of CF.

A potential implication for positive social change is a healthier work force with increased nursing satisfaction related to their jobs, which leads to optimal care being provided to patients and families, resulting in improved health outcomes. Nurses will be in a better mental state to provide compassionate care to patients due to knowledge gained on how to recognize, prevent, and manage CF. Nurses will be able to handle the stressors that come along with providing care to patients in the ED setting.

Summary

In Section 1, I described CFEDN as a local nursing practice problem and defined CF as the inability to provide compassionate care to patients when a nurse is exhausted from exposure to patients' traumatic events. Repeated exposure to these traumatic events leads nurses to experience the signs and symptoms of CF (Henson, 2017). Nurses suffering from CF have increased call outs, high turnover rates, and apathy (Weinstein, 2015). The purpose of this CFEDN project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF with the hopes of decreasing CFEDN at the project facility. I collected the sources of evidence used for this doctoral project through an extensive literature search for relevant articles, the pre-/post-test comparison, content expert evaluations of the curriculum plan, pre-/post-test expert

content validation, and summative evaluations. In this CFEDN doctoral project, I followed the *Walden University Manual for Staff Education Project* (Walden University, 2017) and was guided by the theoretical model of CS-CF (Stamm, 2010). The stakeholders of this doctoral project were nurses, patients, unit managers, unit directors, and the executive leadership team at the hospital. There is potential for the transferability of this CFEDN doctoral project to any area that deals with stressful situations related to providing care to ill patients. One potential implication for positive social change is a healthier EDN work force with increased nursing satisfaction related to their jobs, leading to optimal care being provided to patients and families that will result in improved health outcomes. In Section 2, I will explore the model that framed this project, the relevance of the project to nursing practice, local background and context, my role as the DNP student, and the project team's role in guiding this project.

Section 2: Background and Context

Introduction

The local nursing practice problem that was the focus of this doctoral project was EDNs' lack of knowledge related to CF while providing care to patients suffering from traumatic events. The practice question was: What evidence from the literature supports an educational program on CF for ED staff nurses? The purpose of the CFEDN doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF.

Concepts, Models, and Theories

This CFEDN doctoral project was framed by the theoretical model of CS-CF developed by Stamm (2010). As shown in Figure 1, the CS-CF model depicts the three environments of work, client/person helped, and personal and describes how all three are related to both CS and CF (Stamm, 2010). This model was appropriate for this CFEDN doctoral project because it connected the different environments of the nurse leading to the physical and emotional attributes that are exhibited when suffering from CF. Two specific environments of this model are directly related to this doctoral project: work and client/person helped. These two environments describe the ED setting where nurses provide quality care to patients. While providing care to patients in these environments, nurses are exposed to traumatic events that can lead to the signs and symptoms of CF. CS is understood, according to the theory, to be the positive aspect of providing care while CF is the negative aspect (Stamm, 2010). During my search for literature, I found no articles to date that used Stamm's CS-CF model in their scholarly studies.

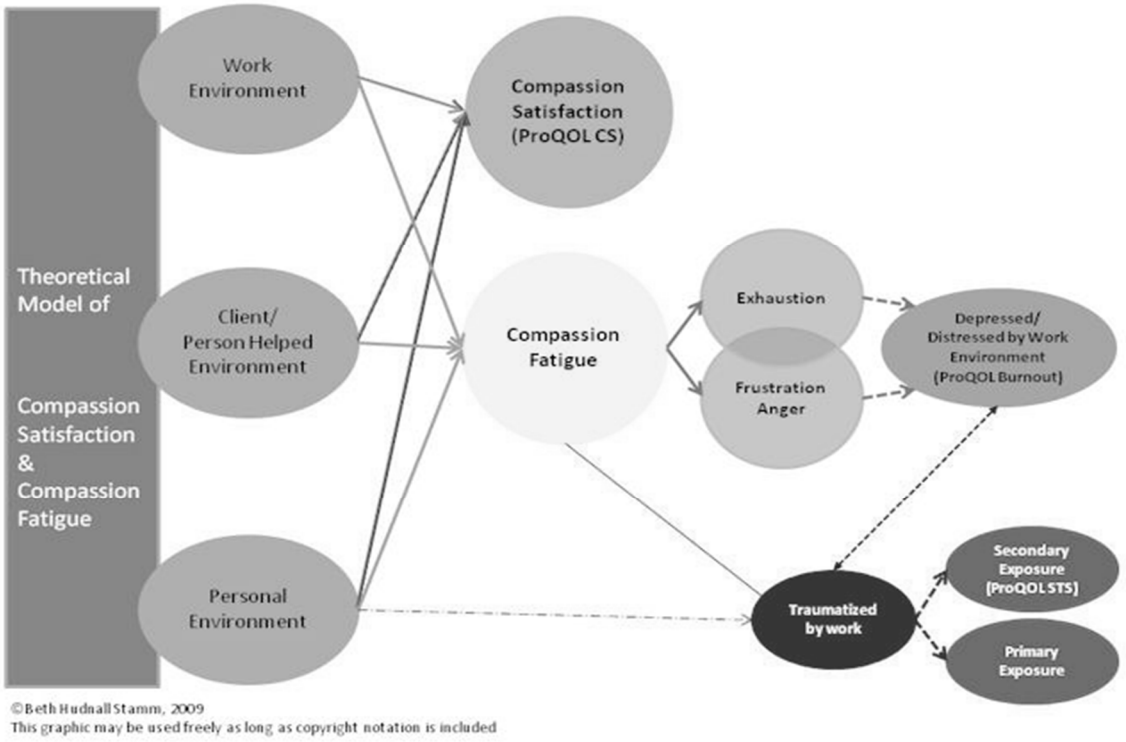

Figure 1. Theoretical model of compassion satisfaction and compassion fatigue. From "Professional Quality of Life Measure," by B. H. Stamm, 2009 (https://proqol.org/Full_CS-CF_Model.html). Copyright 2019 by The Centers for Victims of Torture.

Clarification of Terms

CF is defined as being in a state of physical or psychological distress as a caregiver that occurred after providing ongoing care to individuals feeling pain or suffering from traumatic events (Pehlivan & Guner, 2018; van Mol et al., 2015). CS is understood to be the positive aspect of providing care, while CF is the negative aspect (Stamm, 2010). The main focus of this CFEDN doctoral project was how to recognize, prevent, and manage CF due to its negative impact on EDNs quality of patient care.

Relevance to Nursing Practice

The relevance of CFEDN in the hospital setting is that when nurses are experiencing CF it has a negative impact on the nurse's physical and mental health, job satisfaction, and

performance (Jakel et al., 2016). Nurses with high levels of CF are correlated with a higher intent to leave (Henson, 2017); if CF is unrecognized, a career change may occur (Jakel et al., 2016). Recognizing, preventing, and managing CF will hopefully result in improved positive patient outcomes because nurses will be more able to provide quality, compassionate care to patients.

Compassion Fatigue

CF is a nursing practice problem that was first identified in nursing literature in the early 1990s (Melvin, 2018) and has troubled the nursing profession since. CF has a negative effect on those providing care to persons who are feeling pain or suffering from a traumatic event (Pehlivan & Guner, 2018). When nurses experience CF, they are unable to separate their feelings of stress and anxiety that occur as a result of patient death, trauma, or unexpected outcomes from the care they provide (Henson, 2017). Environmental influences, such as poor staffing, increased workload, high acuity, patient death, unexpected patient outcomes, and lack of leader support, directly impact compassion fatigue in nurses (CFN) because they increase the nurse's level of stress (Henson, 2017). Jakimowicz, Perry, and Lewis (2017) conducted a study on 117 Intensive Care Unit staff nurses that revealed 83% of participants scored average, while 15% scored high for CS. High levels of CS and low levels of CF occur when the work environment has strong leadership, meaningful recognition, and nurse engagement (Henson, 2017).

Compassion Fatigue and Emergency Nurses

Hunsaker et al. (2015) stated there were more than 131 million ED visits in 2011 in the United States. CFEDN is a nursing practice problem because of the level of stress that comes with providing care to patients in this setting. The hospital receives patients who require high levels of care for cardiac arrests, traumas, strokes, and burns, and these life-threatening situations

are stressful for patients, families, and the caregivers. EDNs are stressed due to these complex patient loads, long hours, and a fast-paced working environment that is emotionally and physically challenging (Hunsaker et al., 2015). Because of this continuous exposure of trauma and stress, the EDN is at high risk for developing CF (Schmidt & Haglund, 2017). Other contributing factors of EDNs suffering from CF include role ambiguity, low managerial and peer support, insufficient pay, lack of professional recognition, increased levels of responsibility, and clinical decision-making, which then may lead to absence, high turnover of staff, and early retirement (Dean, 2017). Schmidt and Haglund (2017) also identified external stressors, such as overcrowding, pressure to improve patient flow, patient satisfaction, organizational fiscal goals, and critical incidents, that put the EDNs at a higher risk for suffering from CF.

Recognizing Compassion Fatigue

CF is subtle and often unrecognized but is just as life altering as a traumatic event (Flarity, Gentry, & Mesnikoff, 2013). To recognize CF, an individual must know the signs and symptoms, which include becoming ineffective in their ability to provide care; anxiety; depression; low self-esteem; apathy; low morale; absenteeism; turnover; poor concentration; irritability; mood swings; mental, physical, and emotional exhaustion; avoidance, becoming withdrawn; physical symptoms; and sleep disturbances (Flarity et al., 2013; Hunsaker et al., 2015; Ruff-King, 2018; Sorenson, Bolick, Wright, & Hamilton, 2016). Meadors, Lamson, and Sira (2010) stated symptoms of CF are often unrecognizable until they negatively affect the nurses' ability to care for their patients.

By acting upon CF signs and symptoms, a nurse could continue to provide care to the best of their ability while decreasing the physical, mental, and emotional stressors of the ED

impacted on them. According to Hunsaker et al. (2015), increased awareness of CF leads to improved EDN job satisfaction and, therefore, increased quality patient care. Implementing interventions support a healthy work environment and develop self-coping skills assisting nurses in maintaining compassion and providing quality care to patients (Henson, 2017).

Patients present to the ED to receive care, so all EDNs must always be able to provide the best care possible. The EDN must be functional, empathetic, and sympathetic for patients to be satisfied with their care. Many nurses choose the nursing profession to experience fulfillment while helping others, so it is important for the EDN to maintain their ability to experience work fulfillment and to contribute to patient satisfaction (Hunsaker et al., 2015).

Prevent and Manage Compassion Fatigue

Preventing and managing CF is important to nursing practice because it impacts quality of care. Once CF is recognized, it is important for nurses to act upon this recognition because nurses need to provide quality care to patients. Prolong and intense care leads to a reduction in the nurses' ability to care and provide energy, empathy skills, and compassion (Pehlivan & Guner, 2018). With decreased CF, nurses can provide care with less feelings of exhaustion and mental, physical, and emotional dysfunction. Nurses are more likely to feel and demonstrate compassion when providing care to patients due to learned CF resiliency (Melvin, 2018). Resiliency is a way to prevent and manage CF and is when a nurse can cope with stress, recover easily, reduce their vulnerability to stress, and overcome challenging obstacles (Melvin, 2018). Henson (2017) stated resiliency programs are successful in providing education about CF and promoting self-coping skills in nurses. Healthy management of CF is developing resiliency and using coping mechanisms to manage CF and debriefing after stressful situations.

Flarity et al. (2013) discussed five key elements for coping with CF, including self-regulation, intentionality, perceptual maturation self-validation, connection and support, and self-care and revitalization (see Table 2). Debriefing, an open discussion structured model that occurs after an adverse event, is also identified as management of CF because it provides a support system to promote nurses' well-being (Schmidt & Haglund, 2017). This open discussion allows an opportunity for reflection where nurses can understand their own emotions and experiences and develop ways to manage a traumatic event that can be used in future situations (Schmidt & Haglund, 2017). Debriefing encourages nurses to seek more assistance from other programs, such as the employee assistance program, for further CF counseling from a licensed counselor (Mazzotta, 2015).

Another prevention or management method of CF is through meaningful recognition. Programs, such as the Daisy Awards, clinical ladder program, thank you notes, and Nurses Week, are ways to recognize nursing staff to show appreciation for their hard and diligent work as an EDN (Kelly, 2017). Meaningful recognition is important for contributing to a healthy work environment and supports the reduction of CFN.

Table 2

Coping with Compassion Fatigue

Self-regulation	The practice of regulating one's self despite external stimuli To constantly remain calm even when dealing with a stressful situation
Intentionality	To stay focused on the mission To complete work tasks in a relaxed manner To remain true and honest to one's purpose and principles
Perceptual maturation self-validation	To focus on changing ourselves to better adapt opposed to complaining about the need to change the workplace To relinquish the need for validation from coworkers To recognize that we chose to be caregivers because we want to serve

Connection and support	To have a peer support group to share painful experiences with to assist in the experience not making one symptomatic The peer support groups are authorized people who will confront you if they find you are becoming symptomatic
Self-care and revitalization	To refuel one's self to continue to be able to provide care to others To develop a program of self-care that incorporates all areas of life: relational, physical, spiritual, professional, etc. To engage in behaviors that revitalizes one's self

Note. Adapted from"The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses" by K. Flarity, J. E. Gentry, & N. Mesnikoff. 2013, *Advanced Emergency Nursing Journal*, *35*(3), 247-258. Copyright 2013 by Lippincott, Williams, and Wilkins. .

Managing CF entails self-care, which is important for nurses to maintain their ability to provide care to patients and themselves by decreasing their stress level. Self-care can reduce feeling overwhelmed, staff turnover, and number of sick days used, which all impair the nurses' ability to care for patients and themselves (Meadors et al., 2010). Sorenson et al. (2016) reported self-care as being the most significant preventative measure healthcare professionals can take to protect themselves from developing CF. Ruff-King (2018) suggested nurses take care of themselves by eating properly to nourish the body and stabilize their mood; express their needs, fears, wants, and desires; learn to say "no" and set boundaries; and spend time alone to recharge themselves on a daily basis. Other CF management strategies are spiritual practices, expressive writing, and prayer or meditation (Mazzotta, 2015). Nurses must care for themselves so they can provide the best care to their patients. Khan, Khan, and Bokhari (2016) stated that the most deceitful aspect of CF is that it ruins the nurses' passion for empathy and compassion for others, which is a main factor when providing care to patients.

The findings of this doctoral project fill the gap in practice concerning the lack of knowledge related to CFEDN through an educational program supported by the evidence-based

literature on CF and how nurses can recognize, prevent, and manage CF to hopefully improve nursing practice. I used the pre-/post-test (see Appendix E) to assess nurses' knowledge on CF prior to providing education and evaluating what knowledge was gained after receiving the education. The pre-/post-test results were critical in assessing the EDNs knowledge before and after the education through a comparison of each EDNs pre-/post-tests.

Local Background and Context

The facility where this CFEDN doctoral project was implemented is a 900-bed hospital with a Level 1 trauma unit located in an inner city in the southeast United States serving an underserved and uninsured population. According to the ED charge nurse, due to the population and the location of the hospital, patients seek care at this hospital because they know they will not be refused care and their ability to pay will not hinder the care they receive. Many patients do not have a primary care provider and use the ED as their first access to care; therefore, the hospital is constantly busy with ill patients who need care. There is always an abundance of patients waiting in the waiting area; meanwhile, there are patients arriving in ambulances suffering severe health conditions, such as gunshot wounds, stab wounds, strokes, burns, drug overdoses, alcohol intoxication, and heart attacks. EDNs at the facility reported that they had verbalized their concerns about the number of patients they provide care to, insufficient staff due to high turnover and nurses calling out, and working long hours. The high volume of patients seen in the ED has taken an emotional, physical, and mental toll on the nurses. The EDNs have voiced this ongoing issue during conversations among one another in reference to being overworked. The ED charge nurse stated that there were typically two to five nurse call outs per

shift daily. At the time of this project, the hospital did not have a policy or an educational program with mandatory annual training related to CF and EDNs.

During my search for sources of evidence, I was unable to find any literature or websites related to policies on CF at the federal or state level. The inability in finding literature or websites was unfortunate because with no policies at the federal or state level to guide the hospital setting on how to address CFN, each facility has the responsibility to address CFN as it becomes an apparent nursing practice issue. An example of this is a program, Best evidence statement, that was implemented at Cincinnati Children's Hospital Medical Center. This program decreases CF among pediatric intensive care nurses by using self-care skills and CF training (Guideline Central, 2019).

Role of the DNP Student

My professional relationship to CFNs in the hospital setting and my motivation for this project was that I have personally experienced CF while working on a cardiac unit. I did not realize at the time that I was suffering from CF, but I knew something was wrong. I knew in my heart the time had come to transfer to another area of nursing. I had not given up on nursing all together because nursing is my passion, however, I was not delivering compassionate care to my patients.

My relationship with the facility where the project was implemented is that I am currently an employee and the participants are my co-workers, but in a different department of the hospital. My role in the CFEDN doctoral project was to develop an educational program on CF to increase their knowledge of CF and how to recognize, prevent, and manage CF. The steps required in the *Walden University Manual for Staff Education Project* (Walden University, 2017)

to develop the educational program were planning, implementation, and evaluation. In the planning step, the curriculum plan, educational program, and pre-/post-test were developed. In the implementation step, nurses were invited to participate in the DNP scholarly project by taking the pre-test and receiving the educational program. Lastly, the evaluation step was to have those same nurses take the post-test after receiving the educational program. The pre-test and post-test were compared to assess the knowledge gained from the educational program.

My personal experience with CF and familiarity with the EDNs was a potential bias. My personal experience was bias because I have empathy for nurses suffering from CF since I know what CF is and how it feels based on my experience. My familiarity with the EDNs was a bias because I had spoken to these nurses in previous interactions about their stressful situations and how difficult it is to provide quality care to patients under these conditions. To decrease the bias, literature was found to support CFEDN as a nursing practice problem. The literature supported what CF was as well as ways to recognize, prevent, and manage CF.

Role of the Project Team

The project team included three EDN educators (who were content experts) and myself as leader. The content experts reviewed the educational program (see Appendix D) and reviewed and evaluated the curriculum plan (see Appendix B) and pre-/post-test (see Appendix E). As well, the content experts completed the content expert evaluation of the curriculum plan (see Appendix C) and pre-/post-test expert content validation (see Appendix F). Lastly, an anonymous summative evaluation (see Appendix I) was completed by the content experts once implementation was completed. See Section 4 for results of the evaluations.

Summary

The local nursing practice problem that was the focus of this doctoral project was EDNs lack of knowledge related to CF while providing care to patients suffering from traumatic events. This doctoral project was framed within Stamm's (2010) theoretical model, the CS-CF model. CFEDN is a relevant nursing practice issue because when nurses experience CF, there is a negative impact on the nurse's physical and mental health, job satisfaction and performance (Jakel et al., 2016). By knowing what CF is and how to recognize, prevent, and manage CF will hopefully improve nursing practice. The facility where the project was implemented was a 900-bed hospital with a Level 1 trauma unit located in the inner city in the southeast United States serving an underserved and uninsured population. This population uses the ED as their first access to care, opposed to obtaining a primary care physician, so, the facility is always overcrowded with patients waiting in the waiting area, in addition to patients arriving in ambulances suffering severe health conditions. The role of the DNP student was to perform a literature review; develop the curriculum plan, educational program, and pre-/post-test; to invite participants; administer the educational program; and analyze the results. The role of the doctoral project team was to assess, review, and evaluate specific areas of the education components that best fit each of their roles. In Section 3, I will review the practice problem, practice-focused question, gap in practice, address the sources of evidence in more detail, and the participants, procedures, and protections, along with an analysis and synthesis of the evidence.

Section 3: Collection and Analysis of Evidence

Introduction

The local nursing practice problem that was the focus of this doctoral project was EDNs' lack of knowledge related to CF while providing care to patients suffering from traumatic events. CFEDN is a nursing practice problem due to the negative effect on a nurse's physical and mental health, job satisfaction, and performance (Jakel et al., 2016). The purpose of the CFEDN doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program addressing how to recognize, prevent, and manage CF. Flarity et al. (2013) stated EDNs need support to cope with the negative effects of their work due to the debilitating nature of CF symptoms. Job satisfaction plays an important role, not only in workforce retention and the nurses' well-being, but also is directly related to the quality of care provided to patients by nurses (Jakimowicz et al., 2017). In Section 3, I review the practice-focused question, the evidence generated for this doctoral project related to the participants, procedures, protections, as well as analysis and synthesis of the evidence.

Practice-Focused Question

The practice-focused question that guided this project was: What evidence from the literature supports an educational program on CF for ED staff nurses? Nurses gained knowledge through a staff educational program developed by me that addressed the signs and symptoms of, how to prevent, and ways to manage CF. This approach aligned with the practice-focused question by addressing each area of CF.

Sources of Evidence

I conducted an extensive literature review that involved searching for scholarly research articles related to CF among nurses. To locate extensive literature for this review, I searched databases accessible through the Walden University Library, including CINAHL Plus, Thoreau, and EBSCO Discovery Service dating, for sources published between 2013 and the current day. Keywords used for this search included *CF, CF AND nurses, CF AND ED, CF AND EN, CF AND measuring, CF AND scale, CF AND treatment, CF AND detection, CF AND identification,* and *CF AND educational curriculum*. The literature was used to answer the practice-focused question and provide evidence to support and develop the evidence-based education program in this project.

I collected sources of evidence for this project in two parts. First, the literature review matrix (see Appendix A) and sources were used to develop the educational program (see Appendix D). Evidence published from 2013 to the current day were explored and graded using the *Hierarchy of Evidence for Intervention Studies* by Fineout-Overholt et al. (2010). While reviewing sources of evidence, I decided to keep 20 of the 45 articles found, based on their support of CF as a nursing practice issue; provision of more information on what CF is; and suggestions of how to recognize, prevent, and manage CF. These articles were evidence that answered my practice-focused question by demonstrating educational programs do benefit nurses by teaching them how to recognize, prevent, and manage CF. Educating nurses is the key to decreasing CF in EDNs because nurses must learn to care for themselves in order to provide better care for patients (Meadors et al., 2010).

The second source of evidence was a knowledge-based pre-/post-test (see Appendix E), both comprising the same test items, that I used to explore the EDNs' knowledge of CF before and after the educational program (see Appendix D). An outside PhD assessment expert reviewed the pre-/post-test item construction. I made changes to the pre-/post-test based on his assessment and recommendations. An educational specialist reviewed the curriculum plan (see Appendix B) and three content experts reviewed and evaluated the curriculum plan, educational program, and pre-/post-test items with revisions made per their recommendations. The content experts also validated the pre-/post-test content (see Appendix F). The pre-/post-test was completed by the EDNs before and after the educational program.

Participants

All nurses working in the ED of the hospital were invited to participate in the CFEDN project with 56 out of 100 nurses agreeing to participate. The EDNs were relevant to the practice-focused question because they had experienced a high level of stress while providing care to patients suffering from traumatic events in the ED and sought ways to improve their emotional health to benefit the patients and department as well as themselves. These EDNs were engaged and willing to learn the education content provided to increase their knowledge of CF.

Procedures

Planning. The planning phase was described in Section 1. Once I received approval from the hospital NRC and ROC, the planning phase continued with identification of three content experts who evaluated the curriculum plan (see Appendix C), educational program (see Appendix D), and pre-/post-test (see Appendix E) as well as completed the pre-/post-test expert content validation (Appendix F). An outside PhD assessment expert reviewed the pre-/post-test

item construction, I made changes based on his assessment. Once the content experts evaluated the curriculum plan; educational program, which was delivered in a PowerPoint format handout; and pre-/post-test as well as completed the pre-/post-test expert content validation, the implementation and evaluation phase ensued.

Implementation. I advertised the CFEDN doctoral project by posting flyers the week prior to delivering the educational program (see Appendix D) throughout the ED at nurses' stations, bathrooms, breakrooms, and other approved areas for advertising education projects in the ED. This flyer made the EDN aware of the topic of the education project and when I would visit to discuss the CFEDN doctoral project and recruit participants. I visited the ED during the morning shift to request participation in the CFEDN project to recruit day-shift nurses with a second visit to the ED during the evening shift to recruit night-shift nurses over the course of two different days in 1 week.

I assigned each participant a number with a corresponding number for their pre-test (see Appendix E), educational program (see Appendix D), and post-test (see Appendix E). A pre-test, which was based on the developed educational program, was administered to assess the nurses' knowledge before the educational program was provided. Once each participant completed the numbered pre-test and returned the test to me, I handed them the educational program with their specific participant number. Upon completion and return of the educational program, the same numbered post-test was given. Once all items were completed, they were kept confidential, secured in an envelope and placed into a locked file.

Evaluation. The numbered post-test (see Appendix E) was completed by each participant and returned to me. The numbering of the pre- and post-tests ensured comparison of both tests

from the same participant. I reviewed the results of the pre- and post-tests (see Appendix H) and changes in scores and discussed them with the hospital's director of the education department and director of the ED. This discussion will assist in further staff education programs to be included in the yearly staff development education. The education director also received a copy of the educational program and the results of the pre-/post-test comparison to assist in the yearly staff development education. Upon conclusion of the project, the content experts were asked to complete an anonymous summative evaluation (see Appendix I) of the project.

Protections

I submitted a copy of the project proposal approved by Walden University's IRB (IRB Approval # 06-14-19-0721947) to the NRC and ROC along with a completed project application packet. The facility has no established IRB; however, they use the NRC and ROC for site approval. Site approval was gained after the NRC and ROC reviewed the project proposal and application packet. No risks were identified. Participants completed the consent form for anonymous questionnaires from the *Walden University Manual for Staff Education Project* (Walden University, 2017) prior to participating in the project.

Analysis and Synthesis

I recorded, tracked, and organized the content expert evaluation of the curriculum plan (see Appendix C), expert content validation of the pre-/post-test (see Appendix F), and summative evaluations (see Appendix I) on a Microsoft Excel spreadsheet, from which they were analyzed by hand calculations. The results can be seen in Section 4. The software system I used to record, organize, and analyze the pre-/post-test data was GraphPad Prism 8 (2019), a software system that is downloadable from the Internet and includes a free 30-day trial.

Statistical analysis to address the practice-focused question occurred through a comparison of the results from the pre- and post-tests and were assessed using a paired *t* test (see Appendix H) to measure the nurses' gained knowledge from the educational program (see Appendix D). The paired *t* test was appropriate for this doctoral project because it is a statistical test that compares group means when people in the groups being compared are the same such as before and after comparisons (Polit, 2010). The results will be discussed in further detail in Section 4.

Summary

I found scholarly research articles related to CF among nurses by searching databases accessible through the Walden University Library, including CINAHL Plus, Thoreau, and EBSCO Discovery Service, published from 2013 to current using keywords to narrow the search. These articles were placed into a literature review matrix and graded using the *Hierarchy of Evidence for Intervention Studies* by Fineout-Overholt et al. (2010). After approval was obtained through Walden University IRB and the clinical site, I used these articles to develop the curriculum plan (see Appendix B) and educational program (see Appendix D). The pre-/post-test (see Appendix E), developed based on the curriculum plan and educational program, was used to determine if the EDNs gained knowledge from the educational program on CF.

A team of content experts evaluated the teaching materials, and a PhD assessment expert reviewed the pre-/post-test item construction. I placed a flyer around the ED area to advertise the doctoral project dates and times. Each nurse received a number that corresponded with their pre-test (see Appendix E), educational program (see Appendix D), and post-test (see Appendix E). Providing each nurse with a specific number ensured comparison of each nurse's pre- and post-test. All returned items were kept confidential, secured in an envelope, and placed into a locked

file. The results were discussed and provided to the director of the education department and director of the ED for possible inclusion with the yearly staff development education. No risks were identified. Analysis and synthesis occurred when the content expert evaluation of the curriculum plan (see Appendix C), expert content validation of the pre-/post-test (see Appendix F), and summative evaluations (see Appendix I) were recorded, tracked, and organized on a Microsoft Excel spreadsheet, and analyzed by hand calculations. I used GraphPad Prism 8 for statistical analysis of the data collected from the pre-/post-tests comparisons and was conducted by using a paired *t* test. The information from Section 3 led to the findings and recommendations, which are discussed in Section 4 along with my recommendations, the contributions of the doctoral project team, and the strengths and weaknesses of the project.

Section 4: Findings and Recommendations

Introduction

The local nursing practice problem that was the focus of this doctoral project was EDNs' lack of knowledge related to CF while providing care to patients suffering from traumatic events. The gap in practice was the lack of knowledge concerning CFEDN and how to recognize, prevent, and manage CF. The practice-focused question was: What evidence from the literature supports an educational program on CF for ED staff nurses? The purpose of the doctoral project was to bridge the gap in practice through an educational program addressing how to recognize, prevent, and manage CF.

The sources of evidence I used in this project were the literature review matrix (see Appendix A), the knowledge-based pre-/post-test (see Appendix E), and content expert reviews (see Appendices C and F). The literature review matrix is a compilation of the scholarly research articles found through an extensive literature search to support CFEDN. I used these same articles to develop the curriculum plan (see Appendix B) and the knowledge-based pre-/post-test to assess knowledge gained. The analytical strategy used for the literature review matrix was the *Hierarchy of Evidence for Intervention Studies* (Fineout-Overholt et al., 2010). Employing this analytical strategy, I categorized the type of evidence each article was and identified the level of evidence on the literature review matrix. The content experts evaluated the curriculum plan (see Appendix C) and educational program (see Appendix D), conducted content validation on all pre-/post-test items (see Appendix F), and provided a summative evaluation (see Appendix I).

Findings and Implications

The evaluation of the curriculum plan showed that each content expert agreed that the curriculum plan (see Appendix B) met the learning objectives of the doctoral project. The pre-/post-test expert content validation form showed all content experts agreed that each test item was very relevant to the course objectives of the doctoral project, with each test item scored on the content expert validity index scale (see Appendix G) at 1.00. The summative evaluation showed the doctoral project was explained in detail and provided the purpose of the project.

The pre-/post-test (see Appendix E) was beneficial in assessing EDNs' knowledge prior to and after the educational program (see Appendix D). The results show that the educational program provided useful information to the EDNs through gained knowledge based on the post-test scores (see Appendix H). The project was useful in providing education related to the recognition, prevention, and management of CF and assessed the nurse's knowledge before and after the educational program. The content experts evaluated my leadership as being able to demonstrate identifying a nursing practice problem, researching supportive literature, developing a curriculum plan and pre-/post-test, speaking to the EDNs to explain what the project was about and the purpose, being readily available for questions, and providing clarification when needed.

I determined the results of the CFEDN educational program were determined using paired *t* tests. This statistical test determined the comparison results of the pre-and post-test as the mean of differences of 2.400, showing an increase in knowledge after the educational offering. With a $p < .0001$, there was a statistically significant increase, demonstrating that education could be a meaningful means of increasing awareness; however, with the low number of participants, further studies are required to confirm the results. The mean of all 56 pre-tests

was 7.804; the 25 pre-tests for those completing a post-test had a mean of 7.800; and the mean of the post-tests was 10.20, showing a 30% increase in correct responses. Based on these results, the CFEDN was successful in increasing knowledge related to CF and how to recognize, prevent, and manage CF; however, there is a need for more education on CF for these EDNs and support from the facility will be needed to increase the participation rate.

The CS-CF model guided this doctoral project by identifying the different environments (i.e., work, client/person helped, and personal) of the nurse leading to the physical and emotional attributes exhibited when suffering from CF. Stressors in all three environments can lead to CF, which then leads to exhaustion, frustration, and anger, resulting in being depressed and/or distressed at work (Stamm, 2010). Experiencing depression and/or distress at work can also come from trauma experienced at work due to primary or secondary exposure (Stamm, 2010). Primary exposure occurs when the nurse experiences the traumatic event personally, while secondary exposure is experienced by the nurse while providing care to a patient suffering from a traumatic event (Stamm, 2010). Nurses can recognize, prevent, and manage these symptoms of CF shown on the CS-CF model and apply the knowledge gained from this educational program related to resiliency programs, coping mechanisms, debriefing, and meaningful recognition to bridge the gap in practice.

One unanticipated outcome of the doctoral project was that the hospital did not provide full support for the implementation of the project and did nothing to encourage nurse participation. The low nurse participation, time constraints, and scheduling of this doctoral project at the same time as the yearly, competency-based, learning modules were all limitations as well. One of the content experts stated that a lot of the EDNs are young, new nurses and do

not understand the importance of the advanced degree projects and how they can potentially lead to beneficial changes in the department. Many of the nurses did not take this educational program seriously, as seen by the low participation with more than half of those agreeing to participate only completing the pre-tests. One of the content experts suggested a way to increase participation would be through prizes or incentives to make the project more appealing. Another content expert suggested holding conversations among the EDNs to debrief about current and past issues in a safe environment to increase participation. I did attempt to recruit more nurses in other critical care areas of the hospital for more meaningful data but this would have required another approval process that time constraints did not allow for because it would have taken another 2 months for approval for the critical care areas of the hospital.

All of these unanticipated limitations had a negative impact on the findings because the educational program did not receive the nurses' undivided attention to accurately assess their level of knowledge gained when comparing the pre-/post-test scores. Many EDNs seemed to skim the information on the educational program due to the time constraint. The implications resulting from the findings related to EDNs are that leadership needs to be aware of, as CF is a nursing practice problem. With support from leadership, further knowledge assessment testing and education on CF would be more meaningful. More education is needed because of the high nurse-to-patient ratio, insufficient staff due to high turnover and nurses calling out, and long working hours. There was not enough nurse participation in this doctoral project to accurately assess if there was a lack of knowledge related to CF. My attempt to recruit more nurses in other critical care areas was unsuccessful and would have introduced other variables (i.e., a different setting). One way to improve participation would be to schedule a different format for the

education session, such as a lunch and learn, to increase nurse participation; however, all attempts at alternate educational methods were refused by the leadership. Incentives could be offered and management support or facility requirement of attendance would be beneficial.

One potential implication to positive social change is increased knowledge about CF could result in a reduction of CF, leading to increased nurse satisfaction and improved patient outcomes. The findings of my project could potentially lead to this implication by providing EDNs with knowledge related to how to recognize, prevent, and manage CF. It is hopeful that through the gained knowledge, EDNs will be better able to handle stressful and traumatic events while providing quality care to patients, which then will lead to decreased chances of CF while increasing nurse satisfaction and improving patient outcomes.

Recommendations

One recommendation that would potentially assist in addressing the gap in practice area would be for the hospital administration to acknowledge the need and provide better support of the educational session for the EDNs to learn how to recognize, prevent, and manage CF. The most efficient and effective way to disseminate this education to all hospital nurses would be to include it in the annual competency-based learning modules; however, since the annual competency-based learning modules have passed, this education program could be provided through a mandatory lunch and learn education session for the EDNs to attend in a formal setting. The education program could also be included in the competency-based learning modules to be completed by a specific date for those nurses who are unable to attend the formal education sessions. Knowledge gained could lead to increased retention and nurse satisfaction and, eventually, improved patient outcomes.

Contribution of the Doctoral Project Team

Working with the doctoral project team went well. I asked each team member if they would contribute their expertise in the role that best fit their background. The content experts reviewed the curriculum plan (see Appendix B), educational program (see Appendix D), and pre-/post-tests (see Appendix E). They did not recommend any changes. The content experts also completed the summative evaluation (see Appendix I) of the overall doctoral project. The summative evaluation will assist in making changes to the educational program for future presentations. Everyone was receptive to assisting with the project and carrying out their respective responsibilities to make the project successful. At this time, there are no plans to extend the DNP doctoral project further; however, the hospital does allow lunch and learn sessions to be held by those who have obtained their doctorate degrees already. So, after I have obtained my DNP degree, I plan to request a lunch and learn session to present my project to the EDNs.

Strengths and Limitations of the Project

The strengths of the doctoral project were the support of the extant literature and discussions with EDNs showing CF to be a nursing practice problem. The pre-test scores showed a lack of knowledge related to recognition, prevention, and management of CF, and the post-test scores showed knowledge gained when compared to the pre-test scores. The limitations of the doctoral project were that the hospital did not fully support the project and did nothing to encourage nurse participation, low nurse participation rates, not enough time allotted, and a scheduling conflict between the doctoral project and competency-based learning modules. In planning future educational offerings, schedules should be coordinated to avoid conflicts.

Another recommendation for future projects addressing similar topics and using similar methods would be for the hospital to better support the doctoral project by scheduling a lunch and learn with a specific date, time, and place for EDNs to attend the educational program to increase nurse participation and allotted time. Presenting this educational program as a PowerPoint slideshow in a classroom setting and conducting the presentation during an hour time slot would allow enough time for nurses to be engaged with the material and even allow questions and discussion at the end of the PowerPoint presentation while still completing the pre- and post-tests.

Section 5: Dissemination Plan

For local dissemination, after the completion of this doctoral education project, I reviewed the teaching educational program and results of the pre- and post-tests with the director of the education department and director of the ED for further use as needed. The director of the education department and director of the ED were both receptive to the findings of the doctoral project and agreed this was a nursing practice problem that needed to be addressed in order to assist the nurses with CF. The most efficient and effective way to disseminate this education to all hospital nurses would be to include it in the annual competency-based learning modules; however, since the annual competency-based learning modules have already passed this year, this education program could be provided through a mandatory education session for all nurses to attend in a formal setting. The education program could also be included in the competency-based learning modules to be completed by a specific date for those nurses who are unable to attend the formal education sessions. A presentation of this educational program would also be beneficial at the Emergency Nurses Association conference or submitted for publication in the *Journal of Emergency Nursing* because this project focuses on issues that impact EDNs; therefore, they can relate to the information and learn from the educational program to improve their nursing practice and the quality of care provided to patients.

Analysis of Self

In this doctoral project, my role was that of a practitioner, scholar, and project manager in each phase of the doctoral project. Each of these roles were significant at different phases of this doctoral project. My self-analysis of the three different roles in this doctoral project is provided in the following subsections.

Practitioner

In the role of a practitioner in this doctoral project, I learned what a DNP role in the hospital setting would be like (e.g., implementing new nursing practices based on evidence). Since I will obtain my DNP degree, knowing exactly the role of the DNP-prepared nurse in the hospital setting prior to graduation is beneficial in that I know what will be expected of me. I am better prepared to implement new, evidence-based nursing practices because of this doctoral project experience. As the practitioner, I have learned to be a better advocate for my doctoral project. I could have pushed the envelope more when requesting a date, time, and place to increase nurse participation and for the hospital to show support of the doctoral project by assisting with recruiting nurses to attend the educational program.

Scholar

In the role of the scholar for this doctoral project, I learned how to identify a nursing practice problem; complete a literature review matrix; and search for supportive, evidence-based literature to plan, implement, and evaluate an educational program. This role prepared me to search for and learn new information related to nursing practice in the hospital setting. As a scholar, you must learn new information to expand your knowledge base and use it in your profession to be successful as a practitioner.

Project Manager

In the role of the project manager for this doctoral project, I learned to identify a practice problem based on my observation of the hospital and obtain hospital resources to conduct the project. I conducted my doctoral project with EDNs, collected and compiled my results, then provided the results to the director of the education department and director of the ED for further

use as needed. As the project manager, I oversaw all aspects of the project from beginning to end to ensure all steps were covered according to the *Walden University Manual for Staff Education Project* (Walden University, 2017).

As the project manager, to increase nurse participation and for nurses to take the educational program seriously, I believe I should have been a better advocate for the doctoral project. I should have spoken with the education director and requested a specific date, time, and place for me to present the educational program to the EDNs in a more formal setting. I could have been more assertive with the education director in stating what I needed to ensure my project was successful with more nurse participation. If there had been more nurse participation, I believe the findings would have been more reflective of the need for the education and its benefits.

My long-term professional goal is to combine the aforementioned roles of practitioner, scholar, and project manager with the knowledge gained on how to identify a nursing practice problem, where to find supportive literature that addresses the practice problem, and how to implement a new nursing practice in the hospital setting based on the found supportive literature. After obtaining my degree, I will use this gained knowledge to climb the leadership ladder, starting off as a manager or supervisor, then a unit director, with a 10-year plan of being a hospital Chief Nursing Officer. My degree will fit in my new role as a manager or supervisor of a nursing unit when identifying nursing practice issues that can be improved for better patient outcomes and demonstrating leadership skills. For example, hospital-acquired pressure ulcers are always a nursing practice issue with updated literature to support a practice change to prevent pressure ulcers from occurring. I will demonstrate leadership skills in implementing new,

evidence-based practices; empowering the staff with the most current nursing practices; and holding the staff accountable for these changes. The knowledge I have gained in the DNP program has provided me with the know-how to address nursing practice issues, such as this, in the hospital setting.

The challenges that came along with this doctoral project were not receiving the support of hospital leadership to ensure nurse participation, low nurse interest and participation, and time constraints. The solutions to these problems are for leadership to specify a place for the doctoral project to be presented, make nurse participation mandatory, and allow at least an hour for the doctoral project to be presented. One insight I have gained on this scholarly journey is to be a better advocate of my doctoral project to ensure leadership support and high nurse participation. I believe if leadership took the project seriously, they would have shown more support to ensure nurse participation. Leaders must lead by example, so if nurses do not witness leaders supporting the project, they will not support the project either.

Summary

In conclusion, the local nursing practice problem that was the focus of this CFEDN doctoral project was the lack of EDNs' knowledge related to CF while providing care to patients suffering from traumatic events. The gap in practice was the lack of knowledge related to CFEDN and how to recognize, prevent, and manage CF. The practice question was: What evidence from the literature supported an educational program on CF for ED staff nurses? The purpose of the doctoral project was to bridge the gap in practice concerning the lack of knowledge related to CFEDN through an educational program on CF addressing how to recognize, prevent, and manage CF. In the project, I followed the *Walden University Manual for*

Staff Education Project (Walden University, 2017) and was guided by the theoretical model of CS-CF (Stamm, 2010).

In this doctoral project, I assessed EDNs knowledge before and after the educational program to measure if knowledge was gained from the educational program. Based on the results of the pre- and post-tests, some knowledge was gained; however, more education is needed in a formal presentation setting to ensure nurse participation. CF is experienced by nurses after exposure to a traumatic event (Henson, 2017). With this educational program, the effects of CF that I wish to prevent are decreased quality patient care; feelings of exhaustion; and mental, physical, and emotional dysfunction.

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Appendix A: Literature Review Matrix

	Citation	Conceptual Framework/ Theory	Design/Method	Sample/Setting	Measurement/Data Analysis	Findings	Level of Evidence
1	Dean, E. (2017). Pinpointing and relieving stress in emergency departments. *Emergency Nurse, 25*(5), 8-9. Retrieved from https://journals.rcni.com/emergency-nurse/pinpointing-and-relieving-stress-in-emergency-departments-en.25.5.8.s8	Not a research article	n/a	EDN	n/a	What CFEDN is, signs of stress, employer concerns, thresholds and stress reducing techniques	VII
2	Ermak, L. (2014, January 26). Beating the burnout: Nurses struggle with physical, mental and emotional exhaustion at work. *Holland Sentinel.* Retrieved from https://www.nationalnursesunited.org/news/beating-burnout-nurses-struggle-physical-mental-and-emotional-exhaustion-work	Not a research article	n/a	Community hospital nurses	n/a	Nurses are overworked, short staffing leads to increased infection rates, preventable falls, and death rates. Nurses are retiring and there are not enough graduating nurses to fill these openings.	VII
3	Flarity, K., Gentry, J. E., & Mesnikoff, N. (2013). The	n/a	Qualitative study, pre/post-test	Emergency nurses in 2 hospitals in Colorado	ProQOL 5 as pre/post-test,	43 participants moderate to high level	I

	effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal, 35*(3), 247-258. doi:10.1097/TME.0b013e31829b726f		design, univariate statistics		demographics questionnaire	of BO & 44 participants moderate to high level of STS (total of 87 participants moderate to high level of CF)	
4	Henson, J. S. (2017). When compassion is lost. *Medsurg Nursing: Official Journal of The Academy of Medical-Surgical Nurses*, *26*(2), 139–142. Retrieved from CINAHL Plus with Full. (Accession No. 122315820).	Not a research article	n/a	Nurses	n/a	Background, environmental influence, prevention, nursing practice implications related to CF	VII
5	Hunsaker, S., Chen, H.-C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship*, *47*(2), 186. https://doi-org.ezp.waldenulibrary.org/10.1111/jnu.12122	Maslow's theory of hierarchy of needs, Watson's theory of human caring, stress-process framework, CS-CF model	Nonexperimental, descriptive, and predictive study, multiple regression	1,000 emergency nurses throughout the U.S.	Demographics questionnaire, ProQOL 5	Low to average levels of CF	VII

6	Jakel, P., Kenney, J., Ludan, N., Miller, P. S., McNair, N., & Matesic, E. (2016). Effects of the use of the provider resilience mobile application in reducing compassion fatigue in oncology nursing. *Clinical Journal of Oncology Nursing*, *20*(6), 611–616. Retrieved fromhttp://dx.doi.org.ezp.waldenulibrary.org/10.1188/16.CJON.611-616	n/a	Prospective quasiexperimental design	25 oncology nurses, two nonrandomized groups (intervention and control)	ProQOL 5, Pre/post-test	No statistical significance between the intervention and control groups	VI
7	Jakimowicz, S., Perry, L., & Lewis, J. (2017). Compassion satisfaction and fatigue: A cross-sectional survey of Australian intensive care nurses. *Australian Critical Care: Official Journal of The Confederation of Australian Critical Care Nurses,* 31(6), 396-405. https://doi-org.ezp.waldenulibrary.org/10.1016/j.aucc.2017.10.003	n/a	Two-phase mixed method study, cross-sectional data collection	200 ICU nurses from 2 different hospitals	ProQOL 5 demographic and occupational data, IBM SPSS statistics version 23.0,	66% reported burnout and STS (CF)	V
8	Khan, A. A., Khan, M. A., & Bokhari, S. A. (2016). Association of	n/a	Cross-sectional comparative study	54 HCP working in medicine, surgery, ansthesia,	ProQOL 5 Data analyzed SPSS	20.4% low CF, 68.5% average CF, and 11.1% high CF	IV

	specialty and working hours with compassion fatigue. *Pakistan Armed Forces Medical Journal*, *66*(1), 143–146. Retrieved from International Security & Counter Terrorism Reference Center. (Accession No. 113458293).			and gynecology	version 22		
9	Lachman, V. D. (2016). Compassion fatigue as a threat to ethical practice: Identification, personal and workplace prevention/management strategies. *MEDSURG Nursing, 25*(4), 275-278.	Not a research article	n/a	Nurses in community hospital on a med/surg unit with specialties in orthopedics and nephrology	ProQOL 5	Nurses have to do self-care through identified personal/workplace prevention strategies	VII
10	Mazzotta, C. P. (2015). Paying attention to compassion fatigue in emergency nurses. *The American Journal of Nursing*, *115*(12), 13. https://doi-org.ezp.waldenulibrary.org/10.1097/01.NAJ.0000475268.60265.00	Not a research article	n/a	EDN	n/a	The authors personal experience as an EDN and suffering from CF.	VII
11	Meadors P, Lamson A, & Sira N. (2010). Development of an	Figley2002	n/a	185 HCP	n/a	The CF educational module was one of the	VII

	educational module on provider self-care. *Journal for Nurses in Staff Development*, *26*(4), 152–158. https://doi-org.ezp.waldenulibrary.org/10.1097/NND.0b013e3181b1b9e4					first known seminars to address CF	
12	Melvin, C. S. (2018). Historical review in understanding burnout, professional compassion fatigue, and secondary traumatic stress disorder from a hospice and palliative nursing perspective. *Journal of Hospice & Palliative Nursing*, *17*(1), 66–72. https://doi-org.ezp.waldenulibrary.org/10.1097/NJH.0000000000000126	n/a	n/a	n/a	n/a	Resiliency programs, self-care coping strategies	VII
13	Pehlivan, T., & Güner, P. (2018). Compassion fatigue: The known and unknown. *Journal of Psychiatric Nursing/Psikiyatri Hemsireleri Dernegi*, *9*(2), 129–134. https://doi-org.ezp.waldenulib	Not a research article	n/a	Nurses	n/a	CF background and development, and how concepts are related to CF	VII

	rary.org/10.14744/phd.2017.25582						
14	Ruff-King, M. (2018). Compassion fatigue in nursing. Retrieved from http://nursesusa.org/safety_compassion_fatigue.asp	Not a research article	n/a	Nurses	n/a	Warning signs of CF and coping mechanisms for those suffering from CF	VII
15	Schmidt, M., & Haglund, K. (2017). Debrief in emergency departments to improve compassion fatigue and promote resiliency. *Journal of Trauma Nursing*, *24*(5), 317–322. https://doi-org.ezp.waldenulibrary.org/10.1097/JTN.0000000000000315	n/a	n/a	ED nurses	n/a	Personal Reflective Debrief as an intervention for CF prevention	VII
16	Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship*, *48*(5), 456-465. https://doi-org.ezp.waldenulibrary.org/10.1111/jnu.12229	n/a	Literature review and integrative review	43 of 307 articles met the inclusion criteria	n/a	More research is needed to evaluate CF in HCP in a variety of settings	III

17	van Mol, M. C., Kompanje, E. O., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: A systematic review. *Plos One, 10*(8), e0136955. doi:10.1371/journal.pone.0136955	n/a	Systematic literature review	40 of 1623 identified publications	n/a	True prevalence remains open for dicussion, more research is needed to develop further preventive strategies	II
18	Weinstein, S. (2015). *B is for balance: 12 steps toward a more balanced life at home and at work*. Indianapolis, Indiana: Sigma Theta Tau International.	Not a research article	n/a	Nurses	n/a	Defined fatigue and CF, how they both relate to the nursing world and how it impacts job performance and overall health	VII
19	Wijdenes, K. L., Badger, T. A., & Sheppard, K. G. (2019). Assessing compassion fatigue risk among Nurses in a large urban trauma center. *Journal of Nursing Administration*, *49*(1), 19–23. https://doi-org.ezp.waldenulibrary.org/10.1097/N	None used	Descriptive design	835 RNs were sent surveys, of those 315 responded	ProQOL-5	46% of nurses scored moderate to high for CF risk, this was associated with years of employment, unit worked, job changes, and use of sick days	VII

	NA.0000000000000702						
20	Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research, 23*(4), 191-197. doi:10.1016/j.apnr.2008.09.003	n/a	Quantitative and qualitative	178 RNs in home care, ED, ICU, PCU, oncology, & M/S units in a 123-bed community hospital	ProQOL R-4, demographics questionnaire, statistical analysis used Minitab software	Nurses identified coping strategies, triggers, more studies needed to predict CF and how to avoid CF	I

Appendix B: Curriculum Plan

Title of Project: Compassion Fatigue in Emergency Department Nurses

Student: Michelle C. Lawrence

Problem: Emergency department nurses experiencing compassion fatigue while providing care to patients suffering from traumatic events

Purpose: The purpose of the Compassion Fatigue in Emergency Department Nurses doctoral project is to bridge the gap in practice which was the lack of knowledge related to CFEDN and how to recognize, prevent, and manage CF through an educational program on compassion fatigue addressing how to recognize, prevent, and manage compassion fatigue.

Practice Focused Question: What evidence from the literature supports an educational program on compassion fatigue for emergency department nurses?

Objective Number and Statement At the conclusion of this educational program the emergency department nurses will be able to:	Detailed Content Outline	Evidence (from Literature Review Matrix)	Method of Presenting	Method of Evaluation P/P Item
Objective 1. Define compassion fatigue, why compassion fatigue is a problem and nursing issue, and contributing factors of	Introduction A. What is compassion fatigue a. Associated with caring for patients who have suffered from a traumatic event b. Triggered by a nurses'	1.(Henson , 2017)	PowerPoint handout PowerPoint handout	Question #1, 7

compassion fatigue.	inability to separate feelings of stress and anxiety c. Sudden onset B. Why compassion fatigue is a problem a. Negatively impacts the delivery of patient care • Stress and anxiety result from patient deaths, trauma, and unexpected outcomes C. Nursing issue a. Emergency department nurses experience compassion fatigue while providing care to patients suffering from traumatic events b. For the nurse, this means compassion fatigue leads to stressors while providing care to patients	2. (Henson, 2017) 3. (Lachman, 2016) 4. (Melvin, 2018)	PowerPoint handout PowerPoint handout	Question #5 Question #6 Question #14

	D. Contributing factors of compassion fatigue a. Poor staffing b. Increased workload c. High acuity patients d. Patient deaths e. Unexpected patient outcomes f. Lack of leader support			
Objective 2. Discuss compassion satisfaction versus compassion fatigue, who compassion fatigue affects, nurse stressors, and ways to recognize, prevent, and manage compassion fatigue.	A. Compassion satisfaction instead of compassion satisfaction are experienced when nurses have: a. Strong leadership b. Meaningful recognition • Daisy Awards • Clinical ladder program c. Nurse engagement • Shared governance B. Who compassion satisfaction affects a. Nurses	1.(Pehlivan & Guner, 2018) 2. (Hunsaker et al., 2015; Ruff-King, 2018)	PowerPoint handout PowerPoint handout	Question #2 Question #11, 12, 15

	• Increased stress levels • Inability to provide quality care • Not compassionate or empathetic • High turnover • Call outs daily b. Patients • Do not receive quality care from nurses • Poor patient outcomes • Decreased patient satisfaction c. Unit managers, unit directors, and executive leadership • Patients complain about nurses' inability to provide quality care	3. (Lachman, 2016) 4. (Hunsaker et al., 2015; Ruff-King, 2018)	PowerPoint handout PowerPoint handout	Question #4, 9

	• Focused attention on patient complaints and disciplining nurses • High nurse turnover and call outs • Time spent making changes to improve patient satisfaction based on patient satisfaction survey results C. Nurse stressors a. High call ins b. Complex patient loads c. Long shifts d. Demanding physicians e. Fast-paced environment f. Emotionally and physically challenging area D. Ways to recognize compassion fatigue a. Physical • Absenteeism	5. (Flarity, Gentry, & Mesnikoff, 2013)	PowerPoint handout	Question #3, 10

	• Disturbed sleep patterns • Headache • Exhaustion • Poor concentration • Substance abuse • High turnover b. Emotional • Exhaustion • Anxiety • Depression • Low morale • Irritability • Mood swings • Unempathetic E. Ways to manage compassion fatigue a. Stay calm, cool, and collected (Self-regulation) b. Do not respond or react in a negative manner (Self-regulation) c. Stay focused on providing quality	6. (van Mol et al., 2015)	PowerPoint handout	Question #8, 13

	patient care (Intentionality) d. Provide care to patients confidently (Intentionality) e. Remember why you chose to become a nurse (Intentionality) f. Make changes for the better that demonstrate maturity (Perceptual maturation self-validation) g. Do not expect coworkers to validate you (Perceptual maturation self-validation) h. Remember nurses are caregivers and serve others (Perceptual maturation self-validation) i. Develop or find peer			

	support group to discuss nursing experiences (Connection and support) j. Members of the support group check on each other when symptomatic (Connection and support) k. Revitalize all areas of life; physically, mentally, emotionally, spiritually, and professionally (Self-care and revitalization) • Eat properly • Exercise • Learn to say "No", set boundaries • Spend time alone • Express			

	yourself F. F. Ways to prevent compassion fatigue a. Relaxation exercises • Deep breathing, expressive writing, prayer, meditation, self-care b. Social support system • Debriefing or talking to a group of supportive nurses c. Periodic job rotation • Change job positions when necessary d. Compassion fatigue			

	educational seminar • Resiliency programs • Meaningful recognition			

Appendix C: Content Expert Evaluation of Curriculum Plan

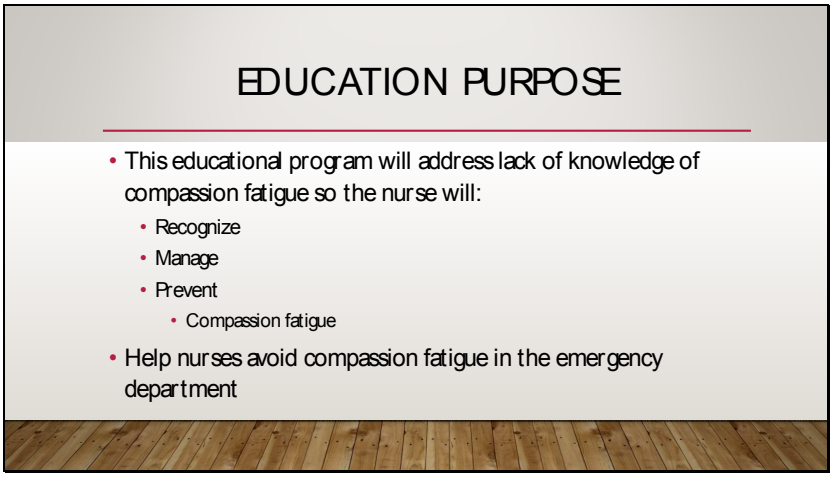
Please rate each objective as met (1) or unmet (2).

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Average Score
1. Define compassion fatigue, why compassion fatigue is a problem and nursing issue, and contributing factors of compassion fatigue.	1	1	1	1
2. Discuss compassion satisfaction versus compassion fatigue, who compassion fatigue affects, nurse stressors, and ways to recognize, prevent, and manage compassion fatigue.	1	1	1	1

Appendix D: Educational Program

Slide 1

Slide 2



Slide 3

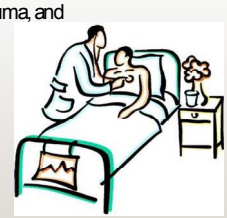
WHAT IS COMPASSION FATIGUE?

- Associated with caring for patients who have suffered from a traumatic event
- Triggered by a nurses' inability to separate feelings of stress and anxiety
- Sudden onset

Slide 4

WHY IS COMPASSION FATIGUE A PROBLEM

- Negatively impacts delivery of patient care
  - Stress and anxiety result from patient deaths, trauma, and unexpected outcomes



Slide 5

THE PROBLEM

- Nursing issue
  - Emergency department nurses experience compassion fatigue while providing care to patients suffering from traumatic events
  - For the nurse, compassion fatigue leads to stressors during the provision of patient

Slide 6

CONTRIBUTING FACTORS

- Environmental influences
  - Poor staffing
  - Increased workload
  - High acuity patients
  - Patient deaths
  - Unexpected patient outcomes
  - Lack of leader support

Slide 7

COMPASSION SATISFACTION INSTEAD OF COMPASSION FATIGUE

- High compassion satisfaction (job satisfaction) and low compassion fatigue are experienced when nurses have:
  - Strong leadership
  - Meaningful recognition
    - Daisy Awards
    - Clinical ladder program
  - Nurse engagement
    - Shared governance

Slide 8

WHO COMPASSION FATIGUE AFFECTS

NURSES

- Increased stress levels
- Inability to provide quality care
- Not compassionate or empathetic
- High turnover
- Call outs daily

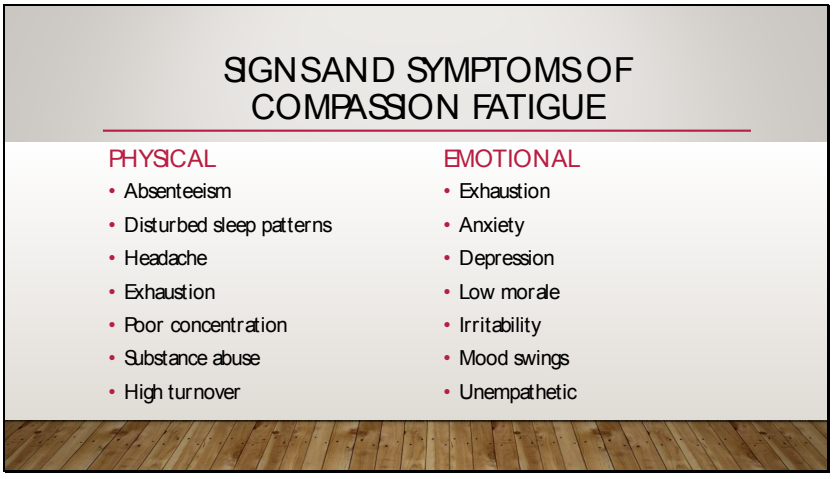
PATIENTS

- Do not receive quality care from nurses
- Poor patient outcomes
- Decreased patient satisfaction

Slide 9

Slide 10

Slide 11



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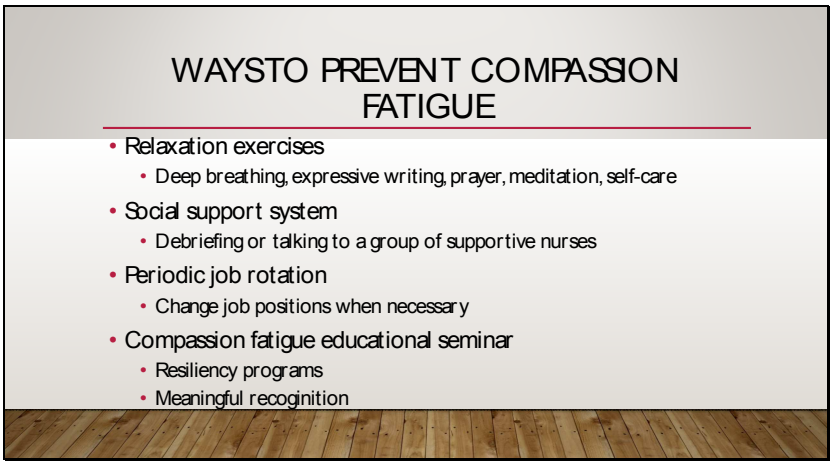

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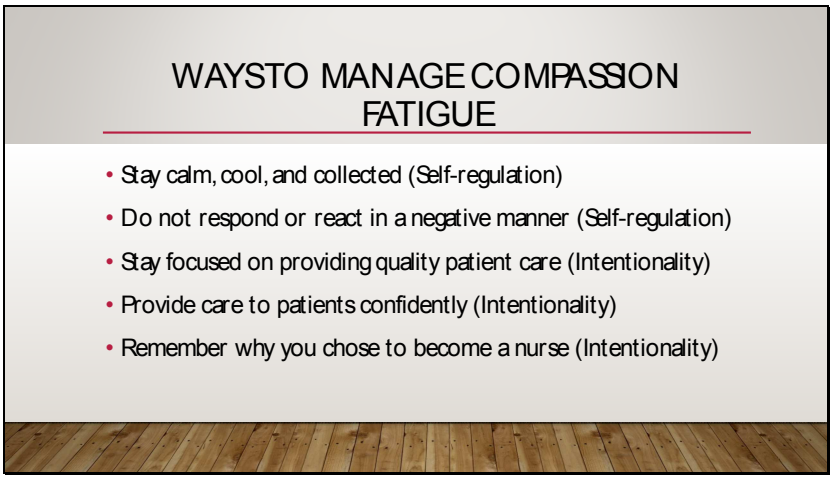

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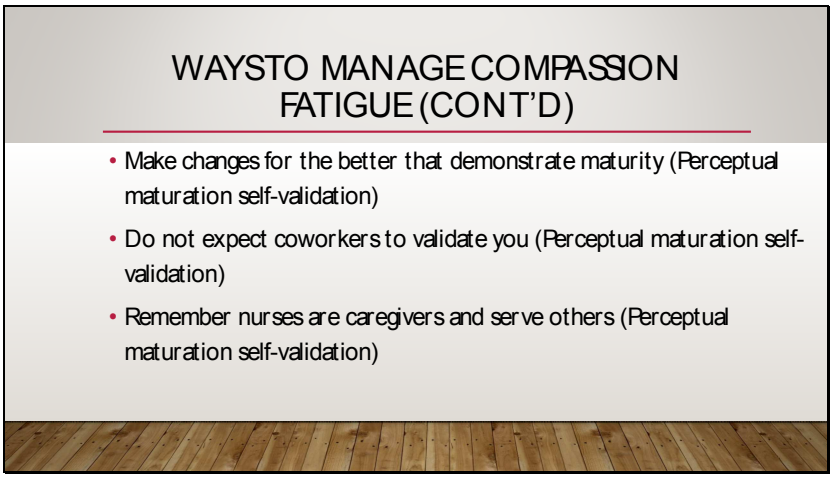

Slide 15

WAYS TO MANAGE COMPASSION FATIGUE (CONT'D)

- Develop or find peer support group to discuss nursing experiences (Connection and support)
- Members of the support group check on each other when symptomatic (Connection and support)

Slide 16

WAYS TO MANAGE COMPASSION FATIGUE (CONT'D)

- Revitalize all areas of life; physically, mentally, emotionally, spiritually, and professionally (Self-care and revitalization)
  - Eat properly
  - Exercise
  - Learn to say "No", set boundaries
  - Spend time alone
  - Express yourself

Slide 17

WHAT DID YOU LEARN FROM THIS PROGRAM?

- This educational program on compassion fatigue showed ways to:
  - Recognize signs/symptoms of compassion fatigue
  - Manage compassion fatigue signs/symptoms
  - Prevent compassion fatigue from occurring

Slide 18

QUESTIONS??

- For any questions, please contact me at michelle.lawrence3@waldenu.edu

Slide 19

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Slide 20

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Appendix E: Pre-/Post-test

Compassion Fatigue Questionnaire-Pre/Post-test

How many years have you been a nurse?

How many years have you worked in the Emergency Department as a nurse?

True or False (circle one)

1. Compassion fatigue has a sudden onset. **True or False**

2. Low compassion satisfaction and high compassion fatigue happens with strong leadership. **True or False**

3. Self-regulation means to stay calm, cool, and collected. **True or False**

4. Depression is a sign of compassion fatigue. **True or False**

5. Stress and anxiety result from patient deaths, trauma, or an unexpected outcome. **True or False**

6. Emergency department nurses experience compassion fatigue when caring for healthy patients. **True or False**

Circle all that apply

7. What is compassion fatigue?
   - When a caregiver no longer provides care to a patient.
   - A nurse refusing an assignment.
   - A sudden onset of anxiety associated with caring for trauma patients.
   - A person dropping a patient off at the Emergency Department.

8. What are ways to prevent compassion fatigue?
   - Relaxation exercises
   - Social support system
   - Staying at the same job
   - Compassion Fatigue educational seminar

9. What are some signs and symptoms of compassion fatigue?
   - Hyperactive
   - Anxiety
   - Sleep disturbances
   - Inability to express empathy to patients

10. What are some ways to manage compassion fatigue?
    - Self-care
    - Debriefing
    - Self-regulation
    - Revitalization

11. Who does compassion fatigue affects?
    - Patients' families
    - Patients
    - Unit managers
    - Unit directors

12. Nurses are stakeholders of compassion fatigue because
    - they receive quality care.
    - they provide quality care.
    - they focus on hospital daily operations.
    - they can prevent and manage compassion fatigue.

13. Debriefing
    - provides a support system to promote nurse's well-being.
    - provides self-care.
    - provides an opportunity to talk the event through.
    - is an intervention for compassion fatigue.

14. Environmental influences include:
    - Poor staffing
    - Increased workload
    - Cell phones
    - Lack of leader support

15. Compassion fatigue affects nurses by:
    - Increasing stress level.
    - Leading to poor patient outcomes.
    - Increasing the number of call outs daily.
    - Leading to high turnover.

Appendix F: Pre-/Post-test Expert Content Validation

PRETEST/POSTTEST EXPERT CONTENT VALIDATION BY CONTENT EXPERTS

TITLE OF PROJECT: Compassion Fatigue in Emergency Department Nurses

Date: August 3, 2019 **Student Name: Michelle Lawrence**

Reviewer's Name:

Packet: Curriculum Plan, Pretest/Posttest with answers, Pretest/Posttest Expert Content Validation Form

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

Test Item #

1 Somewhat Relevant__ Relevant___ Very Relevant___ Not Relevant __

Comments:

2 Somewhat Relevant__ Relevant___ Very Relevant___ Not Relevant__

Comments:

3 Somewhat Relevant__ Relevant___ Very Relevant___ Not Relevant__

Comments:

4 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

5. Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

6 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

7 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

8 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

9 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

10 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

11 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

12 Somewhat Relevant__ Relevant___ Very Relevant__ Not Relevant__

Comments:

13 Somewhat Relevant__ Relevant____ Very Relevant__ Not Relevant__

Comments:

14 Somewhat Relevant__ Relevant____ Very Relevant__ Not Relevant__

Comments:

15 Somewhat Relevant__ Relevant____ Very Relevant__ Not Relevant__

Comments:

Appendix G: Content Expert Validity Index Scale Analysis

Rating on 15-Items Scale by Three Experts on a 4-point Likert Scale

Pretest/Posttest Items	Expert 1	Expert 2	Expert 3	Total rating	Item CVI
1	4	4	4	12	1.00
2	4	4	4	12	1.00
3	4	4	4	12	1.00
4	4	4	4	12	1.00
5	4	4	4	12	1.00
6	4	4	4	12	1.00
7	4	4	4	12	1.00
8	4	4	4	12	1.00
9	4	4	4	12	1.00
10	4	4	4	12	1.00
11	4	4	4	12	1.00
12	4	4	4	12	1.00
13	4	4	4	12	1.00
14	4	4	4	12	1.00
15	4	4	4	12	1.00
Total	60	60	60	180	1.00
Proportion Relevant	1.00	1.00	1.00	S-CVI 1.00	

I-CVI, item-level content validity index.

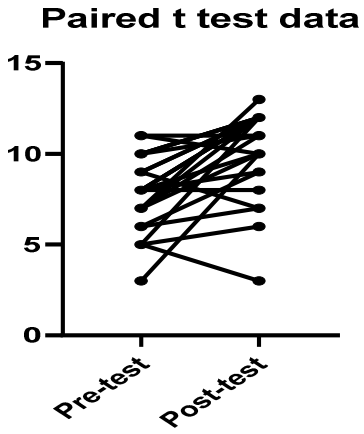
S-CVI/UA, scale-level content validity index, universal agreement calculation method

Adopted from Polit, D. F., & Beck, C. T. (2006). The content validity index.

Appendix H: Test Scores and Paired *t* Test Data Graph

Test Scores

	Pre-test	Post-test	Difference
1	7	10	3
2	5	12	7
3	5	6	1
4	7	13	6
5	8	8	0
6	6	7	1
7	10	12	2
8	10	12	2
9	3	10	7
10	8	12	4
11	8	9	1
12	10	11	1
13	9	12	3
14	9	7	-2
15	7	11	4
16	7	12	5
17	8	10	2
18	5	3	-2
19	11	10	-1
20	9	12	3
21	10	12	2
22	8	12	4
23	8	12	4
24	6	9	3
25	11	11	0



Appendix I: Results of Summative Evaluation

Title of Project: Compassion Fatigue in Emergency Department

Student: Michelle Lawrence

Student Instructions: Compile all comments made by the respondents in the table below and analyze and synthesize your findings.

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

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

Evaluator A	Evaluator B	Evaluator C
The project was initiated during the morning and evening department huddles which encouraged staff participation, because it allowed everyone to receive the same information and expectations.	This project helped me understand the precursors of compassion fatigue, the signs to watch for (in myself and the staff), and ways to manage it appropriately.	The project was very effective. The staff was provided an outlet to verbalize the fatigue they are experiencing related to their specific jobs.

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

Evaluator A	Evaluator B	Evaluator C
As a part of the emergency department, I am able to see that compassion fatigue is very real. I'm glad that I was able to participate in this project.	I understand that I play a pivotal role in ensuring I pass the information on and to assess for the need for intervention for staff.	I feel really good about being a new stakeholder. Being new allows me to provide fresh perspective to the staff. It allows me to provide fresh ideas to help them. Being fresh to the area allows me to come with different experiences that helped me get through the same thing.

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

Evaluator A	Evaluator B	Evaluator C
Since participation was voluntary, I suggest finding a way for more people to be involved. Maybe offer prizes or some sort of incentive to those who return the tests.	Speaking about compassion fatigue amongst team members. It allows for debriefing and also creates a 'safe place' to discuss issues, current and past.	I would like to see true processes implemented and followed through. I would like to see actual change occur.

II. There were outcome products involved in this project including an educational curriculum for ECC nurses and pre/posttest.

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

Evaluator A	Evaluator B	Evaluator C
As a staff member of the department, I took the pre-test, read the powerpoint presentation, and then took the post-test.	I did participate in the creation of the products, and I did partake in completing an evaluation.	I assisted with gathering the staff members and allowing the presenter a platform to help the staff members.

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

Evaluator A	Evaluator B	Evaluator C
I feel that the products were presented appropriately.	Develop a compassion fatigue seminar where nurses can vent, and resources can be provided for prevention and effective management.	I would like to see the follow through. Not so much the development, however the data after the implementation of a project that could help the staff.

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

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

Evaluator A	Evaluator B	Evaluator C
The team leader presented the project in the morning and evening huddles and thoroughly explained the details of the project. Everyone was provided a pre-test, allowed to review the powerpoint presentation, and then given the post-test.	The student was allowed access to the staff and was able to distribute evaluations with the goals of collecting meaningful data.	The student let the staff know the specifics of the project and what details she needed from them.

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

Evaluator A	Evaluator B	Evaluator C
She went to each person individually to answer questions and to provide clarification if needed.	The student was allowed access to the staff and was able to distribute evaluations with the goal of collecting meaningful data.	The leader followed up and answered appropriate questions that the students may have had.

IV. Please offer suggestions for improvement.

Evaluator A	Evaluator B	Evaluator C
The project was presented well and I feel that most of the participants were very receptive.	Staff should be in a forum type of setting so they can express why they feel they have experienced compassion fatigue, and how they, personally, managed the fatigue. This may promote awareness of the issues, give ideas for management, and hopefully, work as a	n/a

	preventative compassion fatigue, as well.	