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Compassion Fatigue among Emergency Department Nurses

Tracy Ann Petleski
Gardner-Webb University

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Compassion Fatigue among Emergency Department Nurses

by

Tracy A. Petleski

A capstone project submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

Boiling Springs

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Submitted by:

Tracy A. Petleski

Date

Approved by:

Mary Alice Hodge, PhD, RN

Date

Approval Page

This capstone project has been approved by the following committee of the Faculty of The Graduate School at Gardner-Webb University.

Approved by:

Janie Carlton, EdD, RN
Committee Member

Date

Reimund Serafica, PhD, RN
Committee Member

Date

Vickie Walker, DNP, RN
Graduate Program Chair

Date

Abstract

Title: Compassion fatigue among emergency department nurses.

Aim: The purpose of this capstone project, was to determine the prevalence of compassion fatigue among emergency department nurses.

Background: Healthcare workers especially nurses working in high acuity areas are at high risk for developing compassion fatigue, burnout, and secondary stress. A concern is nurses working in the emergency department are at risk for developing compassion fatigue and should be aware of the concept, self-care activities, and available resources to improve compassion satisfaction scores and to reduce the effects of compassion fatigue burnout, and secondary stress on nurses' working in stressful environments.

Method: The project was carried out at a large urban emergency department in a Level Two Trauma Center located in the Southeast United States. A total of 24 nurses working full time in the emergency department completed a one hour education module and a Pro QOL version, V Stamm (2009) questionnaire, (100%) of nurses completed the education module and questionnaire.

Findings: The nurses who chose to participate in this project completed the 30-item Pro QOL (Stamm, 2009) and self-scored as part of the education session. Raw scores were converted by the project administrator to t-scores after the education sessions using the raw score to t-score conversion table published by Stamm (2009) in the Pro QOL manual. Average to high compassion satisfaction was reported by 87.5% of respondents, while all participants reported average to high burnout and average to high secondary trauma stress. High burnout was reported by 29.2% of participants and high secondary trauma by 91.7% of participants. Male subjects reported higher levels of burnout and secondary

stress than was reported by the female subjects. Compassion satisfaction mean score was 53.25 (S.D. 9.07), burnout mean score was 53.54 (S.D. 5.43), and secondary trauma mean score was 65.83 (S.D. 6.87). There was no significant correlation between years of experience as a nurse and years of experience as an emergency department nurse on three different variables compassion satisfaction, burnout, and secondary trauma experienced by emergency department nurses. There was a significant correlation in gender. Male subjects reported higher t-scores than female respondent with burnout and secondary stress.

Keywords: Compassion fatigue, compassion, conveying compassion, qualities of compassion, self-compassion, burnout, and emergency department.

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CHAPTER I

Introduction

Workplace challenges that nurse face today can have long term negative consequences for the nurse and the patient (Dunn, 2009). The physical, emotional, and intellectual demands of contemporary nursing are far greater as patients are living longer with chronic illnesses and advances in technology create continual change. With these challenges, today's nurses are more likely to be exposed to secondary stress and are more likely to develop compassion fatigue in the workplace.

Compassion fatigue (CF) is a term originally coined in 1992 by a nurse manager working with emergency department nurses who had lost their ability to nurture patients (Cortzee, 2010). Figley (1995) described CF as the cost of caring for others experiencing trauma. He also characterized compassion fatigue as a secondary form of post-traumatic stress disorder (PTSD).

Young, Cicchillo, and Bressier (2011) found nurses are at risk for becoming emotionally dulled by their caring work. It is at this point when nurses learn to turn off emotionally to their patients that they are at risk for developing CF. Emergency Department (ED) nurses who consistently witness human suffering, pain, traumatic injuries, violence, and death are at high risk for developing CF. The intense nature of the relationships that occur between ED nurses and their patients can often become the source of CF as the nurse becomes both the witness to, and participant in, the patient's traumatic event (Rourke, 2006).

The literature reveals no nursing research on CF among ED nurses. Research exists on CF among oncology nurses, pediatric palliative care nurses, and social workers.

There has been no research identifying if secondary trauma is present among ED nurses. There is sufficient evidence to suggest that CF may be a workplace hazard for ED nurses who provide daily care to patients experiencing traumatic events.

Justification

All caregivers are at risk for emotional exhaustion from their work (Bush, 2009). Nurses are expected to be empathetic and caring towards patients and sympathetic to loss or death of a patient. The capacity for compassion and empathy is at the core of a nurse's ability to do the work; however, they may also become wounded by the work of caring (Stamm, 2009). ED nurses are at high risk of being exposed to secondary trauma and for the development of CF. Figley (1995) described secondary trauma as the consequence of caring for patients suffering from extreme emotional or physical pain, acute and chronic illnesses, and traumatic injuries. Edmonds and Hooker (2002) described CF as the process of "checking out" or distancing oneself from the emotional effects of being indirectly traumatized by caring for someone experiencing trauma. This secondary trauma can lead to physical or emotional symptoms interfering with the nurse's ability to provide care, sleep, concentrate, and enjoy life (Figley, 1995).

Compassion has long been identified as a core value in nursing (Duffy, 2009). Moses, Kolorutis and Ydarraga (2011) describe caring as an essential part of nursing practice. The researchers stated that caring is essential to the nurse's overall sense of well-being, emotional safety, and satisfaction. According to Patterson (2011), the absence of compassion in healthcare has been increasingly remarked upon.

Edmonds and Hooker (2002) states compassion fatigue is a form of burnout. This leads to feelings of guilt and distress in nurses who feel that they cannot rescue or save

their patients from harm or pain. Many ED nurses repeatedly find themselves immersed in the care of patients experiencing a traumatic event. They have no choice but to find a way to deal with the pain of others or dismiss that pain away into a maladaptive coping mechanism. The result is the ED nurse becomes distant when caring for patients; avoiding the pain and suffering of the very people that need the nurse the most.

It is exactly this sensitivity that makes the nurse vulnerable. Over time, compassion can exact an emotional toll on the nurse as caregiver; compassion comes with a price to the caregiver. Caring for others can deplete the nurse, leading to emotional, physical, and spiritual exhaustion. Nurses often care for others before caring for themselves; for example, putting off their need to take a break or eat a meal during their shift so that they can be available to meet the needs of their patients (Duffy, 2009).

Problem Statement

The purpose of this capstone project, “Compassion Fatigue among Emergency Department Nurses”, was to determine the prevalence of compassion fatigue among ED nurses. The capstone project will be a two-step process. In step one the project administrator will provide a teaching session to educate ED nurses about compassion fatigue and identify institutional resources available to the nurses. Recommendations will be made to identify positive lifestyles changes that will maximize the nurses’ ability to cope with the physical and emotional symptoms of compassion fatigue.

Significance

The social impact of CF is profound as patients value compassionate nursing care, yet concerns have been expressed in the literature that compassion is absent in current health care systems across the world. As more Americans face a difficult economy, a

shrinking work force, reductions in available jobs, and loss of insurance coverage, they are increasingly forced to seek primary care in EDs across the United States. Therefore, addressing CF among ED nurses is significant, as they cope with the increased numbers and acuity of ED patients.

Professionally, CF may have long term negative effects on ED nurses such as difficulty sleeping, concentrating, and enjoying life. Compassion fatigue may result in nurses leaving the ED to work in another patient care area or to leave nursing entirely. When nurses become aware of the presence and risks associated with being exposed to secondary trauma and the potential for developing CF, nurses can better prepare themselves to recognize it and effectively cope with the emotions related to caring for traumatized patients. Therefore, this project is significant in assisting ED nurses to recognize and minimize the effects of CF. Although CF among ED nurses may be not be preventable, the lasting effects of secondary trauma can be identified and a plan of recovery can be initiated (Joinson, 1992).

Project Questions

1. What is the RN working in the ED's self-perception of compassion, burnout, and stress related to secondary trauma?
2. What changes in lifestyle behavior do RN's working in the ED identify during a Coping with Compassion Fatigue session?
3. What is the effect of a Coping with Compassion Fatigue session for an RN working in the ED?

Definitions

Compassion

The word compassion is used frequently in hospital advertising, mission and vision statements, and nursing care delivery models, yet a clear conceptualization of the term compassion is lacking (Burnell, 2010). According to Diggins (2010), compassion is founded on recognizing the equality of another person; compassion leads to empathy, and empathy can enable the nurse to *feel* the needs of the patient. Compassion should be a spontaneous accepting of the patient as they are. Compassion is the foundation of the caring relationship, which results in trust between the nurse and the patient, who ultimately experiences the sense of being cared for, heard, and understood.

McHolm (2006) describes the ability to be compassionate as a desirable quality that contributes to establishing a trusting therapeutic effectiveness with patients. It is exactly this sensitivity that makes the nurse vulnerable. Compassion leads to empathy which enables the nurse to feel the needs of others. Compassion should be a spontaneous acceptance of the patient and response to their needs. It is the foundation of the caring relationship, which if present, results in trust between the nurse and the patient. The patient ultimately experiences the sense of being nurtured, feeling understood, and cared for by the nurse. The nurse's ability to be compassionate is a desirable quality that contributes to establishing a trusting therapeutic effectiveness with patients (McHolm, 2006).

Compassion Fatigue

Newsome (2010) defines compassion fatigue as the natural behaviors and emotions experienced by the nurse from caring and knowing about a traumatizing event experienced by others. Newsome described a growing body of research evaluating the true calling of nursing, long hours, stressful work environments, staff shortages, increased patient case loads, and the compelling need to help others. These all place nurses at risk for developing compassion fatigue, secondary stress syndrome, and burnout.

Compassion fatigue in nursing was first described by Joinson (1992) as an expanded form of burnout caused by the unique stressors and their effects on healthcare professionals caring for patients in post-traumatic stress disorder clinics and emergency departments. Compassion fatigue can lead to nurses experiencing underperformance, irritability, and somatic complaints such as headaches, sleep disturbances, and depression (Lester, 2010). Compassion requires the nurse to have self-awareness, to see others as human, to experience the pain and suffering of others, and to have the intention to alleviate that pain and suffering. Compassion Fatigue happens when nurses no longer have the desire or intention to alleviate pain and suffering of others. Bush (2009) described research of compassion fatigue in mental health nursing, oncology nursing, and in palliative caregivers. McHolm (2006) referred to compassion fatigue as a natural behavioral and emotional response that results from caring for patients' suffering from pain and trauma.

Secondary Trauma

Figley (1995) described Compassion Fatigue and secondary stress disorder as being equivalent to post-traumatic stress disorder (PTSD) and burnout. He referred to compassion fatigue as the cost of caring for patients in emotional or physical pain, with the price being the emotional toll that compassion can take over time. Caring for others can lead to emotional, physical, and spiritual exhaustion for nurses, who often care for others before caring for themselves.

Summary

The focus of this project is to identify compassion fatigue among emergency department nurses. Compassion fatigue among emergency department nurses is a concept first identified in the nursing literature during the 1990s. Joinson (1992) reported a concern about ED nurses who had lost their ability to nurture patients. According to Edmonds and Hooker (2010), compassion fatigue has been studied widely in non-nursing professionals, social workers, therapist, and counselors. Bush (2009) stated that compassion fatigue can be referred to as secondary posttraumatic stress disorder, vicarious secondary stress, secondary stress, and burnout.

During this project, “Compassion Fatigue among Emergency Department Nurses”, compassion fatigue will be examined to identify if emergency department nurses are experiencing compassion fatigue. An education program will be developed and presented to ED nurses on compassion fatigue, the possible physical and emotional symptoms of the phenomenon, and available resources will be provided for nurses to use to cope with compassion fatigue.

CHAPTER II

Review of the Literature

Compassion motivates many to pursue a career in nursing. Yet, a recent survey of hospital nurses revealed that one in four nurses would leave the profession if they could (Sturgeon, 2008). Nurses are faced with meeting the physical and emotional needs of patients, while trying to balance the increasingly difficult demands of the healthcare environment, including cost management, systems driven by patient satisfaction scores, and expectations for improved healthcare outcomes. Meanwhile, nurses providing direct patient care are more likely to become exposed to chronic systematic stressors while coping with the compounded stress of caring for others.

Duffy (2009) observed a shift in nurse's attitudes and level of practice, as nurses respond to the changes in their work environment, with the emphasis on the technical and managerial aspects of care rather than the delivery of care. This is significant as Duffy correlated a significant relationship between core nursing values and behaviors which can be linked to health care outcomes and nurses satisfaction scores. Meanwhile, the public is demanding better healthcare experiences and insisting that nursing provide more compassionate patient care. This trend has been reflected in the Johnson & Johnson campaign for nursing. It is this project administrator's interest to discover if CF is an identifiable problem in ED nurses as measured by the PRO QOL tool. The project administrator will measure the occurrence of CF in ED nurses and plan a teaching session to help nurses identify resources available to them and identify self-care activities to prevent future physical and emotional symptoms associated with compassion fatigue in emergency department nurses

Scope

The literature review revealed that the concept of compassion fatigue is not new to nursing. The only seminal article identified relating to compassion fatigue was published in 1992. The literature revealed a gap in the research, the current body of research is aimed at specific areas of nursing such as critical care nursing, hospice nursing, and pediatric palliative care. There were no articles about emergency department nursing facing the issue of compassion fatigue. The purpose of this literature review is to confirm the need for new research to support the foundation of a project aimed at identifying if emergency department nurse experience compassion fatigue. To identify lifestyle changes and to identify self-care behaviors aimed at the nurse's ability to reduce their perceived stress levels, adding to the retention rates of nurses in the emergency department.

A literature review (2008-2013) was performed using the following databases: EBSCO HOST, Cumulative Index of Nursing and Allied Health (CINHAL), OVID and Medline. Keyword combinations were: "compassion", "compassionate nursing care", and "compassion fatigue". The search terms 'in' and 'and' were used to narrow the initial search to: "compassion and nursing," and "compassion fatigue in nursing." Current evidence reveals that there is a lack of evidence or supporting research about CF in ED nurses. Articles containing the words "compassion" and "compassion fatigue" in the title were categorized and used including "compassion", "conveying compassion", "qualities of compassion", "self-compassion", and "compassion fatigue".

Compassion

Schantz (2007) examined the use and meaning of the term compassion by performing a concept analysis of the research using the terms caring, empathy, sympathy, and compassionate care interchangeably. The author used concept analysis seeking to clarify the meaning of compassion and to examine its relevance in the context of everyday nursing. Schantz performed concept analysis by specifically different terms used to describe nursing in the research. Comparing different terms and their meanings: caring, empathy, and compassion, Schantz found that when these terms are used interchangeably, the information is inaccurate and can compromise the validity of nursing research. Schantz suggested a link between compassion and humanity nurses must consistently demonstrate intentional engagement of compassionate behaviors in order for compassion care to be delivered. The use of the terms caring, empathy, sympathy, and compassion are uniquely different and should be used separately. Compassion empowers a person, whereas empathy is condescending and disassociates the nurse from the patient. Compassion should be recognized, internalized, and intentionally used in everyday nursing care.

Compassion was identified by Perry (2009) as the core value of nursing practice. If all nurses acted compassionately in the context of a caring relationship between the nurse and the patient, both parties would benefit from the therapeutic relationship. Perry insisted that staffing and nursing retention rates would improve if nurses could work in a clinical setting where compassion is valued, recognized, and encouraged. Compassionate nurses convey caring to patients by being with dying patients or by *anticipating* the

patient's needs, as both of these behaviors are consistent and reflective of compassionate nursing care.

Tuckett (1999) examined the benefits to the nurse, patient, and community as a result of receiving compassionate care. Tuckett described compassion as the internal goodness in nursing. The result is an intensive form of benevolence that is the foundation of compassionate care. The author further explored the relationship between the concepts of caring and compassion, as they relate to the story of the Good Samaritan. Nurses should demonstrate virtuous caring and intentional compassion as the center of every patient interaction.

Kret (2011) performed a descriptive study to analyze the concept of compassion by identifying compassion as a behavioral quality to be acknowledged, understood, and applied to medical-surgical nursing care. Kret defined compassion as the result of a deep and emotional therapeutic relationship between the nurse and patient. Compassion is a reaction to the patient's suffering, and therefore the nurse must be sensitive to suffering in order for compassion to be present. Caring is defined as the actions and activities directed toward assisting, supporting, or enabling a patient through the phase of illness. When compassion is experienced, it is the reflection of deep caring.

Sturgeon (2008) responded to the public outcry that nurses do not care about patients anymore. Sturgeon utilized a survey to ask patients to describe their experiences with hospital nurses. The author compiled data and developed the compassion index to measure nurses' behavior. Sturgeon suggested publishing the data on an official website set up for consumers of healthcare. The author acknowledged the difficulties and complexities associated with daily nursing practice, but desired to improve

communications between the nurse and patients. Sturgeon believes that patients are entitled to have expectations of their healthcare experience just like any other consumer based service.

Heffernan, Griffin, McNutly, and Fitzpatrick (2010) examined the relationship between self-compassion and emotional intelligence in nurses in acute care settings. They examined the relationships among well-being, self-control, emotionality, and sociability as the four factors that influence the nurses' ability to feel happiness and experience self-esteem. Heffernan et al. (2010) found the research subjects reported being cheerful and satisfied. Nurses who perceive themselves as high achievers reported lower impulsivity, demonstrated the ability to manage job stressors, and demonstrated higher social competency skills which allow them to influence others, making them better able to express compassionate care. Although there is little known about emotional intelligence and self-compassion in nurses, a positive relationship existed between these two concepts. The data supported the notion that lower patient satisfaction scores were correlated with nurses who reported lower self-compassion and lower emotional intelligence scores.

Torjuul, Elstad, and Sorlie (2007) interviewed 10 hospital nurses working in a surgical intensive care unit to determine if nurses were emotionally affected by providing care to surgical patients in difficult ethical situations. During interviews with nurses, the authors identified five themes with compassion being identified as a leading theme. Torjuul et al. (2007) concluded that nurses who expressed sensitivity to their patients' suffering increased their compassion towards their patients. The longer nurses are exposed to patients suffering, the more involved nurses became and the more difficult it

was for the nurses to separate themselves from their work experiences. The nurse must consider the suffering of another as a significant part of nursing care. If there is suffering without hope then nurses internalize the burden of providing compassionate care and internally lose focus of professional boundaries between patient and self and nurses take on patients' pain and suffering.

Cingel (2009) examined questions and contradictions of compassion and the different concepts that affect compassion, such as how compassion is defined, what motives must be present for compassion to take place, whether there is an issue of fault related to compassion, and whether compassion is an emotion. Cingel questioned why compassion is important to nursing and to patients who are suffering if compassion cannot take away suffering, and what conditions need to be present for a nurse to feel compassion. The author contended that nurses must have empathy and recognize suffering as a condition of compassion. Briefly, nurses must be able to set aside their own values and be able to recognize the seriousness of the suffering in order to assign meaning to the patient situation. Cingel described compassion as an emotion, strongly related to feelings which are difficult for the nurse to escape. Conditions of compassion were examined and found to be genuine only when the interests of others' suffering came first.

Compassion Fatigue

McCloskey and Taggart (2010) explored the experience of occupational stressors of pediatric palliative home care nurses related to the emotional demands of providing palliative care to children in a local community. Factors identified were the effects of continued exposure to prolonged emotional stress, being witness to constant suffering,

and loss when a chronically ill child dies. Nurses reported difficulties protecting themselves from repeated emotional injuries and trauma. The nurses reported seeing the parents of a former patient who had suffered and died while in their care as an example of recurrent emotional distress. McCloskey and Taggart (2010) explored the emotional consequences of stressors these nurses experienced including reported negative effects on professional and personal lives as a result of their work. The nurses in this study reported behaviors associated with compassion fatigue including mood swings, irritability, and disruptions in sleep.

Coetzee (2010) identified the categories of compassion fatigue, identifying the characteristics for each of the categories, constructing a connotative definition, and developing a case model with empirical indicators. The author established concept identification, definition, and analysis, suggesting the findings could be used for future research and education of nurses. Compassion fatigue is the final result of progressive and continued exposure to intense patient contact. Compassion fatigue is a cumulative process that results in the nurse developing compassion discomfort, which Coetzee identified as the nurse's inability to recover from the exposure to stressful events. Compassion fatigue is the stage when the nurse has exceeded the restorative process necessary to react to and deal with intense needs and is unable to provide compassionate care.

The consequences nurses face from caring work was explored by Sabo (2006). Compassion fatigue was identified as compassion stress, a term closely associated with secondary traumatic stress disorder used to diagnose and treat healthcare workers who become victim to the stressor nurses face every day. Compassion fatigue is a combination

of secondary trauma and burnout. A disconnect exists between the expectations in role performance and the failure of a healthcare system to support the nurse. Nurses exhibit signs of frustration, anxiety, and sleep disturbances which results in job strain. When the nurse is exposed to triggers of stress in the workplace, there is a manifestations of stress as evidenced by poor work performance.

Young et al. (2011) examined the relationship between burnout in high acuity intensive care nurses and step-down intensive care unit nurses. The authors found that nurses in the high acuity intensive care unit experienced more burnout than those nurses in the step-down unit. Young et al. (2011) also defined the term compassion satisfaction. They found that the nurses working in the step-down intensive care unit reported higher levels of compassion satisfaction scores than did the nurses working in the high acuity intensive care unit. The research findings revealed the environment in the intensive care unit affected the nurses and was perceived as being more stressful, with more complex technology and constant monitoring of both equipment and patient changes.

Bush (2009) performed a qualitative study examining the personal responses of one nurse's experience that described having prolonged periods of stress while at work. Bush identified that all caregivers are at risk for emotional exhaustion. The capacity to care is the very aspect that makes nurses vulnerable to becoming wounded by their work. The authors identified nurses working in oncology, burn centers, and trauma units as being at greatest risk for compassion fatigue. Nurses must practice self-care behaviors, such as establishing firm boundaries between self and patients, adjust their reactions to stressful events, and practice action-centered problem solving.

Aycock and Boyle (2009) identified three different interventions that were used by oncology nurses to reduce their risk for compassion fatigue. Oncology nurses were surveyed to identify different resources that were readily available to them in their current practice settings. The respondents reported that they had access to support groups, employee assistance, and discounted counseling services. Educational programs were identified to help nurses develop coping skills, use adaptation, and learn about emotional self-care. Specialized retreats offered coping skills, stress management, motivation, and inspiration to help oncology nurses reduce their risk of work-related compassion fatigue.

To explore the predisposition of middle age nurses for developing compassion fatigue, Frank and Adkinson (2007) interviewed a group of nurses on deployment caring for hurricane victims in Florida. The research findings revealed that nurses deployed for one to two week deployment periods of time were less likely to develop compassion fatigue than other nurses who were deployed for longer periods of time. The hurricane relief nurses all reported some level of stress related to the disruption in their personal or professional lives, the middle age nurses who had more life experience and seemed to have more effective coping skills reported less likelihood of developing compassion fatigue. Frank and Adkinson (2007) attributed developmental theories for the results of this study. Middle age hurricane relief nurses seems to adapt to the stressors associated with caring for victims of hurricane with less likelihood of compassion fatigue.

Gaps in Literature

There is a gap in the literature relating to compassion fatigue, specifically regarding ED nurses. Only one article was identified that sought to understand CF among emergency department nurses and the impact it may have on the ED nurses' ability to

provide basic care to patients suffering from emotional and physical pain, chronic illnesses, and victimized by trauma.

Strengths and Limitations of Literature

An abundance of literature was found related to compassion, compassionate care, and compassion in nursing. The project administrator identified one research tool available that could be used to measure the concept of compassion, while noting the absences of tools specifically designed to measure the concept of compassion fatigue in nursing.

Theoretical Framework

The Quality of Caring Model (Duffy, 2009) is a revision of Duffy's Quality-Caring theory which focused on the relationship between quality, caring, and human relationships. The Quality of Caring Model is a practice-based model which builds upon the Quality-Caring theory to describe a practice-based model of professional growth through research, professional practice, and understanding the importance of personal reflection.

The Quality of Caring Model assumes humans are capable of change and growth, evolving over time; humans exist in relationship to self, others, communities, nature, and the universe; and humans are inherently worthy. Further, it contends that caring is imbedded in the work of nursing; caring relationships benefit both those providing and receiving care as well as society; and caring relationships contribute to self-advancement of individuals, groups, and systems (Duffy, 2009).

In this model, humans interact with one another through relationships which evolve over time and include the environment. Caring relationships are necessary for

relationship-centered care which is grounded in mutual problem-solving, human respect, attentive reassurance, encouraging manner, and basic human needs. Since humans are multidimensional, they must pay adequate attention to self in order to care for others (Duffy, 2009).

In order for the nurse to care for self and others – patients, families, and others on the health care team – the nurse must practice self-care. The revised Quality of Caring Model describes mind-body intelligence as a model of self-care for the nurse. Only after the nurse practices self-care and intentional reflection can the nurse reach a state of a balanced self from which the nurse can care for self and others.

The concept of the nurse as caring for self was used to examine how CF among ED nurses affects the nurse as caregiver. Education will be offered to ED nurses on symptoms of CF and how it affects both care for self and care for others. The Mind-Body Intelligence (MBI) approach (Duffy, 2009) was presented to offer nurses insight on effective balancing of stressors in order to work more effectively with patients. Learning and practicing the technique of self-reflective analysis, engaging in self-care activities, and using the MBI model can deepen the nurse's sense of self-awareness. From this, the nurse can understand self, identify patterns, build confidence, change behavior, and ultimately become a more fully integrated human (Figure 1).

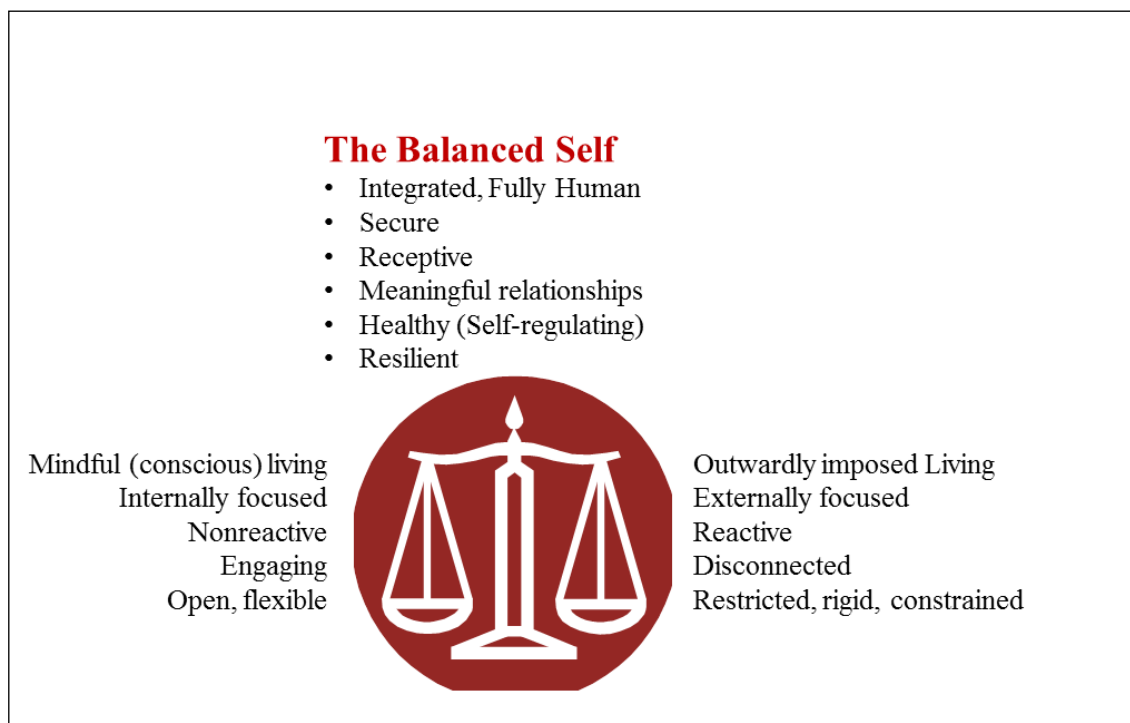


Figure 1. The Balanced Self

The theoretical framework for this study is outlined in Table 1. The metaparadigm was nursing practice with the philosophy of caring which is core to the nursing practice models at the hospital in this project. The conceptual model of compassion satisfaction and compassion fatigues were explored from the perspective of Duffy's Quality-Caring theory. Empirical indicators are the Professional Quality of Life (ProQOL) version 5, self-report of identified changes, and evaluation of the education program.

Table 1.

Theoretical Framework

Components	Components in Project
Metaparadigm	Nursing Practice
Philosophy	Caring
Conceptual Model	Compassion Satisfaction and Compassion Fatigue
Theory	Quality-Caring Theory (Duffy)
Empirical Indicators	Professional Quality of Life (ProQOL) version 5 Self-report of identified changes Evaluation of program

Philosophy

The tertiary care hospital setting for this project identifies nursing as: the nurse as a member of the healthcare team who, in collaboration with other members of the healthcare team, is responsible for: treatments, safety, and recovery of acutely or chronically ill individuals; health promotion and maintenance (Keyser, 2012). Following the recommendations of the Institute of Medicine and the Robert Wood Johnson Foundation to improve the quality of healthcare, this facility is in the process of transforming the way that nursing delivers patient care. The goal is to improve the overall quality of care, increase the retention rates of the nursing staff, and engage and improve the patient and families healthcare experience.

Concept

The revised Quality – Caring Model includes the concepts of relationships with self and others. The concept of the nurse as caring for self was used to examine how CF among ED nurses affects the nurse as caregiver. Education will be offered to ED nurses

on symptoms of CF and how it affects both care for self and care for others. The Mind-Body Intelligence (MBI) approach (Duffy, 2009) was presented to offer nurses insight on effective balancing of stressors in order to work more effectively with patients. Learning and practicing the technique of self-reflective analysis, engaging in self-care activities, and using the MBI model can deepen the nurse's sense of self-awareness. From this, the nurse can understand self, identify patterns, build confidence, change behavior, and ultimately become a more fully integrated human (Figure 1).

Theory

Joanne Duffy has been a nurse for 38 years. She has identified the great divide in nursing as quality and caring. Duffy (2009) discussed the notion of quality advancement as an evolving, dynamic process requiring continuous evaluation and learning. When caring is present, quality improves. Quality improvement and caring are presented as an interactional relationship process. The human, social process of relating, when performed in a caring manner, can change the context of a situation or a department, positively affecting staff, patients and families.

Empirical Indicators

The Professional Quality of Life Tool (Pro QOL) version 5 (Stamm, 2009) was used to identify the presence of compassion fatigue among emergency department nurses in a Level Two Trauma center in the Southeastern United States. The Pro QOL tool is a 30- item survey that measures the presence of compassion satisfaction and compassion fatigue. The identification of potential changes and class evaluation are tools developed by the project administrator to determine both class effectiveness and perceived usefulness of the program for further staff development.

Application of Theory to Project Design

Duffy (2009) describes structure, process, and outcomes in the Quality-Caring theory. Structure includes emergency department as provider, any emergency department patient as patient and the emergency department as environment and system. Process is caring relationships, which was addressed in the education session. Outcomes to be measured by using the Stamm (2009) Pro QOL tool are compassion fatigue and compassion satisfaction level (Figure 2).

Relationships with self and others are important for self-advancing theories. According to Butts and Rich (2011), caring relationships are essential for change, it is hypothesized that caring relationships with patients, families, and other healthcare providers benefit the nurse in terms of professional growth and work satisfaction. According to Roy (2000), understanding human consciousness, awareness of self and environment, and accountability for the integration of human and environment, the creative processes is basic to envision and plan for the future. Caring relationships are crucial for change to occur.

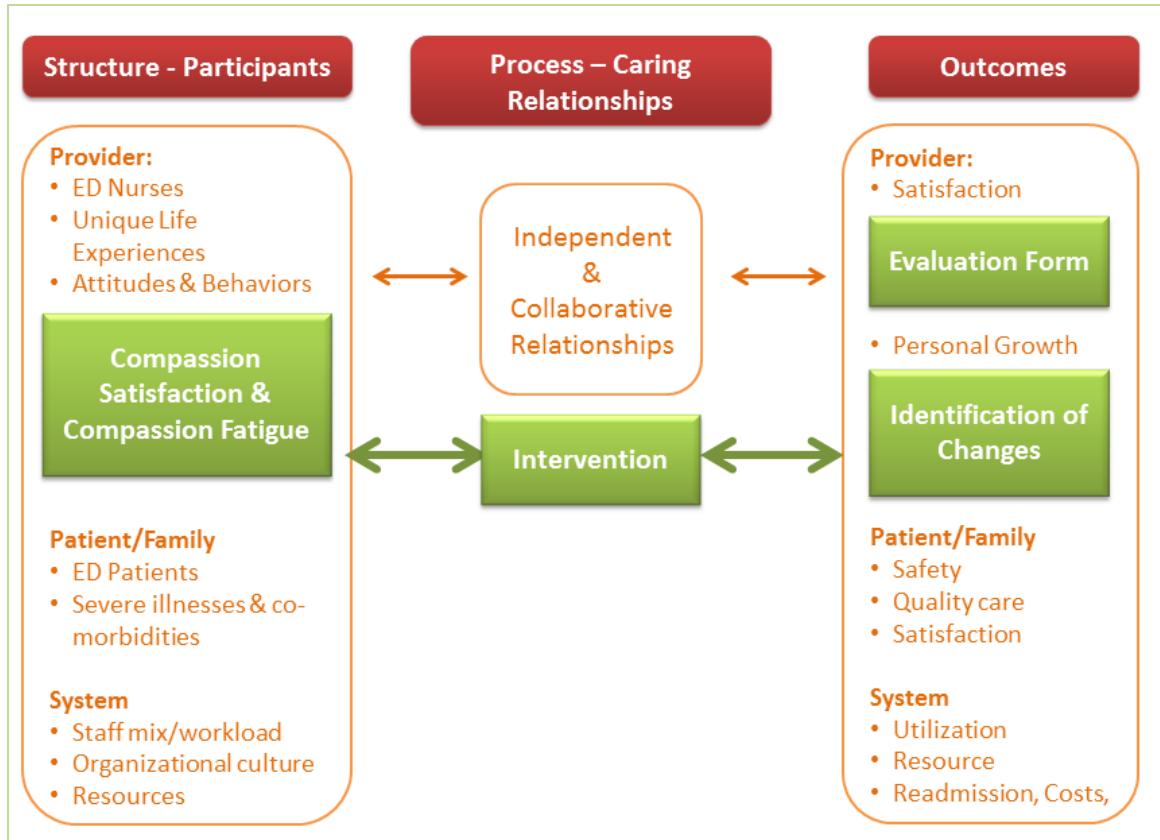


Figure 2. Application of Theory

Project Timetable

January – December 2012:

- Identify project chair, preceptor and content expert
- Literature review
- Submit proposal
- Create program content

May 2013:

- Finalize proposal
- IRB approval

- Present program

May- July 2013:

- Analyze data
- Write results
- Finalize Capstone Project document
- Capstone Project presentation
- Preparation for publication of results

Project Budget

The resources needed to conduct this project were a supply of paper to print questionnaires and fees for copying research tools. The project administrator received no funding, grants, fees, or incentives for conducting this project. The project administrator coordinated the teaching program and data collection.

CHAPTER III

Methods

Nurses have a duty to provide compassionate care for the sick, wounded, and traumatized patients in their care (Cotezee, 2010). Emergency department nurses are faced daily with caring for patients of trauma and violence, which may cause compassion fatigue (Newsome, 2010; Joinson, 1992) or secondary stress (Figley, 1995). Compassion fatigue may lead to nurses experiencing underperformance, irritability, or somatic complaints such as headaches, sleep disturbances, and depression (Lester, 2010).

This capstone project, “Compassion Fatigue among Emergency Department Nurses”, was intended to identify whether emergency department nurses experience compassion fatigue. A second purpose was to educate ED nurses during a “Coping with Compassion Fatigue” class about the possibility of developing compassion fatigue as a result of caring for patients experiencing traumatic life events, the emotional and physical symptoms associated with compassion fatigue and to develop self-care activities that can be implemented at the first sign of compassion fatigue. Finally, the project sought to determine if participating ED nurses evaluated the program as valuable to themselves or of potential value to other ED nurses.

Purpose

The purpose of this project, “Compassion Fatigue among Emergency Department Nurses”, was threefold. The first was to determine the proportion of compassion satisfaction, compassion fatigue, and secondary trauma in ED nurses before an education program about compassion fatigue; inform ED nurses about CS, CF, and ST; impart information about the balanced self so participants could identify potential changes in

behavior in response to identified compassion fatigue; and to evaluate the education program.

Setting and Subjects

Participants at an education program for ED nurses were invited to participate in this project at a large urban emergency department in a Level Two Trauma Center located in the Southeast United States. Invitations to the program included posted flyers and electronic mail to ED nursing staff. Those consenting to participate constituted a convenience sample for this project.

Ethical Considerations

This project was implemented with approval from the institutional review board at each facility involved in the capstone project: the enrolled university, the hospital where the capstone project was implemented, and the project administrator's university of employment. Consent for this project was obtained by the project administrator from each participant in the education program. All tools were kept anonymous with a random code known only to the participant. Tools were submitted to the school IRB chair upon completion of this capstone project. All data will be kept for 10 years in a secure, locked file in a locked office by the university. Data was entered into a password protected computer. Only the project administrator had access to the data. Confidentiality was maintained by the project administrator and data were stored in a locked file cabinet in the project administrator's home office.

Protocol Design

This capstone project used a non-randomized, quasi-experimental design to identify self-reported compassion fatigue, program evaluation, and identification of

behavior changes to decrease compassion fatigue. All tools were completed at the time of the educational program on compassion fatigue.

Step One

On the day of the educational session, a needs assessment was conducted by asking ED nurses to complete a survey on whether or not they experience any physical or emotional symptoms related to caring for patients in the emergency department. The survey was the Professional Quality of Life (Pro QOL) version 5 assessment tool (Appendix A). Nurses self-scored the Pro QOL using the Self-Scoring Guide (Appendix B).

Step Two

The education module included an introduction to the concept of compassion fatigue, definition of terms, identification of available resources, and lifestyles changes to balance work and personal life. Reference materials were distributed including the Pro QOL pocket guide for future reference (Appendix C) and an in-house resource list for those nurses needing further follow-up prompted by any information or discussion at the program.

Step Three

Upon completion of the education module, participants completed a demographic survey (Appendix D), an Identification of Changes tool (Appendix E), and an evaluation of the program (Appendix F), all of which were in an envelope with their Pro QOL survey. They were asked to seal the envelope and return it to the project administrator.

Step Four

Data analysis and statistical review were conducted

Step Five

Presentation and dissemination of data.

Instruments

Demographic Survey

The demographic survey (Appendix D) contained three questions: gender, years as a registered nurse, and years working in the ED. Descriptive statistics including means and standard deviations were calculated. Correlation statistics were conducted.

Professional Quality of Life Scale

The Professional Quality of Life Scale: Compassion Satisfaction and Fatigue version 5 (Pro QOL, Appendix A) and the Self-Scoring Guide (Appendix B) were developed by B. Hundall Stamm (2009) who grants full license to use these tools provided they credited, not altered, and not sold. The Pro QOL measures the frequency and the level of the nurse's response to a 30-item questionnaire about compassion and their related work experiences. Each item is scored using a five-point Likert-type scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, 5 = *very often*) in response to statements such as "I feel connected to others" and "I feel worn out because of my work as a helper".

Three constructs are measured: compassion satisfaction, compassion fatigue (also defined as burnout), and secondary trauma. Young et al. (2011) reported the alpha reliability scores on a sample of 463 heart and vascular intensive care nurses as follows: Compassion (.87), Burnout (.72), and Compassion Fatigue (.80). The construct validity of

the Pro QOL has been well established in the literature. The subscale intercorrelations are low, suggesting that the subscales measure three distinct concepts.

Identification of Change Tool

On the Identification of Changes tool (Appendix E), attendees listed three changes they intend to implement in the coming month. The changes could be based on those suggested in class materials or could be in their own words. The Identification of Changes tool was created by the project administrator for this project.

Evaluation of Program

The final instrument was an Evaluation of Program tool (Appendix F). Descriptive statistics were analyzed. The Evaluation of Program tool was created by the project administrator for this project.

Education Program

The project administrator presented a one hour teaching session, “Coping with Compassion Fatigue”. This class began with completion of a needs assessment using the self-scored Pro QOL.

The project administrator introduced the concepts of CS, CF, and ST, and the balanced life to promote CS and reduce CF. The group discussed potential lifestyles changes to balance work and personal life.

Reference materials were distributed. These included a laminated Pro QOL pocket card (Appendix C) for future reference and a list of in-house resource information for those nurses needing further follow-up prompted by any information or discussion at the program.

The project administrator remained available as a “silent witness” to all attendees whether or not they participated in data collection. Silent witness is a voluntary exercise for participants willing to share their experiences with compassion fatigue, as part of acknowledging their stories to assist the participants in the intentional self reflective analysis process.

Evaluation Plan

The evaluation process was a formative process during the course of the capstone project. As a part of the educational session, participants were asked to complete the Pro QOL tool. Following the educational session, plans were in place to repeat the Pro QOL in six months for summative evaluation. The data were statistically analyzed using IBM SPSS Statistics 21.

Limitations

A potential limitation of this project was that participants self-selected to participate may have had more motivation, expressed more optimism, and experienced better life-work balance than if the class was required and participants were not necessarily interested in the topic. Another limitation based on the voluntary nature of the teaching session was the potential for a small sample size.

Summary

The intentions of this project were to determine the extent to which emergency department nurses experience CF, CS, and ST; to offer an education program about compassion fatigue, the meaning and impact of compassion fatigue for ED nurses, and possible coping mechanisms; and to determine if ED nurses attending a program on

compassion fatigue perceive the program to be of value to themselves and potentially to other ED nurses.

CHAPTER IV

Results

Emergency Department (ED) nurses may experience compassion fatigue and secondary trauma from the intense relationships that ED nurses have with patients. The relationship between the ED nurse and the patient is vital as patients are experiencing suffering and vulnerability. If the ED nurse can develop a relationship of trust and confidence with the patient, the healing and spiritual needs of the patient are met. Compassion is a thread that unites people during times of suffering and distress. When ED staff experience CF and/or ST, this may negatively impact the potential for a caring relationship between the patient and the ED nurse.

This project included a needs assessment to determine the presence of compassion fatigue among ED nurses as measured by the Pro QOL; a one hour education offering; an opportunity for nurses to identify activities they plan to implement to improve work-life balance to potentially decrease CF; and finally an evaluation of the value of the class. The one-hour education session, “Coping with Compassion Fatigue”, included information about CS, CF, and ST, and the balanced life as described by Duffy’s Caring Model.

The questions to be answered by this project were:

1. What is the RN working in the ED’s self-perception of compassion, burnout, and stress related to secondary trauma?
2. What changes in lifestyle behavior do RN’s working in the ED identify during a Coping with Compassion Fatigue session?
3. What is the effect of a Coping with Compassion Fatigue session for an RN working in the ED?

Demographics

The participants included 24 emergency department registered nurses. Ninety-one percent of the subjects were female (N = 22) and eight percent of the subjects were male (N = 2). One nurse did not report years in nursing or years in emergency department. The other 23 nurses reported a mean of 9.13 years of nursing experience (standard deviation 10.56) with a mean of 6.78 years (standard deviation 6.98) in the ED (Table 2) (Appendix G & H).

Table 2

Participant Demographics

	N	Minimum	Maximum	Mean	SD
Years Nursing	23	1.00	40.00	9.13	10.56
Years in ED	23	1.00	29.00	6.78	6.98

Self-perception of Compassion Satisfaction, Compassion Fatigue (Burnout), and Secondary Trauma Stress

The nurses who chose to participate completed the 30-item Pro QOL (Stamm, 2009) and self-scored their responses as part of the education session. Raw scores were converted by the project administrator to t-scores after the education session using the raw score to t-score conversion table published by Stamm (2009) in the Pro QOL manual, which is published on the Pro QOL Internet website. For each measure, t-scores less than or equal to 43 are defined as low, t-scores between 44 and 56 are defined as average, and t-scores 57 or greater are defined as high.

Average to high compassion satisfaction was reported by 87.5% of respondents, while all participants reported average to high burnout and average to high secondary trauma stress. High burnout was reported by 29.2% of participants and high secondary trauma by 91.7% of participants (Table 3).

Table 3

Pro QOL Score Distribution

	Compassion Satisfaction		Burnout		Secondary Trauma	
	N	Percent	N	Percent	N	Percent
Low (t-score \leq 43)	3	12.5	0	0	0	0
Average (t-score 44-56)	9	37.5	17	70.8	2	8.3
High (t-score \geq 57)	12	50	7	29.2	22	91.7

The mean t-score for compassion satisfaction was 53.25 ($sd = 9.07$). The mean t-score for burnout was 53.54 ($sd = 5.43$). The mean t-score for secondary trauma was 65.83 (S.D. 6.87) (Appendix I, J & K).

There was also no correlation between female nurses and the three sub-scales while male nurses reported lower compassion satisfaction scores, and higher scores of burnout and secondary stress.

Identification of Lifestyle Changes

The intervention chosen for this project was a one-hour education session, “Coping with Compassion Fatigue”. The education included 10 activities to improve self-care and work-life balance. These activities potentially assist staff to cope more effectively with the compassion fatigue and secondary trauma associated with working as an ED nurse.

After the education session was completed, the participants were asked to identify three lifestyle changes that they would implement in the next two weeks to help them cope with working in the ED. The activities and themes are listed in Table 4. The themes most often identified by the subjects were: getting more exercise, meditating, deep breathing exercises, getting more sleep, increasing communication, going to lunch, and taking 15 minute breaks during their work day.

Table 4

Lifestyle Changes

Theme	Specific Activities Identified
Exercise	Running
Meditation	Yoga
Deep breathing	Cleansing Breaths
Sleep	Regular Sleeping schedule
Communication	Practice communicating
Breaks	Take break when offered

Evaluation of a Coping with Compassion Fatigue Education Session

Participants of the education session were invited to complete a course evaluation tool to determine the effectiveness of the class and their opinion on the value of the class to other ED nurses. Seven nurses completed written evaluations tools. Their responses to questions 1, 2, 3, 5, and 6 are summarized in Tables 5 through 7.

Table 5

Evaluation Responses-Question 1

Question	Responses
What will you do differently in your practice as a result of this educational session?	<p>Develop an awareness of the different concepts of compassion satisfaction, compassion fatigue, burnout and secondary stress that come along with caring for patients in the ED</p> <p>Be more aware of other peoples feeling and address changes to address their attitudes towards their work</p> <p>Work on anticipating changes and plan more effectively to deal with the changes during their shift</p> <p>Use more communication and identify the need to diffuse stressful events while working in the ED</p> <p>Take more time for self- care like taking more breaks</p> <p>Use delegation frequently</p>

Table 6

Evaluation Responses-Questions 2 and 3

What do you feel your strengths are after this presentation?	What do you feel your weaknesses are after this presentation?
Longevity	Lack of experience and practical knowledge
Experience as a nurse	Becoming stressed over uncontrollable events
Life experience	Doing too much and not delegating appropriate tasks to others
Compassion	Changing technology
Consistency	Responsibility of keeping up with current policies and best practice to be prepared to work in the ED

Table 7

Evaluation Responses-Questions 5 and 6

How can we improve this process of caring for patients in the Emergency department?	What additional education would you like to have in the future?
Hire more nurses	Coping skills
Work shorter hours	Team building
Take more breaks	Communication
Communication	Compassion fatigue
Team building	
Debriefing sessions	

The fourth question on the evaluation survey invited participants to identify the degree to which they would recommend this program to other nurses in the ED. The choices were based on a Likert-type scale with 1 = “definitely not”, 2 = “probably not”, 3 = “neutral”, 4 = “probably yes”, and 5 = “definitely yes”. The results were reported as definitely yes.

CHAPTER V

Discussion

Emergency department nurses are at risk of compassion fatigue, burnout, or secondary stress as a result of the intensity of the work environment. Although the literature highlights the presence of compassion fatigue in healthcare workers, a gap exists in terms of ED nurses and their self perceptions of compassion satisfaction, compassion fatigue, burnout, and secondary stress. This project demonstrated results consistent with the literature review in terms of validating the presence of compassion fatigue and secondary trauma among healthcare workers

The findings indicated gaps in literature between the male nurses in this project. Self-reported lower compassion satisfaction scores, and higher self- reported burnout scores and secondary stress scores indicating the need for further education and assessment of compassion satisfaction and compassion fatigue among male emergency department nurses. This project was developed to measure the presence of compassion fatigue among emergency department nurses..

Self-perception of Compassion Satisfaction, Compassion Fatigue (Burnout), and Secondary Trauma Stress

Nurses surveyed during this project were employed full-time as emergency department staff. The distribution of female and male (91% and 8% respectively) is reflective of the emergency department where this project was completed. Over 87% of participants reported average to high compassion satisfaction. However, almost one-third of participants reported high burnout and over 90% reported high secondary trauma stress related to their work as emergency department nurses.

These data are consistent with results in the literature which describe that nurses caring for patients experiencing illness, traumatic life events, and death are vulnerable to experiencing compassion fatigue, burnout, and secondary traumatic stress.

Identification of Lifestyle Changes

Participants were given the Pro QOL pocket card as a reminder to implement positive lifestyle changes. Nurses reported that they would implement three changes in the next two weeks. The changes most often identified by the participants are consistent with The Quality of Caring Model (Duffy, 2009) and the concept of life-work balance. These included: getting more exercise, meditating, deep breathing exercises, getting more sleep, increasing communication, going to lunch, and taking 15 minute breaks during their work day.

Nurses participating in this project commented on the importance of learning about the different concepts and how they affected their practice as ED nurses. Participants reported feeling surprised by learning the physical and emotional symptoms associated with these concepts and the easy steps they could take to improve their coping skills.

Evaluation of a Coping with Compassion Fatigue Education Session

Evaluation of the education program by participants underscored the concept and importance of personal reflection in Duffy's Quality of Caring Model. This model assumes that humans are capable of change and grow over time, and that humans exist in relationships to self, others, and communities. It is through caring relationships that nurses have with self and others that allow them to change.

Participants reported the importance of taking time to make a commitment to self-care activities away from work. They also reported feelings of relief and encouragement after the one hour education session. The relief was a result of learning that what they were feeling about their work was real. The encouragement was a result of their learning that they could change their sense of burnout or secondary trauma by implementing lifestyles activities to relieve the burdens of their work. Participants reported an awareness of having coping skills they could use to deal with the stressor of returning to work in a high acuity setting.

Participants identified several future learning topics. These included the request for more opportunities to learn about CF, burnout and ST.

Application to the Conceptual Framework

This project demonstrated support of the theoretical framework. All participants had average to high burnout and secondary trauma scores on the Pro QOL. Nurses who attended the “Coping with Compassion Fatigue” program learned about compassion fatigue, self-care activities, the importance of developing relationships with others, and the effects of caring for others on nurses. They were able to identify changes in self-care behavior they would implement and their personal strengths and weaknesses in that regard. They also evaluated the program as effective. The theoretical framework suggested that when nurses change their attitudes about self and others, they can improve their compassion satisfaction which would hopefully improve their care of patients.

Nurses participating in this project reported having a strong sense of mind-body intelligence and a stronger need for a balanced self, which is supported by the theoretical framework. They identified a relationship between self-reflection and self-care activities

with compassion satisfaction. The framework suggests that nurses must practice self-care before they can effectively care for others.

Male nurses reported higher self perception scores of burnout and secondary stress than did female nurses. Data reported by male nurses is an indication for the need of future education sessions and replication of this project. A replication project will help to validate these findings. Sprang (2009) surveyed a variety of healthcare workers across six states using the Pro QOL version IV, Stamm (2009) questionnaire and also found that male nurses reported significantly higher rates of burnout than did female nurses. These reports support the findings of male nurses in this project, reporting higher self perception scores of burnout and secondary stress than were previously revealed in the literature review.

The current literature provided minimal guidance on specific variables affecting burnout and secondary stress among male emergency department nurses. Sprang (2009) suggests that all healthcare workers who are repeatedly exposed to working in a stressful environment with minimal organizational support are more likely to experience burnout and secondary stress. Payne (2001) also correlated job stress as a strong predictor for burnout and secondary stress among male nurses which resulted in male nurses reporting higher turnover rates than female nurses.

Unanticipated Outcomes

Several unanticipated outcomes were observed. The first was the perception by the project administrator that the nurses attending the program were unexpectedly willing to discuss openly their feelings of compassion satisfaction, compassion fatigue, burnout, and secondary stress as a result of working in the emergency department.

Only seven nurses returned their written evaluation forms, which was an unanticipated limitation. However, nurses participating in this project verbally denied feelings of secondary stress from caring for patients who were experiencing stressful events. Rather, they reported experiencing feelings of secondary stress from other nurses' outward manifestation of stress and feeling secondary stress as a result of departmental stressors like overwhelming assignments, call outs, and short staffing.

Nurses attending the class did report experiences such as dreaming about work, feelings of dread before coming to work, frequent headaches, or gastric complaints. Before the class, they did not correlate these symptoms with compassion fatigue, burnout, or secondary stress. They verbally acknowledged this awareness as a result of the program.

A final unexpected finding was that the participants were so enthusiastic about participating in this project, they shared their experiences with other staff nurses who asked to participate in future Pro QOL surveys and educational sessions. The ED educator and clinical shift supervisors invited the project administrator to repeat the education session two more times the day of the project presentation. Data was not collected at these two additional sessions.

Limitations

Nurses participating in this project may demonstrate higher emotional intelligence than those who chose not to participate in the project. Nurses participating in the education session and survey seemed to demonstrate stronger professional inquiry and demonstrate a stronger desire for life-long learning. The issue of under-reporting may also have affected the findings of this project as the participants may not be

representative of all ED nurses. Identifying and applying these concepts to the role of the ED nurses' care was the most difficult for the participants involved. Participants were reluctant to associate their feelings and practice to theory and knowledge. Application of theory to practice seemed to be limitation of the participants.

The date and setting of the educational session was determined by the facility. The facility wanted the education session and data collection to take place in the ED so nurses could report to work immediately after participating in the project. The week of implementing the education session, the ED lost power and the air conditioning went out. This may have affected the willingness of nurses to participate due unfavorable classroom conditions.

Implications for Nursing

Nurses have a great potential for influencing healthcare outcomes. If nurses working in the ED experience compassion fatigue, burnout, and secondary stress from their work, this may affect their ability to care for patients in the ED. Nurses can develop self-awareness of compassion satisfaction, compassion fatigue, burnout, and secondary stress through an education program such as that offered in this project. Nurses participating in this project were also able to identify potential changes in behavior in order to improve compassion satisfaction and self-care in order to improve the care they provide patients in the ED.

Recommendation

The literature suggests that nurses working in high acuity areas experience more emotional exhaustion, sleep disturbances, and burnout as a result of their work. Compassion fatigue is progressive and accumulative for nurses working in higher acuity

areas. This project demonstrated that nurses can change the way they feel about their work, learn coping skills, and implement self-care activities that may reduce the risk of compassion fatigue. Nurses can also implement daily debriefing sessions and initiate weekly or monthly support groups to continue open lines of communication between staff.

This project suggests that education of nurses about compassion satisfaction, compassion fatigue, burnout, and secondary trauma is of value to high-intensity clinical areas such as the ED. Future programs have been requested at the same ED to assist nurses in learning about these concepts and lifestyle changes that can be implemented to reduce the emotional and physical effects that ED experience as a result of their work. Further validation regarding the appropriateness of the theoretical framework and intervention could be gleaned by conducting further assessment and evaluation of nurses working in the ED.

Conclusion

Nurses involved in this project demonstrated a willingness to be present and open during class discussions. Many of the nurses seemed to have a strong sense of internal foci of self care, while other others reported after the class that they wanted to make a stronger commitment to self care activities. Nurses reported wanting to learn more about balancing self and work, practice self-reflection, and engage in more self care activities. Nurses verbalized the link between understanding self and changing their behaviors to ultimately become a more fully integrated human better able to provide care to patients in a stressful environment.

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Appendix A

Pro QOL

Professional Quality of Life Scale (ProQOL)

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

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

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

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

Appendix B

Pro QOL Self-Scoring Guide

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

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

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about

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

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

You Wrote	Change to	the effects of helping when you are not happy so you reverse the score
	5	
2	4	
3	3	
4	2	
5	1	

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your ratings on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

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

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Appendix C

Pro QOL Pocket Card

CARING FOR YOURSELF IN THE FACE OF DIFFICULT WORK

Our work can be overwhelming. Our challenge is to maintain our resilience so that we can keep doing the work with care, energy, and compassion.

10 things to do for each day

- | | |
|-------------------------------|--------------------------------|
| 1. Get enough sleep. | 6. Focus on what you did well. |
| 2. Get enough to eat. | 7. Learn from your mistakes. |
| 3. Do some light exercise. | 8. Share a private joke. |
| 4. Vary the work that you do. | 9. Pray, meditate or relax. |
| 5. Do something pleasurable. | 10. Support a colleague. |

For more information see your supervisor and visit www.psychosocial.org or www.proqol.org

Beth Hudnall Stamm, Ph.D., *ProQOL.org* and *Idaho State University*
 Craig Higson-Smith, M.A., *South African Institute of Traumatic Stress*
 Amy C. Hudnall, M.A., *ProQOL.org* and *Appalachian State University*
 Henry E. Stamm, Ph.D., *ProQOL.org*

SWITCHING ON AND OFF

It is your empathy for others helps you do this work. It is vital to take good care of your thoughts and feelings by monitoring how you use them. Resilient workers know how to turn their feelings off when they go on duty, but on again when they go off duty. This is not denial; it is a coping strategy. It is a way they get maximum protection while working (switched off) and maximum support while resting (switched on).

How to become better at switching on and off

1. Switching is a conscious process. Talk to yourself as you switch.
2. Use images that make you feel safe and protected (switch off) or connected and cared for (switch on) to help you switch.
3. Find rituals that help you switch as you start and stop work.
4. Breathe slowly and deeply to calm yourself when starting a tough job.

Appendix D
Demographic Questionnaire

ID _____

Gender: ____ Female ____ Male

Years in Nursing: ____ years

Years in Emergency Department Nursing: ____ years

Appendix E
Identification of Changes

ID _____

Three things I will do in the next two weeks to care for myself or cope with stressful work in the Emergency Department:

1. _____
2. _____
3. _____

Appendix F

Evaluation

COMPASSION FATIGUE
Tracy Petleski, MSN
Gardner-Webb University
EVALUATION OF PRESENTATION

Please take a moment to answer the following questions. Your comments are an important contribution to my capstone project.

What will you do **differently** in your practice as a result of this educational session?



How likely are you to make this change? 1 = not at all likely 2 = not likely 3 = neutral 4 = likely 5 = very likely

What do you feel your **strengths** are after this presentation?



What do you feel your **weaknesses** are after this presentation?



Would you recommend this program to other nurses in the ED?

1 = definitely not 2 = probably not 3 = neutral 4 = probably yes 5 = definitely yes

How can we **improve** this process of caring for patients in the Emergency department?

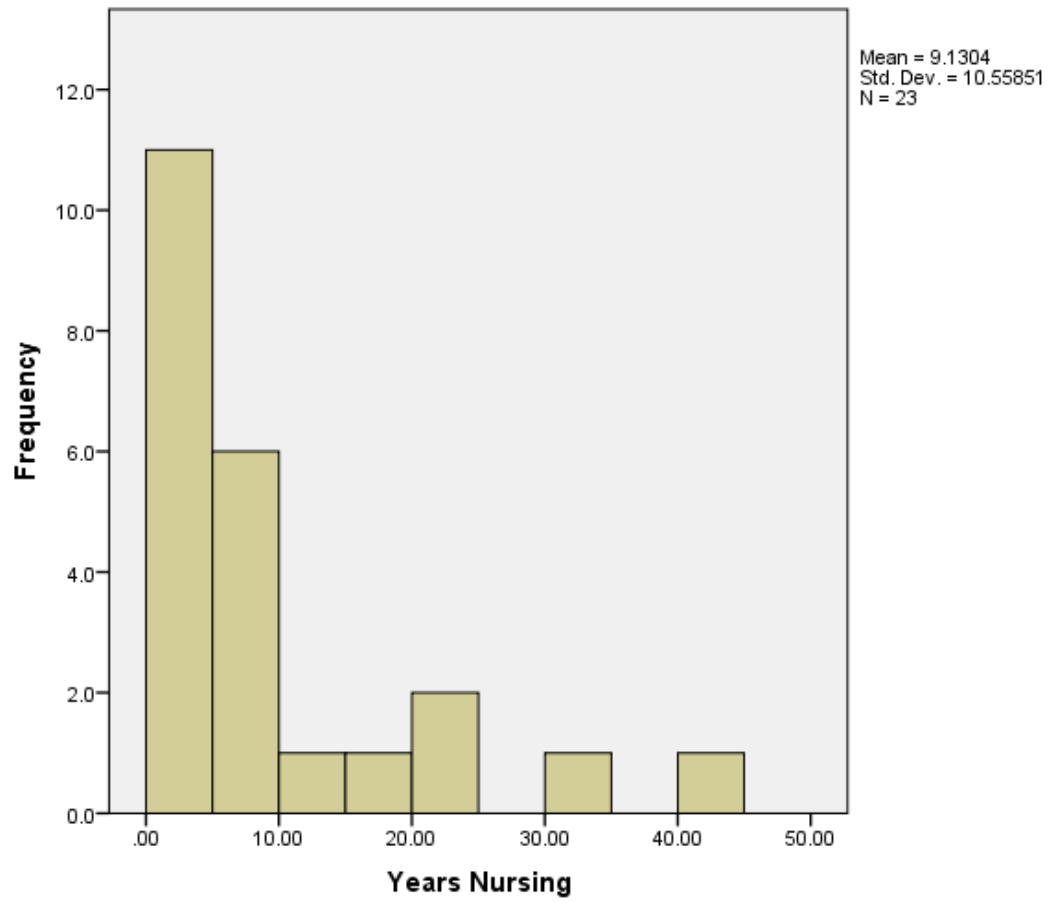


What **additional** education would you like to have in the future?



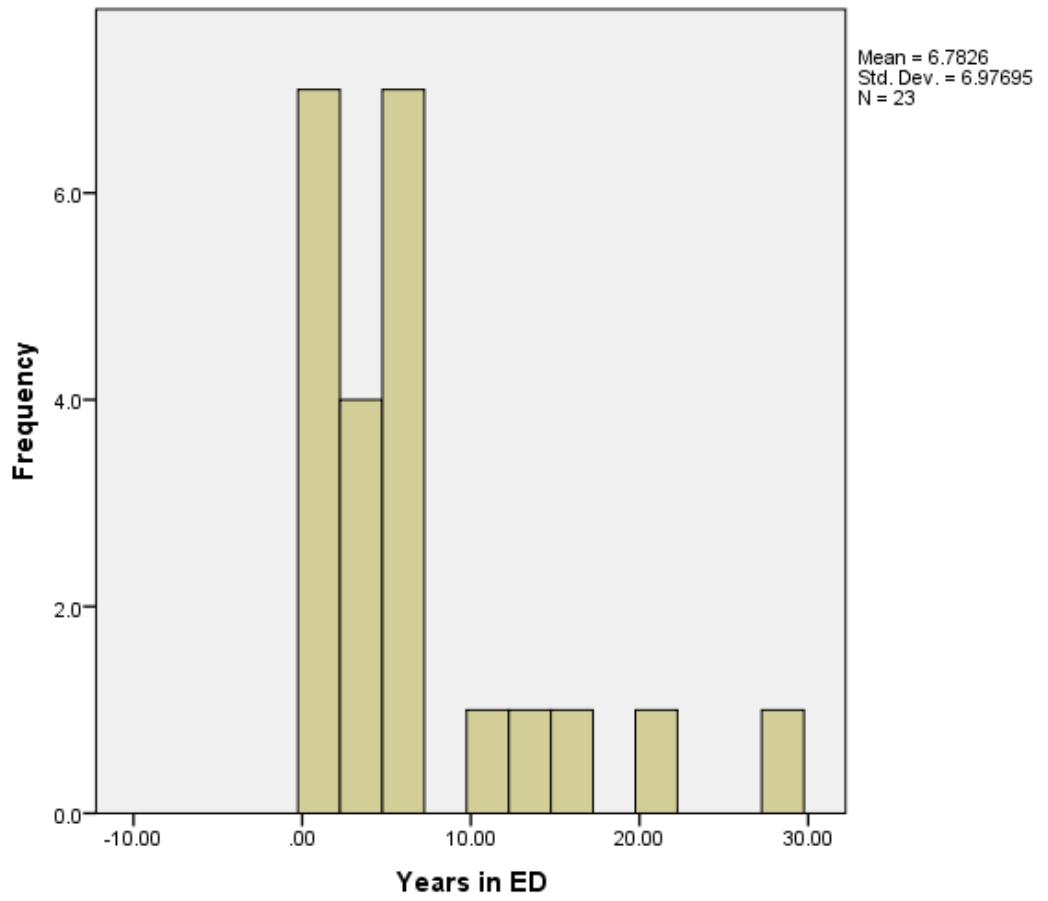
Appendix G

Years in Nursing



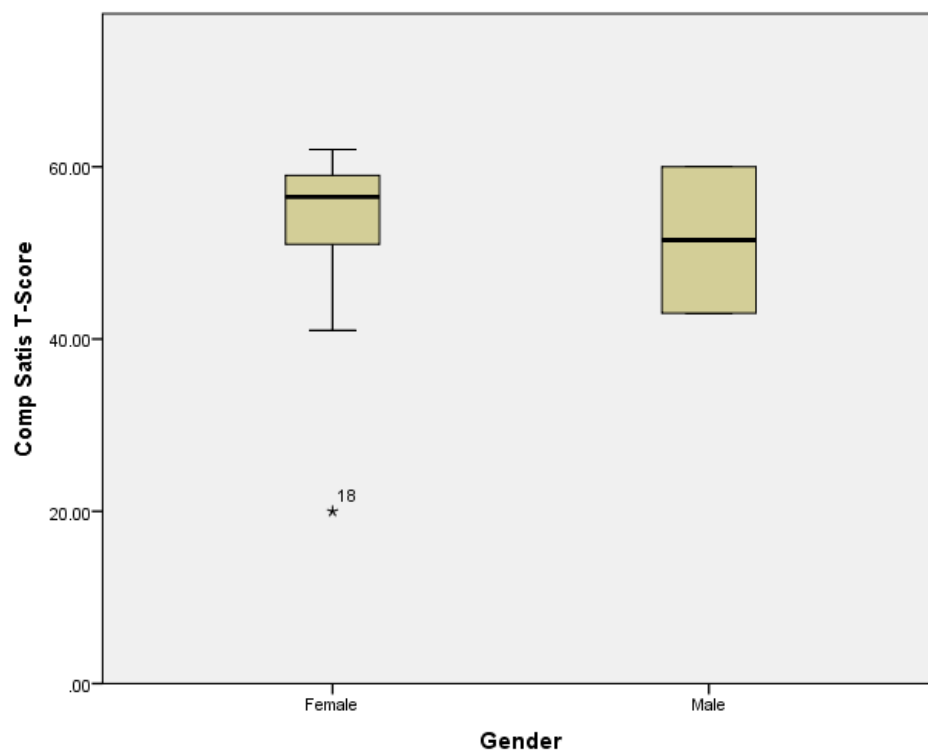
Appendix H

Years in Emergency Department



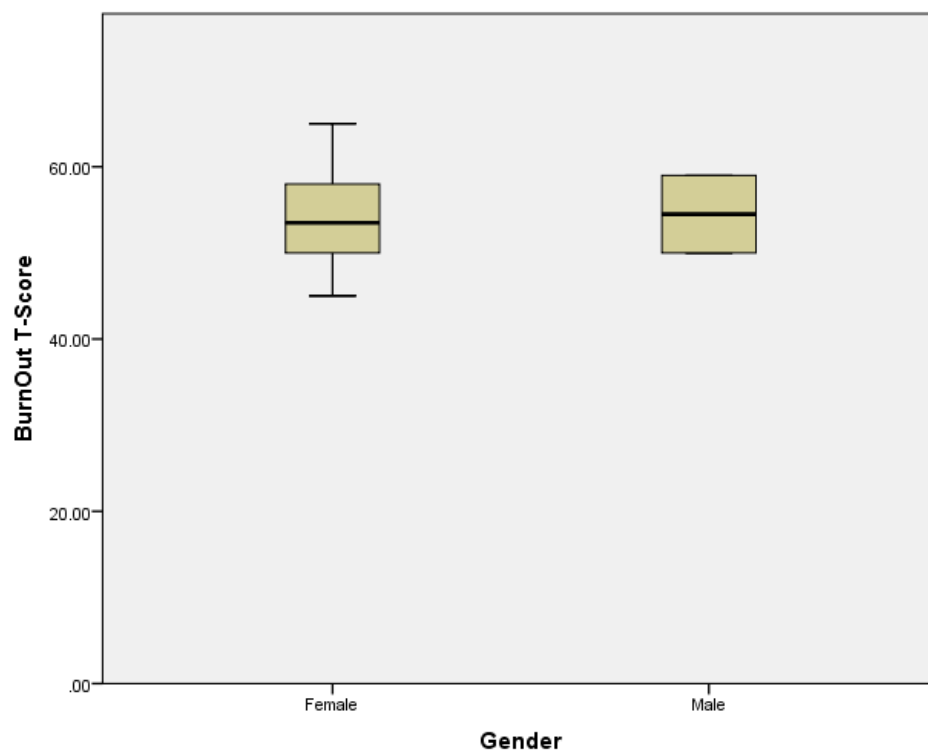
Appendix I

Compassion Satisfaction



Appendix J

Burnout



Appendix K
Secondary Trauma

