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Rekindling the Passion for Nursing

Susan M. Cannon
Gardner-Webb University

Rekindling the Passion for Nursing

by

Susan M. Cannon

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Submitted by:	Approved by:
_____	_____
Susan M. Cannon	Dr. Sharon Starr
_____	_____
Date	Date

Approval Page

This capstone project has been approved by the following committee members:

Approved by:

_____	_____
Elaine S. Haynes MSN, RN, NEA-BC, Committee Member	Date
_____	_____
Pamela Dellinger, PhD, MSN, RNC, NE-BC Committee Member	Date
_____	_____
Cindy Miller, PhD, RN Graduate Program Chair	Date

Abstract

Nurses often experience compassion fatigue and burnout when working in stressful environments. Nurses tend to put the needs of their patients above their own needs. It is imperative for the work environment to promote relaxation and restoration, to avert compassion fatigue and nursing burnout. All employees of the project director's organization were encouraged to attend Caring for the Caregiver Day, a hospital-sponsored event which provided education and promoted self-help interventions aimed to decrease compassion fatigue and burnout. The event included aromatherapy, music therapy, art therapy, pet therapy, massage therapy, and education on compassion fatigue for nurses. In addition, the Progressive Care Unit nurses were encouraged to utilize a created serenity room, a relaxing atmosphere equipped with massage chairs, aromatherapy, and soothing sounds. To evaluate the effectiveness, nurses were requested to complete the Professional Quality of Life Scale Version V questionnaire assessing burnout, compassion satisfaction, and secondary traumatic stress pre- and post-intervention. To evaluate employee engagement, the Press Ganey Employee Engagement survey was utilized. Engagement is demonstrated by employee behaviors, such as a willingness to go "above and beyond," energy and enthusiasm for their work, loyalty to the organization. The Press Ganey Patient Satisfaction survey assists organizations to understand and improve patient experience with significant benchmarking and actionable data to continually improve the patient experience.

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The heart of nursing is caring and compassion for those we serve and heal. McHolm (2006) described compassion as an emotion in which we enter into the world of the patient, becoming conscious of their distress and taking action to comfort them. However, nursing can be a strenuous, emotionally challenging, and stressful career. Compassion fatigue occurs when nurses give more vitality and compassion than they receive, and is exhibited as exhaustion in the physical, emotional, and spiritual realm (Frandsen, 2010).

Problem Recognition

Identified Need

In this project director's organization, the nursing unit with the highest daily patient census and patient turnover, was experiencing emotional exhaustion evidenced by disengagement and turnover of staff. The annualized turnover rate on the Progressive Care Unit for 2014 was 11.2. Seven teammates separated from the organization and 11 transferred from the unit within the organization. The employee engagement scores declined significantly from 2013 to 2014, from a tier one department to a tier two department based on Morehead/Press Ganey's Employee Engagement Survey. This means that work force engagement was solid, but there were opportunities for action planning that if addressed would create higher levels of engagement. The survey assessed the employee's perception of "the environment makes teammates in my department want to go above and beyond what's expected of them". The Progressive Care Unit scored 3.43 on a scale of one to five; with 23% unfavorable responses. This item was 0.55 points lower than the organization's score of 3.98 for this item (Press

Ganey, 2015). In addition, patient satisfaction scores were less than optimal according to Press Ganey results. For the question "Did staff address your emotional needs?" the scores remained below the target of 75 consistently for the past year. In regards to the "communication with nurses" domain (comprised of nurse's explain in a way you understood, nurse's treat you with courtesy and respect, and nurse's listen carefully to you), the organization's target was a score of 82.4 or higher. The Progressive Care Unit fell below target six out of the past 12 months (Press Ganey, 2016). The patient's perceptions are vital for the success of our organization and nurses.

When this project director questioned nurses about the increase in nursing turnover and low morale, nurses expressed feelings of being overworked, exhausted, inability to care for themselves due to the workload. One nurse stated "we are tired". Others stated "it's too much" and "we are burned out". Upon exploring the nurse's comments, compassion fatigue was evident by the "lack of desire, ability, and energy to care for others, lack of compassion satisfaction and compassion fatigue" ("I've fallen", 2012). Compassion fatigue occurs when caregivers do not have the time to attend to their own needs. They give of themselves during the long shifts at work and at home, allowing the stress to abolish their passion and foundation their profession is built upon (Bush, 2009).

A culture of caring is relationship centered, recognizing people are interdependent on others. Organizational values harmonious with a culture of caring are reflected in the mission and value. Value-based leaders help sustain a culture of caring, compassion, and collaboration (Faith, 2013). Burnout is alleviated, retention is enhanced, and patient care is improved when nurses feel supported and cared for (Peate, 2015).

The project director's organization recognized and prioritized efforts to alleviate compassion fatigue of healthcare workers: "We believe in the integration of peaceful spaces throughout our enterprise which will promote healing and alleviate suffering. Spaces are meant to be nurturing and therapeutic, which will reduce stress for our patients and for our teammates". The executive director of Spiritual Care and Education at the facility stated "compassion for the self is correlated with compassion for others, and most of the time it's not even a conscious thing. The more we allow ourselves to heal emotionally, mentally, and spiritually from stressful situations, the better we can treat patients and help others. ... caring, compassion, and empathy are antidotes to compassion fatigue" (Carl, 2015).

Problem Statement

For nurses on the progressive care unit at this project director's organization, what is the effect of self-care activities (Caring for the Caregiver education and use of a serenity room) on compassion satisfaction, compassion fatigue, and engagement scores for nurses on a progressive care unit?

Literature Review

Compassion Fatigue and Burnout

A study involved practicing clinicians in Haryana, India. The 60 consented participants were evaluated for compassion satisfaction, burnout, and secondary traumatic stress. The participants completed a semi-structured questionnaire to collect personal, professional, anthropometric, and metabolic information of the participants. The personal data included type of practice, working condition, emergencies, chronic care patients, elderly patients, and financial limitations. The anthropometric assessments

included height, weight, body mass index, waist circumference, waist hip ratio, and waist circumference to height ratio. The metabolic data consisted of fasting blood glucose, HBA1c, lipid profile, and blood pressure. The participants completed the Professional Quality of Life Scale (ProQol Version V), a 20-point questionnaire assessing burnout, compassion satisfaction, and secondary traumatic stress. A compassion satisfaction score below 40 and burnout score below 57 indicated the participant suffered compassion fatigue. Results revealed in the professional domain, the participants involved in the diabetology practice had higher burnout scores. Perhaps this association is related to the demands of patients with diabetes mellitus to achieve therapeutic goals. Patient education is vital for these patients and clinicians are extremely involved. Greater years of practice and those in private practice reported higher compassion satisfaction. Clinicians in reported unfortunate working conditions had more burnout and less compassion satisfaction. Personal, anthropometric, and metabolic data showed no significant correlation to burnout, compassion satisfaction, and secondary traumatic scores. The participant's gender, specialty, and percentage of chronic disease or elderly patients showed no significant correlation. Other factors significantly correlated to burnout and lower compassion satisfaction: young age, poor working conditions, government work settings, and financial constraints. Increased workloads of the clinicians predicted burnout and compassion fatigue. This study advocates for better work conditions, including staff working at the center, positive work environment, and newest equipment, to reduce burnout and compassion fatigue. Possessing effective ways to deal with chronic care patients have a significant impact as well as having financial satisfaction to ensure quality health care. The study also stressed the importance of

clinicians receiving stress management and coping skills to decrease burnout and compassion fatigue. Clinicians must care for themselves in order to provide care to patients (Bhutani, Bhutani, Bulhara, & Kalra, 2012).

Another cross-sectional study explored compassion satisfaction and compassion fatigue measured by the Professional Quality of Life Scale (ProQOL) self-report tool in a community hospital in the United States. The participants included 139 registered nurses, physicians, and nursing assistants who worked in a 250-bed community-owned, magnet-designated hospital in a northwestern region of the United States. The study explored differences in ProQOL scores among unit types, licensed and non-licensed staff, and stationary staff versus floating staff. The researchers also explored the relationships between sleep habits, shift rotations, years in the profession, marital status, and educational level and ProQOL scores. Results revealed a negative correlation between compassion satisfaction and burnout, negative correlation between compassion satisfaction and secondary traumatic stress, and positive correlation between secondary traumatic stress and burnout. Shift worked, average hours of sleep per night, average hours of activity per week, marital status, and working in a critical care area proved to be a significant predictor of compassion fatigue. Participants in the emergency department and critical care had lower burnout scores than those working on the general medical unit. Sleep was identified as a possible area of focus for reducing compassion fatigue. Night shift staff showed a higher association with burnout and compassion fatigue due to poor sleep quality. In addition, a good fit between the organization settings and personal values prove to be related to higher job engagement and less social dysfunction (Smart et al., 2014).

A study was done to evaluate a resiliency program designed to instruct oncology nurses on compassion fatigue. The study participants were 13 oncology nurses at Siteman Cancer Center, an outpatient infusion center, at Barnes-Jewish Hospital in St. Louis, MO. The nurses attended a five-session program consisting of five 90-minute sessions. After the third week of training, the participants attended a four-hour retreat. The resiliency program educated participants about compassion fatigue, including contributing factors and effects of chronic stress. Participants received instruction on self-regulation, intentionality, self-validation, connection, and self-care. The participants completed a set of questionnaires before, immediately after the program, and at three and six months following the program. These instruments measured compassion fatigue, job satisfaction, and burnout. The tools used in this study comprised of the Maslach Burnout Inventory (MBI) - Human Services Survey, the ProQOL, the Impact of Event Scale-Revised, and the Nursing Job Satisfaction Scale. The MBI is a 22-item survey measuring job-related feelings and is predictive of burnout. The ProQOL is a 30-item tool measuring compassion satisfaction, secondary traumatic stress, and burnout. The Impact of Event Scale -Revised (IES-R) is a 22-item survey measuring the participant's distress caused by a recent traumatic event. The Nursing Job Satisfaction Scale is a 28-item tool assessing the nurse's enjoyment and satisfaction with one's job. Prior to the implementation of the program, the MBI scores were below high risk. The ProQOL scores indicated participants were at high risk for burnout and secondary traumatic stress. Participant's age, number of years in nursing, and years in oncology did not show a significant correlation with the outcome measures. There was no significant difference in prior and post program MBI scores, however, scores for emotional exhaustion improved

immediately and six months after the program. The ProQOL compassion scores did not significantly change. Burnout scores decreased slightly after the implementation of the program, but not statistically significant. Secondary traumatization scores showed a statistically significant decrease at six months mark. The mean IES-R scores improved significantly at each time interval. The nurse job satisfaction scores remained variable but with no statistical significant change. The participants in the compassion fatigue resiliency program conveyed personal and professional benefits. The program proved great success for informing nurses about the impact of compassion fatigue, therefore the researcher reported the intention of examining the program can improve job satisfaction, decrease turnover, and improve patient satisfaction within the hospital (Potter et al., 2013).

A study explored the correlation between compassion satisfaction, nurse job satisfaction, stress, burnout, compassion fatigue, and nurse caring. Nurse caring is a predictor to patient satisfaction and the most significant element influencing advocating for patients. Maslow's Theory of Hierarchy of Needs and Watson's Theory of Human Caring served as the theoretical framework. A correlational study of 126 nurses was conducted at a 450 bed academic medical center in the southwest region of the US. Four valid research tools were utilized: the Mueller McCloskey Satisfaction Scale (MMSS), the Professional Quality of Life Scale (ProQOL), the Stress in General State (SIG), and the Caring Behaviors Inventory (CBI-24). Based on the CBI scores, the results indicated a moderately positive correlation between compassion satisfaction and nurse caring. There was a weak correlation between nurse job satisfaction and nurse caring. A statistically significantly weak correlation existed between stress and nurse caring, as

well as between burnout and nurse caring. Compassion fatigue was not significantly negatively correlated to nurse caring with the exception of negative correlation of knowledge and skill. Using MMSS scores, the researchers established a significant correlation between satisfaction with interaction opportunities (a subscale of nurse job satisfaction) and nurse caring. One can conclude practices aimed at enhancing compassion satisfaction and social engagement of nursing staff may also enhance nurse caring, as nursing is viewed as a purposeful calling which enhances the meaningful of life. Compassion fatigue is more prevalent among nurses in the acute care setting, especially for young, inexperienced nurses and is correlated to nurse burnout. Nurturing a nurse's internal motivation to care for others increases their caring behaviors, which in turn improves patient satisfaction (Burtson & Stichler, 2010).

The aim of another study was to study the incidence of symptoms of burnout and compassion fatigue and the role social supports plays in predicting these symptoms in 164 mental health nurses working in hospitals in Malayer, Iran. In addition to collecting socio-demographic data, the researcher used the ProQOL instrument to measure compassion satisfaction, compassion fatigue, and burnout. The multidimensional scale of perceived social support (MSPSS) tool was used to measure perceived social support from family, friends, and significant others. The study revealed 45.7% of the nurses surveyed were at risk for compassion fatigue and 15.03% at risk for burnout. In addition, 54.3% of emergency and 35.4% of non-emergency nurses suffered from compassion fatigue. Furthermore, 19.2% of emergency and 11.4% of non-emergency nurses were at risk for burnout. An opposite correlation between social support and burnout, but no significant correlation between social support and compassion fatigue. Social support

from family and significant other was negatively correlated to burnout. In addition, support from family was correlated to compassion fatigue. However, an opposite correlation existed between social support from friends and burnout. Nurses fall susceptible to stress because they are empathic due to their time with the patients, their emotional reserve, and frequent experience with loss. Emergency nurses could be at risk for compassion fatigue and burnout from working with victims or survivors. Their patients are frequently exposed to traumatized, injured, and dying patients. Social support plays an imperative role in the reduction of compassion fatigue and burnout symptoms in nurses. Family members play an important role in reducing the symptoms of compassion fatigue and burnout of hospital nurses, as they offer emotional support (Ariapooran, 2014).

A nonexperimental, descriptive, correlational design study was conducted to explore the effect of compassion satisfaction compassion fatigue, moral distress, and level of nursing education on critical care nurses' work engagement. Jean Watson's Theory of Human Caring served as the theoretical framework to focus on the nurse-patient relationship. The participants, 26 trauma intensive care nurses, completed the survey, consisting of (1) highest nursing educational level; (2) Professional Quality of Life Scale (ProQOL-5); (3) Utrecht Work Engagement Scale (UWES); and (4) a 7-item moral situations subscale called "not in the patient's best interest" from Mary Corley's Moral Distress Scale. All participants worked 12-hour shifts, either days, nights, or rotating shifts. Compassion satisfaction scores were average for 73% of the participants, whereas 27% scored high. There were no low compassion satisfaction scores. There was no difference between the nurse's worked shifts. Burnout scores were average for 58%

and 42% scored low. No participants scored high for burnout. Compassion fatigue scores were average for 38% of the nurses; while 62% scored low. There were no high scores for the secondary traumatic stress scale. The UWES work engagement was low, which reflected lower work engagement. The overall mean moral distress situations subscale score was elevated, indicating high moral distress. The results showed a positive correlation between work engagement and ProQol-5 compassion satisfaction scale. As work engagement increases, compassion satisfaction increases. As work engagement scores increase, burnout and compassion fatigue decrease. The evidence recommends nurses in clinical practice to implement tactics to reduce moral distress. These tactics include storytelling, debriefing, social gatherings, address unit issues such as staffing, conflict, supplies, and nurse-patient ratios. Caring for the caregiver is essential to the practice of nursing (Mason, Leslie, Lyons, Walke, & Griffin, 2014).

The incidence of professional compassion fatigue (PCF) amid hospice and palliative care nurses was explored. In addition, the effects of PCF and coping strategies were evaluated. The descriptive qualitative study used semi-structured one-on-one interviews with six nurses with 11-33 years' experience. The goal was to answer the following questions: Are nurses who deal with death and dying continually at risk of developing professional compassion fatigue? What are the physical and emotional consequences of continually dealing with death? Predominantly, the study showed without adequate coping strategies, the participants were likely to develop professional compassion fatigue. There was a definite risk for PCF with repeated exposure for deaths for an extended period of time. Therefore, nurses have a physical and emotional sacrifice for caring for hospice and palliative care patients. Nurses in this setting must possess the

ability to set boundaries and implement healthy coping strategies. Nurses must learn how to care for themselves. Their personal strategies for self-care included adequate sleep, healthy nutrition, exercise, and relaxation. Work-life balance is essential; non-work activities are crucial to rejuvenate the caregiver. Medication, deep breathing, self-reflection, use of humor, and massage are methods to maintain work-life balance. The nurse manager must be able to identify symptoms of PCF, as well as create a safe environment for the nurses to express their feelings (Melvin, 2012).

The purpose of this nonexperimental, cross sectional study was to conclude the correlation between compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals (FMHP). Researchers administered the Professional Quality of Life Revision IV (ProQOL), the Areas of Work Life Survey, Maslach Burnout Inventory-General Survey and a demographic data sheet to 169 participants. Ray, Wong, White, and Heaslip (2013) referenced previous research studies on CF, CS, and burnout to support their study. Austin, Goble, Leier, and Byrne (2009) established nurses who perceived themselves as experiencing compassion fatigue felt it affected their work performance. They found they were distancing themselves from family and having a cynical view about positive change. Abendroth and Flannery (2006) reported 80% of the hospice nurses they surveyed were at moderate risk for compassion fatigue. Yoder (2010) studied factors triggering compassion fatigue or burnout among nurses. They categorized the factors as caring for patients, system problems, and personal issues. Additionally, they studied triggering factors, including high census, heavy patient assignment, high acuity, overtime, and extra work days. Results of data from 280 Canadian mental health professionals, acknowledged as trauma

therapists, revealed therapists with past personal histories of trauma who worked with high caseloads of traumatized patients experienced high levels of compassion fatigue. Researchers Lee and Ashforth (1996) correlated supervisor and coworker support with lower burnout. Aiken, Clarke, Sloanne, Sochalski, and Siber (2002) confirmed elevated levels of emotional exhaustion and increased job dissatisfaction among nurses with high patient caseloads. Whereas, Janssen, deJonge, and Bakker (1996) reported emotional exhaustion or burnout was associated with a lack of social support and demanding work. Killian (2008) surveyed 20 social workers, psychologists, counselors, and marriage therapists regarding triggers correlated with work stress and compassion fatigue. The factors affecting CF were high caseload and demanding work schedules, personal trauma experience, access to their supervisor, lack of a supportive work environment, and lack of social support, optimism or cynicism perspective, and self-awareness of their own needs. Killian (2008) also surveyed 104 therapists using a questionnaire assessing social support, personal trauma, affective coping style, self-care strategies, burnout, emotional self-awareness, work environment stressors, and work exhaustion. The most predictive factor for compassion fatigue was lack of social support from family friends, and their community; working many hours with traumatized patients decreased compassion satisfaction, and having a sense of control in their work environment was associated with higher compassion satisfaction. This study correlated work environments with CF and CS. In addition, Ray et al. (2013) referenced studies indicating pleasure derived from work will diminish work stress, therefore preventing compassion fatigue and burnout. This study showed a correlation of compassion satisfaction and compassion fatigue to overall person-job match in the areas of work life (workload, control, reward,

community, values, and fairness) for frontline mental health professionals. Furthermore, the researchers found increased compassion satisfaction, lower compassion fatigue, and increased person-job match forecasted lower burnout (Ray et al., 2013).

A descriptive, cross-sectional survey of 153 oncology healthcare providers was conducted to explore the prevalence of burnout and compassion fatigue. Nurse Managers at a large national cancer center in Midwestern United States examined the issue of compassion fatigue among the staff. The Professional Quality of Life (ProQOLR-IV) instrument was distributed to all eligible staff to measure compassion fatigue, compassion satisfaction, and burnout. There was a significant correlation between compassion satisfaction and work setting. Staff of inpatient nursing units had the highest percentage of high-risk compassion fatigue scores. This result supports previous research indicating inpatient nursing units are particularly stressful. Inpatient nursing stress encompass higher patient acuity, more patient deaths, more complications of treatment and disease, and more severe clinical symptoms. Furthermore, inpatient staff are burdened with inadequate staffing and evening hours. Compassion fatigue and burnout scores were not significantly different between inpatient and outpatient staff. The limitation of this study includes small sample size, in particular a very small number of medical assistants and radiology technicians. The results of this study were used to support a program to meet the needs of the staff. The nurses were offered a series of four 90-minute training session and a four-hour retreat. The program is aimed to assist RNs to learn the skills to diminish their own compassion fatigue and burnout (Potter et al., 2010).

An additional study was conducted to identify available workplace resources to prevent compassion fatigue. The tool assessed three classifications: accessibility to on-

site professional resources, provision of educational programs, and retreat availability. There were 103 survey responses received from oncology nurses belonging to the Oncology Nursing Society (ONS). No participants indicated mandatory participation requirement of End of Life Nursing Education Consortium (ELNEC). However, 62 respondents conveyed availability to an employee assistance program (EAP). Participants indicated barriers to utilization of EAP such as delay between request and scheduled appointment time, and psychiatrist's lack of availability. Five percent of nurses reported the availability of support groups in their workplace. Eighteen participants reported no professional support was available in their workplace. Forty-five percent of the respondents reported no educational opportunities on coping, adaption, and emotional self-care were offered at their workplace. Thirty-one received sporadic educational offering. None of the participants conveyed their employer required mandatory education on nursing care of the dying (i.e. ELNEC), though 17% had ELNEC education as a resource. Eleven respondents confirmed access to online education on coping. Overall, an average of one or two in-services were available to staff annually. Results confirmed retreats were rarely offered to participants. Only ten participants reported access to annual retreats, whereas six reported sporadic access to retreats. Three participants reported a yearly retreat was mandatory at their work setting. Researchers suggest oncology nurses have different educational opportunities. New nurses should be made aware of the risk of emotional distress and the options to manage it. Training should include communication skills, conflict resolution, ethical issues, and self-care. These topics of education should be viewed as important as clinical skills, such as central venous catheter care and chemotherapy administration. Nurses should be

educated on the symptoms of compassion fatigue. They recommended an on-site counselor with opportunities for staff to discuss feelings and be assured they are not alone. Dedicated time with on-site pastoral care could benefit nurses. Retreats could also be beneficial for oncology nurses. Peer support has a positive impact on nurse retention, however it should not be the only resource for nurses in the work setting. To combat compassion fatigue for nurses, organizations must provide resources and better work environments (Aycock & Boyle, 2009).

Researchers set out to determine the predominance of compassion fatigue (CF), compassion satisfaction (CS), and burnout (BO) in emergency department nurses practicing in the United States, as well as to determine the demographic and work-related factors affecting the development of CF, CS, and BO. The researchers chose a nonexperimental, descriptive, and predictive study design utilizing a self-administered survey. A demographic questionnaire and the Professional Quality of Life Scale version 5 (ProQOL 5) were mailed to 1,000 emergency department nurses across the US. There were 284 questionnaires returned. The results indicated the older nurses correlated to higher levels of compassion satisfaction, whereas the younger the nurse, the higher the burnout score. Nurses reporting support from their manager had higher CS scores, as well as lower CF and burnout scores. Low to average levels of CF and burnout among emergency department nurses, however the researchers concluded healthy work environments, including manager support, recognition, and shared decision-making leads to nurse retention, reduced staff turnover, and increased job satisfaction. It is imperative to address support, strategies, and solutions to enable an increased level of work contentment among ED nurses. (Hunsaker, Chen, Maughn, & Heaston 2015).

Researchers replicated and expanded the Persky, Nelson, Watson, and Bent study of nurses effective in using Watson's Cartas framework. The finding of Persky et al. study (as sited in Berry et al., 2013) suggested poorer work environments are associated with higher levels of caring. This study occurred on medical/surgical units at a 400-bed hospital in Midwestern United States. The researchers surveyed 20 nurses and collected data from 10 patients per nurse. The nurses completed the healthcare environment survey (HES), which included demographic data as well as open–ended questions assessing what they like about their work, what creates stress for them at work, what makes them want to leave the organization, and what makes them want to stay. The patients were asked to complete the CFS, which is based on Watson's Caritas framework. The CFS assesses the patients' perception of nurse's caring and loving consciousness toward them as a whole person. Although Persky et al. found a negative relationship between the HES and CFS, this study revealed a positive correlation between the HES and CFS. As greater nurses' positive perceptions of their work environment, the higher patients' perception of caring. In addition, the researchers found higher scores on the workload dimension associated with higher CFS scores although Persky et al. reported nurses more frustration with their workload showed higher CFS scores. This study indicated nurses' healthy work environment will foster greater patient perceptions of Caritas irrespective of nurses' regularity in being effective in a Caritas framework (Berry et al., 2013). Scholars examined the physical and emotional cost of hospice/palliative care nurses caring for patients in their suffering and actively dying. These nurses experience emotions associated with guilt, dissatisfaction, letting patients down, and concern about not being there to support the patient and family when they are off. One nurse described the pain

and suffering of the patient having the ripple effect, even to the point it is difficult to discern between the patient's pain and her own. Nurses with professional compassion fatigue suffer physically, mentally, and spiritually exhausted, however they continue providing care to their patients. Resiliency is the process of developing the inborn self, motivational factor, or strength within. A nurse's resiliency has a positive effect on their ability to cope with stress, fall susceptible to illness, and restore themselves. Self-care strategies to address professional compassion fatigue and burnout are ample sleep, adequate nutrition, exercise, and relaxation. The ability of the nurse to distance themselves from the work environment is essential to healthy coping. The role of the nurse manager is to identify nurses suffering with compassion fatigue. It is the responsibility of the manager to establish the work environment. Nurses practicing at the bedside can benefit from educational programs focusing on personal coping strategies, developing caring communication styles, establishing boundaries, and resolving interpersonal relationships (Melvin, 2015).

Awareness to compassion fatigue with intervention achieves a healthy work-life balance. Schroeter (2014) defines compassion fatigue as physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress. Compassion fatigue affects nurse's job satisfaction and emotional and physical health, as well as the workplace environment by decreasing productivity and increasing turnover. Nurses are sometimes forced to put their feelings aside to care for critically ill patients. There are times a nurse experiences the patient's intense emotions as their own. If the nurse is unable to relieve stress, they can reach a critical point and experience compassion fatigue. Awareness is being in harmony with one's own needs,

limits, emotions, and resources. Nurses should be aware of how to refresh themselves. It is imperative for nurses to maintain a work-life balance. Connectivity is important for nurses to uphold; to be involved in family, work, community, social, friends, and religious faith. Interventions strategies to reduce compassion fatigue include schedule vacations regularly, attempt alternative therapies, go out to eat, pursue interests and enjoyments, encourage recreation and relaxation, schedule private time on a daily basis, and spend time with family and friends. It is essential for nurses to be aware of compassion fatigue symptoms and interventions. It is just as crucial for health care organizations to create healthy work environments to support nurses suffering from compassion fatigue, as well as allowing nurses to meet their personal needs as well as the needs of the patients (Schroeter, 2014).

Mendes (2014) explored how nurses experiencing compassion fatigue can renew their emotional energy. When nurses care for others regularly, if they do not take time to refill their emotional reserves, compassion fatigue ensues. Nurses often leave their workplace and go home to nurture their own families and find themselves emotionally fatigued. In addition, nurses put extreme pressure upon themselves to achieve a certain outcome and assume blame when it doesn't transpire. It is difficult for nurses to recognize compassion fatigue in themselves. Out of nearly 3,000 nurses in England, 40% were suffering from emotional exhaustion or burnout. The responsibility of managing stress with offering programs, resources, personal support, and education fall on the employer. Educating nurses about compassion fatigue, including tactics to do at work and home, is vital for the organization. The author reveals an organization's tactic to combat compassion fatigue by creating a "Watson room". Part of a room on the unit was

transformed into a decompression room with warm curtains, a rug, fresh paint and a comfortable chair. The room serves as a stress free zone, allowing nurses to decompress a few minutes at any time during their shift. It is vital for one to be aware of the risk of compassion fatigue and engage in activities to renew their energy (Mendes, 2014).

Needs Assessment

Literature Search

Work environment. Interventions to improve job satisfaction among employees at Florida Health Shands Hospital, Gainesville was explored. One of the greatest factors driving employee commitment and engagement is workplace culture. Results from the National Database of Nursing Quality Indicators (NDNQI) Registered Nurse (RN) Survey and Morehead Survey led to the formation of a focus group of post-anesthesia care unit (PACU) nurses. The survey results revealed opportunities for improvement. One of the interventions was to ensure staff members were offered a lunch break. The team created a serenity area, complete with massage chair, dim lighting, and a waterfall to provide an area for relaxation. Not all staff use the area although some staff like the room. The author states utilization may be greater if serenity area was off the unit. The role of Patient Ambassador was created to facilitate communication with patients and families, as well as call patients the day post-surgery. The team ensured the unit was free from bullying and unprofessional behavior. Peer interviews were initiated and training of peer interviewers was offered. In addition, fun activities, such as football Fridays, potluck lunches, and group outings. The unit had a team t-shirt designed to wear on Fridays. As part of the unit change, the team redesigned the area. Scheduling was adapted for job satisfaction, as educational opportunities were improved. Reward

programs included professional practice recognition practice, the DAISY award, and a nursing leadership fellowship program. Over a three-year period, the focus group worked on many initiatives to improve job satisfaction. The NDNQI and Morehead surveys improved, turnover increases initially and then stabilized, and retention rates increased. The authors described the culture as a satisfied, engaged team, where staff are active participants on the unit (Brunges & Foley-Brinza, 2014).

The value of recovery of two different break-time activities was evaluated. After eating lunch, the participants are asked to take a walk in a park, participate in a relaxation session, or spend their lunch break as usual (control group). The five research questions assessing how exposure to nature/relaxation during lunch breaks affect recovery processes, physiological health, work well-being, job performance, and creativity. Researchers assess the immediate effect (after lunch break), short term effects (end of the work day), medium effect (the evening before going to bed), and long term effects (effects in the morning a couple of days later during the intervention period, effects in the morning a couple of after intervention, during the first week and again after three weeks after the intervention. Recovery experiences are measured with an online questionnaire before and after the intervention, focusing on feelings and thoughts during the break related to relaxation, energy level and mental disengagement from work. Health was assessed before and after the intervention by asking the participants to rate their general health status using a Likert scale from one to ten. Physical complaints were measured using an abbreviated version of Physical Symptoms Inventory. Work engagement is measured using the Utrecht Work Engagement Scale. Fatigue is assessed by asking participants how often they felt tired during the day within the last month. Burnout is

assessed using the Finnish translation of the Maslach Burnout Inventory. Stress is assessed by asking participants to indicate their level to the statement: “Right now, at the end of my work day, feel stressed and tense”. General well-being was measured before and after the intervention, querying participants using “How happy do you feel in general” and “How satisfied do you generally feel about your life”. Additionally, participants are assessed four times a day using “I feel happy”. Sleep quality is evaluated using questions based on the Sleep Quality Index. Participants rate how they slept the night prior. Job performance is assessed by measuring task completion and concentration. Creativity is measured by the Alternative Uses Task instrument assessing fluency, cognitive flexibility, and originality. The researchers also measured physiological measures including saliva sampling and blood pressure measurements. The article described the development and design of a study intended to improve workers’ recovery during lunch breaks and examine work stress (Bloom, Kinnunen, & Korpela 2014).

Worker fatigue is an unfavorable sequence when workload-staffing imbalances occurs, leading to overtime, fatigue, staff burnout, turnover, and compromised patient safety. Risk of medication errors increases after eight hours of work, while increasing even more after 12.5 hours. Additionally, employee accident risks increase after nine hours, doubling after 12 hours. The Joint Commission has taken a stand, outlining interventions to safeguard worker well-being and patient safety. Among these interventions is implementation of evidence-based strategies, such as flexible staffing and staff education on sleep hygiene, including the risk of fatigue on safety (Rosenberg, 2014).

McClelland and Vogus (2014) recognized rewarding and recognizing compassionate acts and supporting nurses in coping with the stress experienced at work motivates the nurse-patient relationship and inspires nurses to respond emphatically to a patient's suffering. By supporting more holistic and tailored care, compassion practices promotes gratification with the caregiving experience and in turn, yields more favorable patient perceptions of quality of care. Practices supporting caregivers help manage the costs of compassion for caregivers such as compassion fatigue and nurse burnout. Without focus on these mechanisms to reduce exhaustion and workplace strain, organizations experience reduced productivity and nurse burnout, leading to less compassionate care to patients. Organizational practices help caregivers cope with the overwhelming demands of their work by providing them an outlet to deal with their emotions and provide support. Supporting the caregivers increases engagement and loyalty to the organization, as well as enthuses care providers to exhibit compassionate behavior. This study provided evidence to support the significance of specific managerial interventions to enrich compassionate care which leads to more positive patient perceptions of care and quality of delivered care. Exhibiting compassion reinforces compassion as an expectation that patients deserve. Compassion practices remained positively and significantly associated with Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ratings (McClelland & Vogus, 2014).

Integrative Healing Modalities

Aromatherapy. Aromatherapy or Essential Oil (EO) is considered an alternative medicine altering one's moods, cognitive, psychological, or physical well-being using a plant's aroma-producing oils. Oils from aromatic plants possess stimulating or sedatives effects. The scents affect the hypothalamus, the part of the brain with influences on the hormonal system. Additional medicinal properties of EO are antibiotic, anti-inflammatory, antiseptic, antidepressant, anti-asthmatic, antifungal, cellular protection, and diuretic. Aromatherapy can help support sleep, headaches, allergies, focus, pain, anxiety, depression, and hormone balancing. Essential Oils have an effect on one's mind and emotions, therefore all aromas have a potential emotional impact. Essential Oils are used in more than 50 hospitals to improve the smell of the hospital, raise the morale of workers, ward off infections, and cut down absenteeism. Vanderbilt Hospital used EO in the Emergency Room. Prior to their implementation of using oils, 41% of staff reported job stress and 60% reported job frustration. After using oils, 3% reported stress and 6% reported job frustration. Lavender relaxes body and reduces anxiety, relieves insomnia, reduces high blood pressure, and supports hormone balance. Peppermint can be used to improve focus, energy, and concentration. Using EOs daily can support emotional and physical health and helps achieve homeostasis (Friends & Tremblay, 2015).

Massage therapy. Does massage therapy reduce physiological and psychological stress of nurses working in an acute care setting? A randomized controlled trial was conducted in a 200 bed campus where 350 nurses were employed. There were 58 participants, whereas 30 nurses received massage and 28 served as the control group without massage. The intervention group received a full back massage using grape seed

oil, however the control group was requested to continue their customary work schedule meal breaks and personal lifestyle. Participants were asked to complete a questionnaire measuring the participants' perceptions of personal life events experienced the prior four weeks allowing researchers to assess predisposed situations affecting physiological and psychological stress. The measurements utilized for this study were the Spielberger State-Trait Anxiety Inventory (STAI) mean arterial blood pressure and urinary cortisol levels. Data was collected over a period of a five weeks. Additionally each participant was asked to supply a first morning urine specimen in the first third and fifth weeks to assess their cortisol levels. The researcher assessed the blood pressures of the both groups weekly, with the intervention groups' measurements occurring prior to massage. The results of the study revealed weekly massage therapy decreased anxiety levels in nurses compared to the control group. Conversely, massage therapy did not appear to have a physiological effect of stress. The researcher concluded offering weekly massages could impact psychological stress and nurse retention (Bost & Wallis 2006).

The effect of weekly 15 minute chair massages during the work shift of nurses working 12 hour shifts was assessed on an inpatient psychiatric inpatient unit. The 38 participants received a 15 minute chair massage once weekly for a 10 week period. The study utilized the Linear Analog Self-Assessment (LASA) scale to assess overall quality of life; overall mental physical, emotional, and spiritual well-being, as well as social activity. The researchers also applied the Perceived Stress Scale-14 (PSS-14) to measure perceived stress; the Smith Anxiety Scale (SAS) to discern between cognitive and somatic anxiety symptoms; and the Symptom Visual Analog Scale (SX-VAS) to assess level of anxiety relaxation, insomnia, alertness fatigue, tension/muscular discomfort and

pain, along with pain frequency of headaches, overall mood, energy level, and job satisfaction. The tools were administered at baseline five weeks and ten weeks. Amid the 38 participating nurses, 35 reported improved sleep and reduction of pain, headaches, tension, and stress. The results indicated the nurses were more relaxed and reenergized, as well as more satisfied with their job as a result of the massages (Engen et al., 2012).

A quasi-experimental study was administered at a Canadian residential care facility with high rates of sick time and musculoskeletal injuries (MSI). The 145 participants received a 20 minute massage weekly for four weeks in addition to their regular breaks during their work shift. Participants received six questionnaires, three pre-intervention and three post-intervention. The questionnaires consisted of questions relating to psychological and social work factors, derived from the General Nordic Questionnaire for Psychological and Social Factors at Work (QPS Nordic) which assesses organizational culture job demands, social interaction, and control at work. The participants were also asked to complete a brief pain inventory. This study indicated individuals with preexisting musculoskeletal signs and symptoms benefit from a massage therapy workplace wellness program. Short-term pain relief was also observed (Back, Tam, Lee, & Haraldsson 2009).

Art therapy. Does art-therapy-based supervision reduce burnout and death anxiety of end-of-life care workers? Art therapy allows expression of oneself through images and metaphors. Researchers used a quasi-experimental design involving 132 total supervised participants, 69 enrolled in a six-week, 18-hour art-therapy-based group and 63 enrolled in a three-day, 18-hour standard skill-based group. Assessments using the Maslach Burnout Inventory, Five Facet Mindfulness Questionnaire, and the Death

Attitude Profile was administered pre- and post-intervention. Participant group consisted of nurses, social workers, counselors, clergy, physical therapists, occupational therapists, and volunteers working in settings which deal with death dying, and bereavement. The study discovered both groups experienced a decrease in exhaustion, however the art-therapy-based supervision group was the only group with a significant reduction from baseline to post-intervention. Both groups had increases in cynicism, but only the skills-based group had significant increase. The results revealed art-therapy-based supervision can reduce burnout by decreasing exhaustion fostering emotional awareness and promoting comfort in thinking and talking about death (Potash, Y.Ho, Chan, Wang, & Cheng, 2014).

Pet therapy. How effectively cognitive-behavioral therapy (CBT) versus animal-assisted therapy (AAT) with cognitive-behavioral therapy (CBT) relieved stress in adults. The study comprised of 30 participants, divided into two groups, a CBT group and a CBT plus AAT group. Cognitive-behavioral therapy is a form of psychotherapy, with the purpose of developing skills. Animal-assisted therapy for this study is defined as an invention utilizing a dog to improve cognitive, physical, social, and emotional functioning of patients. The instruments used were the Visual Analogue Scale (VAS), evaluating the level of stress the participants perceived; the Perceived Stress Scale (PSS); the Patient Health Questionnaire (PHQ), to evaluate the severity of somatic symptoms; and evaluation of the final session. Participants attended five sessions. In session one, transactional stress was discussed with all participants. A relaxation technique was guided for both groups with the CBT group focusing on their breathing, while the AAT group was asked to focus on the dog's breathing. In session two, effective and

ineffective stress management was discussed. The CBT group was guided in relaxation exercise, while the AT group petted a dog during the guided relaxation technique. In session three, the participants identified automatic thought stress triggers and questioned those automatic thoughts. The CBT group wrote a negative thought followed by an alternative thought. The AAT participants were asked to comment on what could cause the dog (beaten, scolded, abandoned) to have a certain behavior (i.e. remain lying on the floor). They discussed the importance of automatic thoughts eliciting stress. Session four centered around cognitive restructuring. Both groups walked along a line representing the past, present, and future. The AAT participants had the dog walking beside them. Session five comprised of problem-solving skills. In the CBT group, the therapist discussed the decision-making process to use during a stressful situation. The AAT group worked with a handler, presenting an issue to the dog. The team discussed the process the dog used to solve the problem. The results of the study showed the presence of a dog was favorable for reducing stress in adults (Gonzales-Ramirez, Ortiz-Jimenez, & Landero-Hernandez, 2013).

Music therapy. A randomized crossover controlled trial with 54 nurses was used to evaluate the effects of music on stress levels and the association between stress and preference of music. The participants were randomly assigned to a music/chair rest sequence or chair rest/music sequence. Those in the music condition listened to self-selected soothing music on headphones for 30 minutes as those in the rest condition sat quietly for 30 minutes. Measurements included heart rate, mean arterial pressure, finger temperature, and cortisol levels of the participants every 15 minutes during the intervention. Results indicated music has a beneficial effect on stress of nurses, with the

most dominant factor affecting vital signs was the listener's musical preference. Participants listening to music had lower professed stress levels, cortisol, heart rate, mean arterial pressure, and higher finger temperature. Researchers promote listening to soothing music as a stress reduction intervention for nurses (Lai & Li, 2011).

Colors and employee stress reduction. Colors have the ability to influence moods and reduce stress for workers. Violet is the most relaxing color; decreasing blood pressure, pulse, and respiration. Violet is better as an accent color, as violet alone is too strong. Blue has been named as the best color for break areas, as it decreases blood pressure, pulse, and respiration as well. It is the color of choice for most people, followed in status by red, green, violet, orange, and yellow. Blue helps to treat headaches, hypertension, and insomnia. Green falls in the middle of the stress reduction spectrum, as several hues of green are enjoyed by most people (Ward, 1995).

Population/Community

The project's site is a 101-licensed bed acute care facility located in a rural community with a population of 79,829 (US Census Bureau, 2015). The Progressive Care Unit is a 38-bed unit staffed with registered nurses, certified nursing assistants, and healthcare technicians. Only registered nurses were surveyed for this project.

Sponsor/Stakeholders

Key stakeholders for this project included the nursing team, Clinical Supervisors, Nurse Manager, and Assistant Vice President of the Progressive Care Unit. Other stakeholders are the senior administrative team and patient experience coordinator with responsibility for patient satisfaction results. Patients and families may benefit from caring, compassionate care delivered by the nursing team post-intervention.

Organizational Assessment

Values of the organization. This project director's organization recognizes employees as the most valuable asset and identifies four core values successful employees need to strive for to accomplish the mission.

- Caring**:** Treating customers with dignity, giving them the courtesy and gentleness they need. Being helpful, listening, communicating, and responding to patient needs.
- Commitment: Dedicated to the organization, taking pride in our organization and our jobs, projecting a professional image and striving to be the best in all aspects.
- Integrity: Honoring and upholding confidentiality, being honest and ethical, keeping commitments, accepting responsibility for actions and respecting the rights of patients, families and each other.
- Teamwork**:** Linked by a common mission, the organization respects the professionalism and contributions of coworkers, understands physicians are an integral part of the team, values diversity in all its forms and recognizes people are our greatest assets.

These values are consistent with the values of this project and the project director.

Mission and vision of the organization. The mission of the project's site is to create and operate a comprehensive system to provide healthcare and related services, including education and research opportunities, for the benefit of the people served. The vision is "to be recognized nationally as a leader in the transformation of healthcare delivery and chosen for the quality and value of services provided".

Strengths, weaknesses, opportunities, and threats. Strengths included supportive culture, a supportive leadership and administration, interdepartmental partnerships, and being a small community-based hospital. Weaknesses consisted of less focus on employees, large size of the nursing unit, lack of layers of leadership, fatigued leaders, lack of recognition of compassion fatigue, lack on education on compassion fatigue and self- management, and declined employee engagement scores. Opportunities comprised of available resources from CFC (Compassion fatigue champion), outside resources willing to assist, a serenity room created at another facility, and pet therapy program in progress. Threats were financial constraints, healthcare reform, and life safety standards. (Figure 1)

Strengths • Supportive culture on unit • Supportive leadership/administration • Interdepartmental partnerships • Small community-based hospital • Pet therapy program in progress	Weaknesses • Focus on results, as opposed to employees • Large size of unit • Lack of layers of leadership • Fatigued leaders • Recognition of compassion fatigue • Lack on education on compassion fatigue and self- management • Decline in employee engagement scores
Opportunities • Resources available from hospital system (Compassion fatigue champion) • Outside resources willing to assist • Serenity room created other CHS facility •	Threats • Financial constraints • Healthcare reform • Life safety standards (define)

Figure 1. Strengths, Weaknesses, Opportunities, and Threats

Available Resources

The setting for the serenity room was on the staff lounge on the nursing unit. An area of the room was utilized and separated with a decorative room divider. The nursing team chose this location because the lights could be dimmed, it is on the nursing unit, and utilized frequently. The location for the hospital-sponsored event "Caring for the Caregiver" was in a large meeting room/ classroom located in the Medical Office Plaza adjacent to the hospital.

Desired Outcomes

The project leader desired for the nursing team of the Progressive Care Unit to rekindle their passion for caring for others. Following the implementation of the project, it was anticipated the nursing team would feel improved compassion satisfaction; less compassion fatigue and nurse burnout; as well as increased Tier levels on the employee engagement scores and communication with nurse's patient satisfaction scores. Optimistically, nurses would also identify self-help tactics to combat stress outside of the work environment. The nursing team expressed excitement about having an area designated for them to relax and de-stress during their hectic work day. This project director was optimistic about the improvement of employee engagement scores overall and on the item related to their work environment. In addition, patient satisfaction was predicted to improve for communication with nurses, as well as for the question, "did staff address your emotional needs?"

Team Selection

All team members were employees of the project director's organization. The Director of Workforce Development served as the practicum partner and assisted with

project implementation. The Vice President of Patient Services served as the administrative representative, as well as served on the committee. The team also consisted of the facility chaplain, nurse manager, and clinical supervisors of the Progressive Care Unit. Various nursing team members of the Progressive Care Unit participated as needed for decision making in product and decoration selection.

Cost/Benefit Analysis

Serenity Area:

- Relax vinyl wall decal.....$30.00
- Createforlife Home Decoration Vinyl Wall Sticker Decals Mural Art Purple Butterflies and Blossoms $16.00
- Butterfly Vine Flower Wall Art Stickers.....$9.00
- Homedics Incorporated Sound Spa Portable $30.00
- HoMedics Massaging Lumbar Support Rest, Black (battery).....$22.00
- Conair Massaging Back and Seat Cushion (battery) $45.00
- NaturEarth French Lavender oil (4 oz).....$22.00
- Boutique 1583 Mechanical Owl 60 Minutes Kitchen Cooking Timer.....$12.00
- Aromatherapy Top 6 100% Pure Therapeutic Grade Basic Sampler Essential Oil Gift Set (Lavender, Tea Tree, Eucalyptus, Lemongrass, Orange, Peppermint).....$27.00
- 4 panel Cherry Blossom Design Room Divider, 4-panel, black.....$72.00
- Flameless candles, CD player, Spa CDs (donated)..... no cost

The total estimated cost for the intervention was $285.00. In comparison, the average cost of nursing turnover in the United States is $20,561.00 per nurse (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014).

Scope of Project

The purpose of the project was to increase compassion satisfaction, decrease compassion fatigue and burnout among the nursing team of the Progressive Care Unit and improve employee engagement and patient satisfaction scores. In order for the nursing team to be engaged team members and provide compassionate care to their patients, they must have a healthy, reenergizing work environment. Expectantly, fulfilled care providers may remain with the organization, providing the best care to the patients. In turn, nurse satisfaction scores, as well as patient satisfaction scores may increase. The return on investment was in meeting the organization's goals.

To promote compassion satisfaction and reduce compassion fatigue, this project director created a serenity area. Additionally, nurses were encouraged to attend "Caring for the Caregiver Day", a hospital-sponsored event which educated and promoted self-help interventions to decrease compassion fatigue and burnout. The event included aromatherapy, music therapy, art therapy, pet therapy, massage therapy, and education on compassion fatigue for nurses.

Goals, Objectives, and Mission Statement

Goals

The goal for this project was to increase compassion satisfaction, decrease compassion fatigue and burnout among the nursing team of the Progressive Care Unit and improve employee engagement and patient satisfaction scores by providing

educational resources and improving the work environment. When compassion fatigue and burnout are addressed, job satisfaction may improve and nurses may be better equipped to deliver caring, compassionate care to their patients. It remains vital for the nursing team to relax, rejuvenate, and de-stress during their work day. When nurses feel cared for, they are be more likely to treat others with caring and compassion. Self-management when caring for others remains important to allow revitalization of the caregiver.

Process/Outcome Objectives

- Nurses would demonstrate increased compassion satisfaction, decreased compassion fatigue, and less secondary stress trauma as measured by their pre- and post- intervention scores on the ProQol V survey
- Nurses would demonstrate increased employee engagement as measured by the Press Ganey employee engagement scores on item "the environment at the facility makes teammates in my department want to go above and beyond what's expected to them", as well as overall Tier score.
- Patient's perception would improve as evidenced by an increase in Press Ganey patient satisfaction scores for the question "did staff address your emotional needs?" and communication with nurses domain (comprised of nurse's explained in a way you understood, nurse's treat you with courtesy and respect, and nurse's listen carefully to you).

Mission Statement

This project was intended to provide a caring work environment for relaxation and restoration, as well as education on self-help integrative modalities for the nursing

team of the Progressive Care Unit, which would decrease compassion fatigue and burnout, increase compassion satisfaction, improve employee engagement, and increase patient satisfaction.

Theoretical Underpinnings

Theory

The described project was based on Jean Watson's Theory of Human Caring. The foundation of Watson's theory is the empathetic relationship between the nurse and patient; promoting relationship-based nursing (RBN). The core of relationship-based nursing is empathy for the patient and the family (Lombardo & Eyre, 2011). Watson defined caring based on 10 carative factors:

1. formation of a humanistic-altruistic system of values
2. instillation of faith and hope
3. cultivation of sensitivity to oneself and to others
4. development of a helping-trusting human caring relationship
5. promotion and acceptance of the expression of both positive and negative feelings
6. systematic use of a creative problem-solving caring process
7. promotion of transpersonal teaching-learning
8. provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. assistance with gratification of human needs
10. allowance for existential-phenomenological-spiritual focus (Duffy, 2015)

Jean Watson's Theory of Human Caring advocates for relationship-based nursing and centers around the empathetic relationship between the nurse and patient. At the core

of the nurse-patient relationship is empathy, the ability to understand a patient's feelings. In addition, three core relationships using relationship-based nursing are identified: nurse's relationship with self, nurse's relationship with colleagues, and nurse's relationship with patient and families. The relationship with self is essential for one's health, being empathetic for others, and being a productive member of the healthcare team. Compassion fatigue is experienced by those who help others. Compassion fatigue has also been described as secondary traumatic stress, resulting from providing care for patients in physical or emotional stress. This empathetic relationship can contribute to compassion fatigue if interventions are not taken to avoid this (Lombardo & Eyre, 2011).

When healthcare providers care for themselves, they can provide care for others. Modeling self-care and caring for others and making self-available to others demonstrates loving kindness and equanimity within the context of caring consciousness. Being authentically present, enabling and sustaining the deep belief system of self and one being cared for is essential for the patient to feel cared for (D' Alfonso, Duffy & Woodward, 2007).

When nurses feel supported, cared for, and exercising self-care, the nurse is able to strengthen the nurse-patient relationship. As a nurse, one must be fulfilled to be able to give to the patients. If one's bucket is empty, he/she cannot give any to others. (Figure 2)

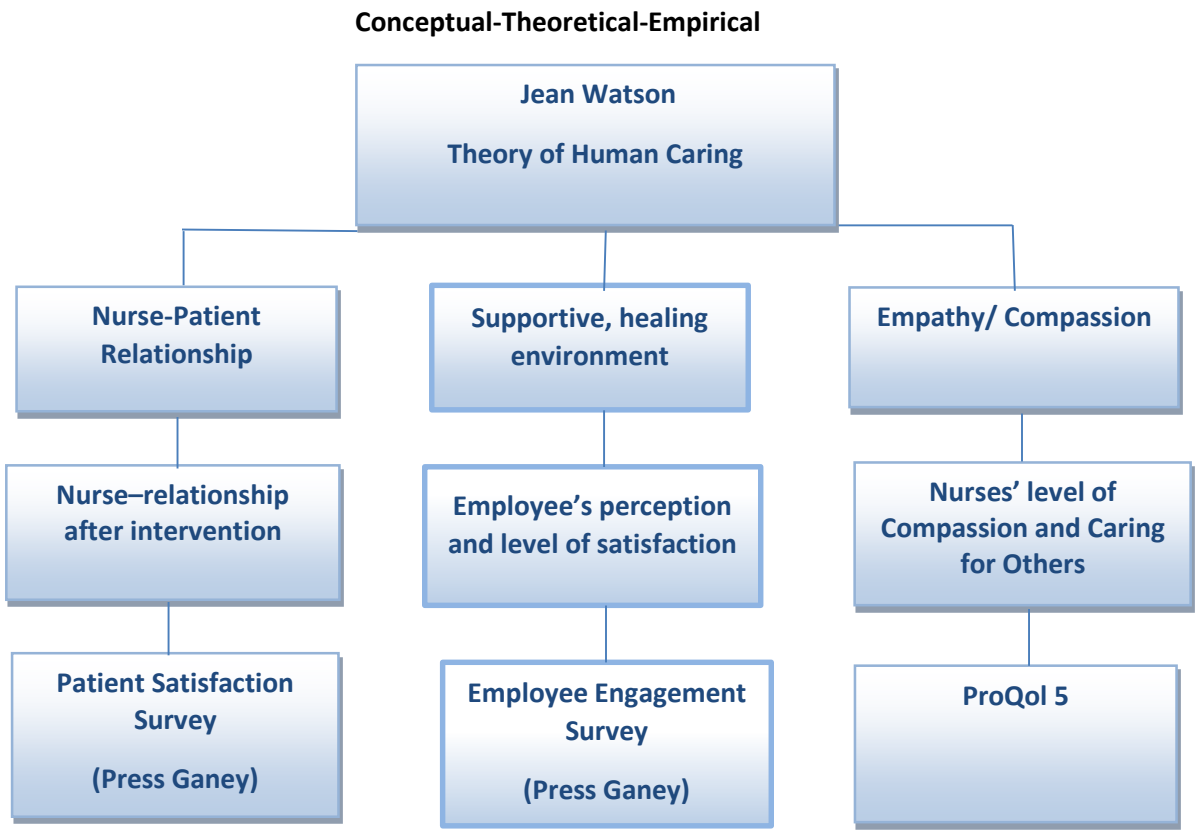

Figure 2. Conceptual-Theoretical-Empirical

Intervention

To promote compassion satisfaction and reduce compassion fatigue, this project director created a serenity area on the largest nursing unit of the writer's organization. The soothing atmosphere was equipped with soothing colors, a recliner with massage chair insert, and aromatherapy. A spa-like" atmosphere to promote relaxation and rejuvenation was offered to all nursing staff working on the unit. A recliner, along with a massage chair insert was placed in the room. All breakroom chairs were equipped with back massage cushions strapped on the back. Flameless candles set the tone and atmosphere. Spa music and a sound machine were available to teammates to listen to during their relaxation time. Lavender and other essential oils were made available to the teammates. A basket with art supplies (markers, colored pencils, foam boards, neon index cards, and foam stickers) was available in the room. The walls were decorated with wall decals; violet flowers and a "relax" decal to create a soothing environment. As requested by the teammates, a timer was available to avoid teammates falling asleep, losing track of time, and abandoning their patients.

Additionally, team members were encouraged to attend the hospital-sponsored "Caring for the Caregiver Day", offered on three days (two weekdays and one weekend day) from 0700-1600. This event was based on the book "How Full is Your Bucket?" (Rath & Clifton, 2004), which teaches how even the momentary contacts affect your relationships, productivity, health, and longevity. The authors used a metaphor of a dipper and a bucket to illustrate how to significantly increase the positive moments in your work and life while reducing the negative. The event included aromatherapy, music therapy, art therapy, pet therapy, massage therapy, and education on compassion fatigue

for nurses. A "relaxation" area with spa waters and healthy snacks were offered. Prizes were raffled off for team members who attended. Gift baskets contained the book "How Full is Your Bucket?" along with manager reward gifts given as prizes.

Nurses were asked to participate in a pre-intervention and post-intervention survey, using the Professional Quality of Life (ProQOL) instrument, a self-report survey measuring compassion satisfaction, compassion fatigue, burnout, and secondary stress trauma (Hunsaker et al., 2015). The Professional Quality of Life Scale (ProQol Version V), is a 20-point questionnaire measuring Compassion Satisfaction and Compassion Fatigue. Compassion fatigue is measured through two subscales: Burnout and Secondary Traumatic Stress. (Figure 3).

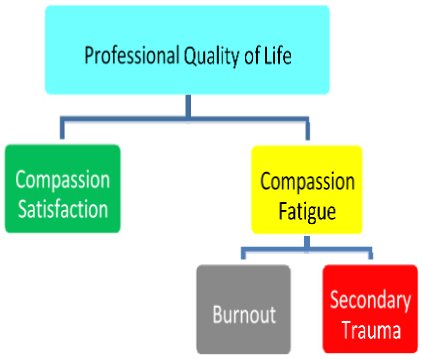

Figure 3. Professional Quality of Life Scale

A compassion satisfaction score below 40 and burnout score above 57 indicates compassion fatigue. A secondary traumatic stress score above 57 indicates a need to think what is frightening to the nurse at work. Pre-and post- intervention surveys were sent via survey monkey to nurses working on the Progressive Care Unit. Two additional questions were added to posttest (1) Have you used the serenity room? (2) Did you attend the Day of the Caregiver event?

With over 200 published papers and in excess of 100,000 articles on the internet, the ProQOL V has good construct validity. Of the 100 published research papers on compassion fatigue and secondary traumatic stress approximately 50% have utilized the ProQOL or one of its earlier versions. The three scales measure distinct constructs. The inter-scale correlations show 2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with Burnout. Despite a shared variance between Burnout and Secondary Traumatic Stress, the two scales measure different standards with the shared discrepancy likely reflecting distress common to both conditions. The shared variance between these two scales is 34% (r=.58; co-σ = 34%; 14 n=1187). Although both scales measure negative affect, they remain evidently different as the BO scale does not address fear but the STS scale does (Stamm, 2010).

Project Management Tools

Gantt Chart

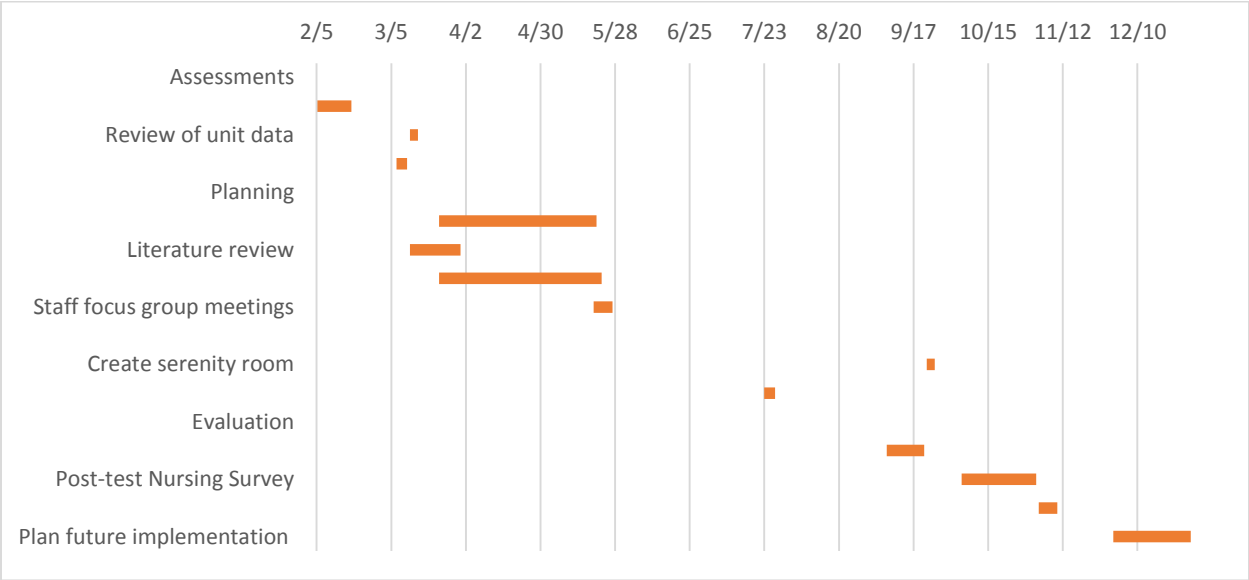

Figure 4. Gantt Chart

Proposed Timeline

See Appendix A

Proposed Budget

See Appendix B

Evaluation Planning

Evaluation Plan

Two weeks prior to the creation of the serenity room the nursing team members were asked to complete the ProQOL 5 survey. Four weeks after the creation of the serenity room, the nursing team members were asked to complete the ProQOL 5 questionnaire with the addition of two additional questions (1) Have you used the

serenity room? (2) Did you attend the Day of the Caregiver event? Employee engagement and patient satisfaction scores from the Press Ganey Employee Engagement Survey were compared for differences between pre- and post-intervention. (Figure 5).

Logic Model Development

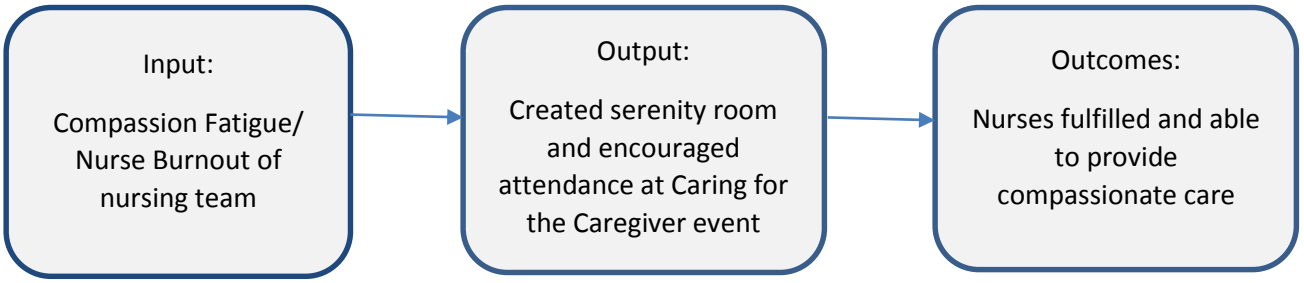

Figure 5. Logic Model Development

Quality Improvement Methods

Plan: Nurses of the Progressive Care Unit were invited to complete the ProQOL V survey via survey monkey two weeks prior to intervention and were given a two week time limit to complete. Four weeks after completion of the serenity room, the nurses assigned to the Progressive Care Unit at the project director's organization received a ProQOL V survey with the two additional questions: (1) Have you used the serenity room? (2) Did you attend the Day of the Caregiver event? No personal demographic information was requested and participants remained anonymous. A patient information leaflet accompanied each survey which explained the participants' rights. Participants were able to choose to complete each survey or not based on the information in the leaflet.

The ProQOL survey with the two additional question was distributed via Survey Monkey. The responses were collected anonymously via Survey Monkey. The amount of time spent in the room was not assessed; however the room remained their staff lounge/break room. Therefore, each nurse accessed the room each shift worked. The Caring for the Caregiver day was offered prior to the creation of the serenity room, which allowed more time for the nurses to implement strategies they learned.

Employee engagement scores was compared using August 2014 survey scores and August 2015 scores. Patient satisfaction scores were evaluated monthly. The project director monitored the trend line for the patient satisfaction scores to evaluate impact.

Do: The project director created a serenity area, an area equipped with massage chair inserts, essential oils, and soothing sounds. All teammates of the designated unit of the project director's organization had access to the serenity room, although this project was focused on nurses. Additionally, team members were encouraged to attend "Caring for the Caregiver Day", an event which educated and promoted self-help interventions to decrease compassion fatigue and burnout. The event included aromatherapy, music therapy, art therapy, pet therapy, massage therapy, and education on compassion fatigue for nurses.

Check: A statistician conducted the data analysis. SPSS was used for all statistical analyses.

Act: Since interventions had significant positive results (increased compassion satisfaction and decreased compassion fatigue), nurse leaders were encouraged to create serenity areas on each nursing unit. In addition, a recommendation was made to

administration to offer Caring for the Caregiver event annually or biannually. Future studies may be offered at a future date to validate the findings of this study.

Implementation

Institutional Review Board Process

Nursing Scientific Advisory Committee (NSAC) approval was obtained from the project director's organization on August 10, 2015. IRB approval was received from the project director's organization's IRB committee on August 19, 2015. The project director's university's IRB approval was received on September 9, 2015.

Threats and Barriers

The foreseeable threats to the project included administration approval, lack of funding, and time constraints. Approval from administration and funding was secured early in the project planning. In order to carry out implementation of the project, the project director created the serenity room during the weekend during off-work time, avoiding a work conflict. The unforeseeable threats and barriers to the project included life safety regulatory standards and change in leadership. The project director worked directly with the Director of Plant Operations to comply with life safety standards during implementation. To meet life safety standards, all purchased items utilized batteries to keep area free of electrical cords; fabric was draped on the walls as opposed to draping from ceiling tile framing; diffuser operated by fan, without the use of water and mist; and canned lighting was added with capability of dimming lighting and turning off standard fluorescent lighting. In addition, no change in leadership occurred during project implementation. The project director had support of all levels of leadership on the Progressive Care Unit in preparation of any unforeseen administrative changes.

Implementation Phase

The project director created the ProQol survey via Survey Monkey. The survey was successfully tested on one of the registered nurses on the Progressive Care Unit on September 11, 2015. On September 12, 2015, the survey was extended to all registered nurses on the unit (n=36) and remained open through September 26, 2015. The flyer was posted on the unit encouraging participation in the survey. The project director rounded on the unit daily to encourage participation, as well as call charge nurses on off shifts to remind the registered nurses to take survey.

The serenity room was created on September 27, 2015. The project director draped lavender organza fabric on the walls of the breakroom. Purple flower and butterfly wall decals were added to improve the décor and create tranquility. Chair massage inserts were added to all eight existing breakroom chairs around the table. A room divider was utilized to separate the breakroom table from the recliner. Behind the room divider, a recliner with a massage cushion was placed for staff relaxation. An aromatherapy diffuser was used to disperse essential oils in the room. The room was equipped with a timer per staff request to alleviate the opportunity of sleeping or losing track of time. A soothing sound machine is available for use. Additionally, relaxing music can be tuned in on the existing television in the room. An art bucket was placed in the room which includes markers; foam letters, numbers, boards, and designs; coloring sheets; glue; and glitter. On October 4, 2015, additional fabric and wall decals were added to the room to complete it.

On October 26, 2015, the post-intervention ProQol survey was sent to the 36 registered nurses on the Progressive Unit who were invited to participate in the pre-

intervention survey. The survey was extended through November 9, 2015. A flyer was posted, as well as rounding and calls by the project director to encourage participation in the post-intervention survey.

Actual Timeline

The actual timeline occurred two to four weeks later than the original proposed timeline. The IRB approval process delayed the project due to deferred approvals during a holiday. Overall, the project was slightly delayed but no obvious impact on project success. (Figure 6)

DATE	MILESTONE
5-Feb	Project Start
7-Mar	Literature review
2-Mar	Met with CNE
23-Mar	Project Committee Formed
23-Mar	Serenity room planning
20-May	Focus staff interviews
23-Jun	Order furniture/items for serenity room
12-Sept	Pre-test Nursing Survey
27-Sept	Create serenity room
26-Oct	Post-test Nursing Survey
9-Nov	Deadline for returned survey/review data
30-Dec	Project End

Figure 6. Actual Timeline

Project Closure

Positive verbal feedback was received immediately after the serenity room was created. Teammates of the Progressive Unit verbalized appreciation of the room. One nurse verbalized she was able to get through a busy shift by "sitting in the massage chair while doing art" for a period of time. This nurse created art during her shifts and put them on her coworker's lockers during the first two weeks of having the art bucket. Nurses stated the smell of lavender in the room made a difference in their day; only one nurse verbalized displeasure of the scent. Most teammates appreciated the chair inserts in the breakroom chairs, however the project director found some staff preferred to remove them from the chairs. Teammates from the Medical/Surgical Unit and the Critical Care Unit requested to utilize the serenity room. The positive comments included "we love it"; "it makes a difference in my day"; the art supplies are the best thing we've ever had"; "coloring takes me to a different place"; "coming in here (breakroom) just makes you relax"; "love the massage chair"; "the dim lighting makes such a difference"; and "the smell of the room sets your mood". A group of night shift teammates utilized the art supplies to create flowers to give to a patient. Another teammate utilized the essential oils to help a patient sleep.

Based on the immediate positive staff feedback and results of the employee engagement survey, the Chief Executive Officer of the organization requested to expand the creation of the serenity room to other nursing units while awaiting the results of the ProQol survey. The serenity room expansion began in early October. The following timeline demonstrates the serenity room expansion. (Figure 7).

DATE	MILESTONE
11/29/2015	New Beginnings serenity room
12/04/2015	Critical Care serenity room
01/03/2016	Medical/Surgical Unit serenity room
01/15/2016	Pain Center serenity room
01/17/2016	Emergency Department serenity room
01/18/2016	Surgical Services serenity room

Figure 7. Expansion Timeline

The project director offered to assist with development of serenity rooms in the support departments, however the leaders did not choose to create serenity rooms for their teammates.

Interpretation of the Data

The study used a three-step analytic strategy. First, descriptive statistics were used to examine the characteristics (i.e., the distribution and spread) of the sample. The purpose of the descriptive statistics was to provide insight into the composition of the sample and serve as a screening process to assess whether the assumptions for the subsequent inferential statistical analysis were adequately met.

The second phase of the analysis involved data reduction procedures to create measurement indices to be used in the inferential statistical tests. Per the recommendation of the ProQOL V manual, the study used the summation method to create the indices for three constructs namely, compassion satisfaction, burnout, and secondary trauma stress. In accordance with best practices, negatively worded items were reverse-coded before

items for each subscale were aggregated. The aggregated scores for the three subscales were converted into a z-score.

The last phase of the analysis involved inferential statistical tests to address the research question of whether participation in the intervention improved participants' level compassion satisfaction, and decreased their likelihood of burnout as well as secondary trauma stress level. Specifically, the study conducted one-sample t-tests to assess whether there are statistically significant changes in the pre and posttest scores. Although, a paired sample t-test is ideal for analyzing change before and after an intervention, that data analytic approach was not used in this study because the pre-test and post-test data did not have unique identification numbers to allow for merger of the two waves of data.

Independent sample t-test was used to examine whether respondents who attended the Caring for the Caregiver event and those who did not attend differed on their level of compassion satisfaction, burnout, and secondary trauma stress. SPSS version 18 was used for used for all statistical analyses. The study assessed statistical significance at the .05 significance level. All statistical tests were two-tailed tests. (Table 1)

Results

Table 1

ProQOL Results

	Pretest mean (SD)	Posttest mean (SD)	t-test	Statistically Significant?
Compassion Satisfaction	40.2 (4.79)	41.63 (5.51)	1.27	No
Burnout Scale	19.96 (4.16)	19.74 (4.44)	-2.16	Yes
Secondary Stress Trauma	24.04 (4.51)	21.72 (5.56)	-2.02	Yes

Compassion satisfaction. The summation method was used to create a compassion satisfaction scale by aggregating the scores of 10 items that tap into the amount pleasure respondents derive from being able to do their work well. Majority of respondents were rated high on their companion satisfaction scale at both pre-test and post, which suggests that most respondents derived a high level of professional satisfaction from their position both before and after the intervention.

Burnout scale. To create the burnout scale, 10 items were aggregated; five of the 10 items were reverse coded to align all 10 responses to positively worded items. On the burnout subscale, a higher score indicates higher level of burnout. To assess whether the 0.22-point decline in burnout level was statistically significant, a one-sample t-test was used to compare the post-test scores to the average pre-test mean score of 19.96. The choice of this statistical method was because the pre- and post-test scores could not be merged due of the lack of a unique linking variable. The test results showed a

statistically significant difference between the post-test mean and the pre-test mean with $p < .05$ (two-tailed). This means respondents were at a slightly lower risk of burnout after receiving the intervention.

Secondary trauma stress. Per the guidelines of the ProQOL Manual, the simple summation method was used to create a secondary trauma stress subscale. The subscale is made up of 10 items that tap into the extent of a respondents' secondary exposure to a traumatically stressful event. Higher scores on the secondary trauma stress subscale indicate more stress. To test whether the 2.32 pre- and post-difference was statistically significant, a one-sample t-test was conducted to assess whether the two means are statistically significantly different. The test results were statistically significant: $t (24) = -2.02$, $p < .05$ (two-tailed). The significant results mean that respondents who received the intervention had a lower secondary trauma stress level. (Table 2).

Table 2

Caring for the Caregiver Event Results

	Did Attend (SD)	Did Not Attend (SD)	t-test	Statistically Significant?
Compassion Satisfaction	43.00 (4.72)	39.33 (6.22)	1.90	No
Burnout Scale	16.73 (3.43)	20.00 (4.72)	1.64	No
Secondary Stress Trauma	20.00 (4.44)	24.68 (6.25)	-2.14	Yes

Caring for the Caregiver event. Three independent sample t-tests were used to test whether the post intervention scores on the three subscales—compassion satisfaction, burnout, and secondary trauma stress—were significantly differently between respondents who attended the Caring for the Caregiver event and those who did not attend the event. The Levene's test for equal variances were not statistically significant, suggesting that the assumption of homogeneity of variances is not violated. Results of the independent sample t-test show that respondents who attended the Caring for the Caregiver event and those who did not attend have statistically significantly different secondary trauma stress level at post-test ($p < .05$), but not compassion satisfaction level ($p = .07$) and burnout ($p = .12$). Respondents who attended the Caring for the Caregiver event have a slightly lower score on the secondary trauma stress scale compared those who did not attend the event. In other words, respondents who did not attend the event experience significantly higher stress level compared to those who attended the event. (Table 3)

Table 3

Press Ganey Results

	Pretest score	Posttest score
Patient Satisfaction		
Communication with Nurses	78.2	85.6
Staff Addressed Emotional Needs	55.6	60.5
Employee Engagement		
Tier Score	Tier II	Tier I
The Environment Makes Teammates in my Department Want to Go Above and Beyond What's Expected of Them	3.43	4.04

Press Ganey patient satisfaction survey. Press Ganey patient satisfaction survey results has shown improvement since the project implementation (Appendix C and D). This indicates meeting the needs of the nurses increases their caring behaviors, which in turn improves patient satisfaction.

Press Ganey employee engagement survey. The employee engagement scores improved significantly from 2014 to 2015, from a tier two department to a tier one department based on Morehead/Press Ganey's Employee Engagement Survey (Appendix E). Press Ganey employee engagement survey results for "The environment makes teammates in my department want to go above and beyond what's expected of them" improved in 2015.

Conclusion

Nursing is a profession of giving more than receiving. Nurses give so much of themselves, they need to be refilled. Nurses can suffer from low compassion satisfaction, burnout, and compassion fatigue, as evidenced by feeling emotionally drained; having negative, uncaring attitude; and struggling to give quality input into their work (Trewick, 2008). In a study conducted by the American Nurses Association in 2001 revealed 70.5% of nurses reported acute and chronic effects of stress and overworked. Of the surveyed nurses, 75.8% conveyed unsafe working conditions hinder with their ability to provide quality nursing care ("Holistic Stress," 2015).

Prior to the intervention, nurses of the Progressive Care Unit verbally expressed feelings of emotional exhaustion and low morale. The Progressive Care Unit declined in employee engagement scores from 2013 to 2014. In 2014, the unit declined in overall score, as well as on the item "the environment makes teammates in my department want to go above and beyond what's expected of them". After the use of the serenity room, the employee engagement scores climbed back to Tier 1 status. In addition, for the item "the environment makes teammates in my department want to go above and beyond what's expected of them", the score improved significantly 0.61 points from 2014 to 2015.

Patient satisfaction scores were also on the downward slope. For the communication with nurses' domain, scores fell below the organization's target 50% of the time over the year. For the question, "Did staff address your emotional needs?' scores had remained lower than the target consistently over the year. However, after the nurses were able to rejuvenate in the serenity room during their 12 hour shift, patient's

perception of the communication from nurses improved. The patients also reported an improvement in the staff's attention to their emotional needs.

The serenity room allows nurses to renew themselves during their shift. It creates a place for them to destress and take time for themselves. Whether sitting in the massage chair, coloring, listening to soothing sounds, or simply enjoying the aromatherapy, the room creates an atmosphere for them to relax and recommence their compassion for patients. Nurses reported a decline in nurse burnout and secondary trauma stress after using the serenity room. Nurses who learned about strategies to care for themselves at the Caring for the Caregiver event reported less stress than those who did not.

The Caring for the Caregiver event and the serenity room were aimed to improve compassion satisfaction, decrease nurse burnout, decrease secondary trauma stress, improve employee engagement, and increase patient satisfaction. The nurses' responses to the serenity room was evidence the project was successful. The nurses' gratitude and perpetual positive feedback is overwhelming and has made this project worthwhile. Because of the positive responses and results, an additional six nursing units have serenity rooms. The project director recreated the serenity room in every nursing department of the project site. The nurses had the same positive verbal responses as the Progressive Care Unit nurses.

Allowing nurses to decompress and relax during their shift can replenish the nurse to be able to care of others with compassion and caring. A serenity area to relax, take breaks, and eat meals can allow the nurse to rejuvenate and rest. It is imperative to help nurses deal with stress by educating on symptoms and self-help interventions to combat compassion fatigue and burnout and increase compassion satisfaction, which may

improve employee engagement and patient satisfaction scores. Nurses can only provide compassionate, caring care to others when they are filled themselves. For this writer's organization to fulfill the mission, vision, and core values, an investment in the direct caregivers becomes a necessity.

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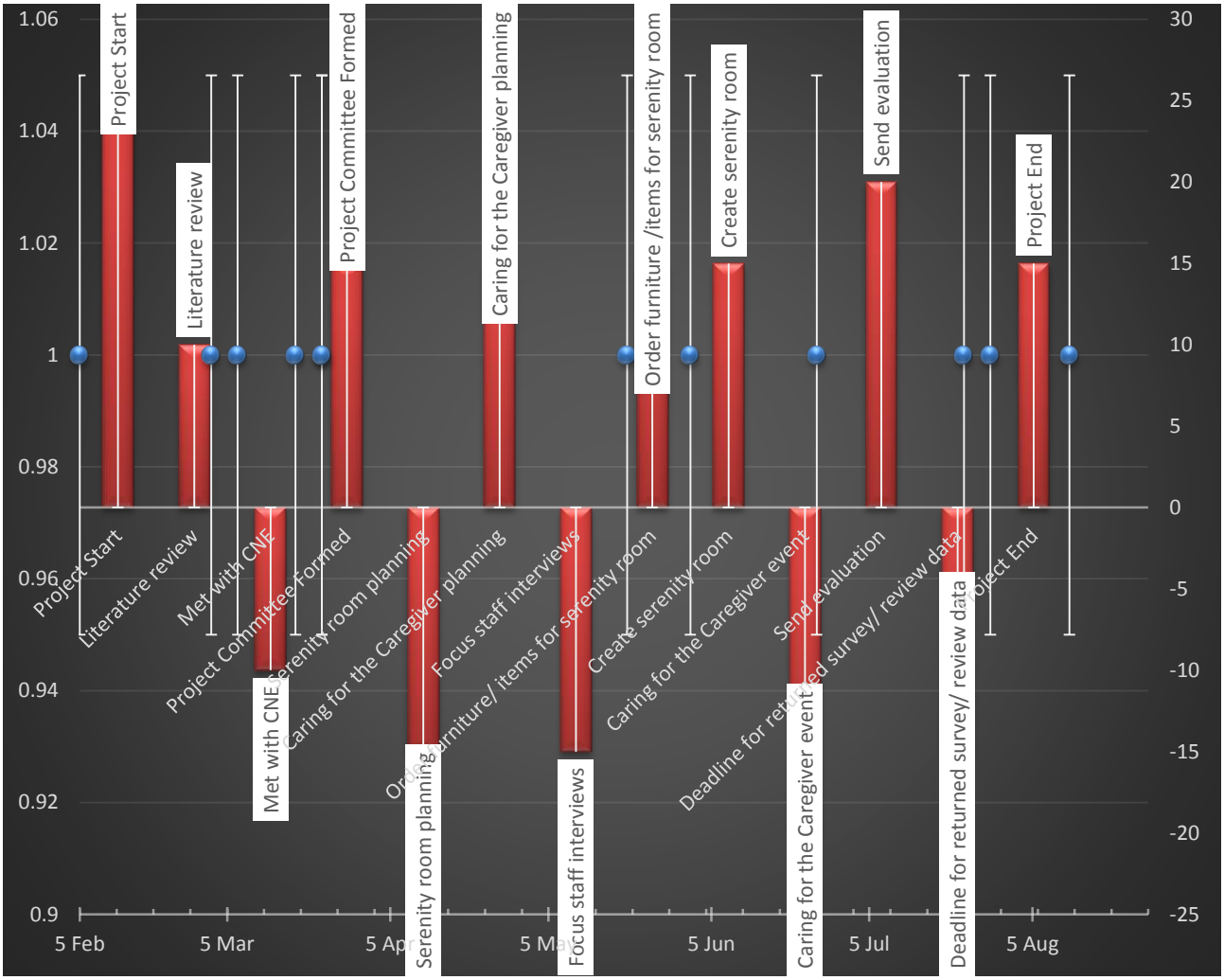
Appendix A

Proposed Timeline



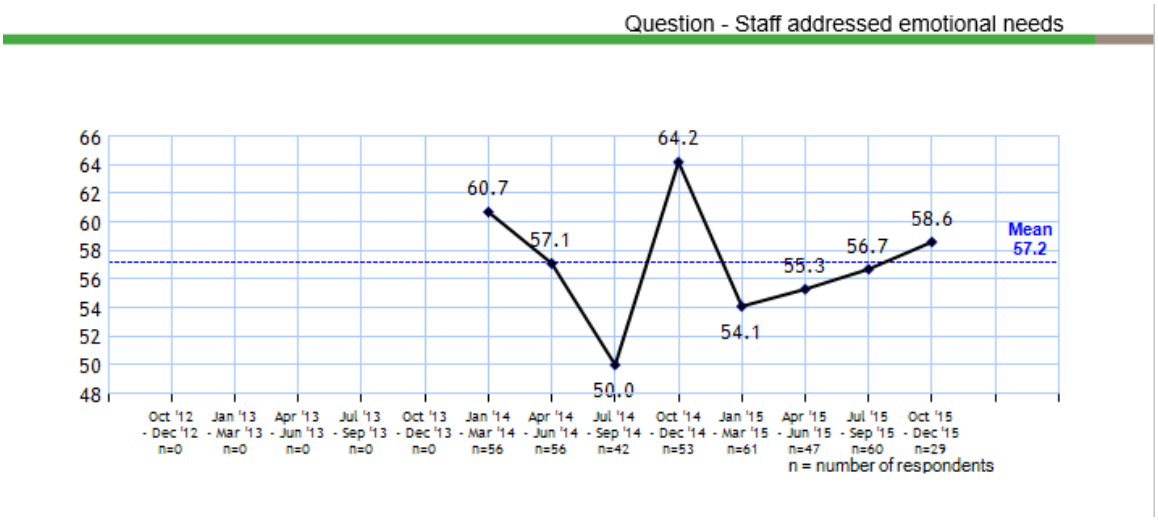
Appendix B

Proposed Budget

	PROJECT TASKS	LABOR HOURS	LABOR COST ($)	MATERIAL COST ($)	TRAVEL COST ($)	OTHER COST ($)	TOTAL PER TASK
Serenity Room	Vinyl Relax Decal	0.0	$0.00	$30.00	$0.00	$0.00	$30.00
	Wall Sticker Decals	0.0	$0.00	$25.00	$0.00	$0.00	$25.00
	Sound Spa	0.0	$0.00	$30.00	$0.00	$0.00	$30.00
	Essential Oils	0.0	$0.00	$49.00	$0.00	$0.00	$49.00
	Timer	0.0	$0.00	$12.00	$0.00	$0.00	$12.00
	Room Divider	0.0	$0.00	$72.00	$0.00	$0.00	$72.00
	Massage Chair inserts	0.0	$0.00	$67.00	$0.00	$0.00	$67.00
	Candles/CD player/CDs	0.0	$0.00	$0.00	$0.00	$0.00	$0.00
	Subtotal	**0.0**	**$0.00**	**$285.00**	**$0.00**	**$0.00**	**$285.00**

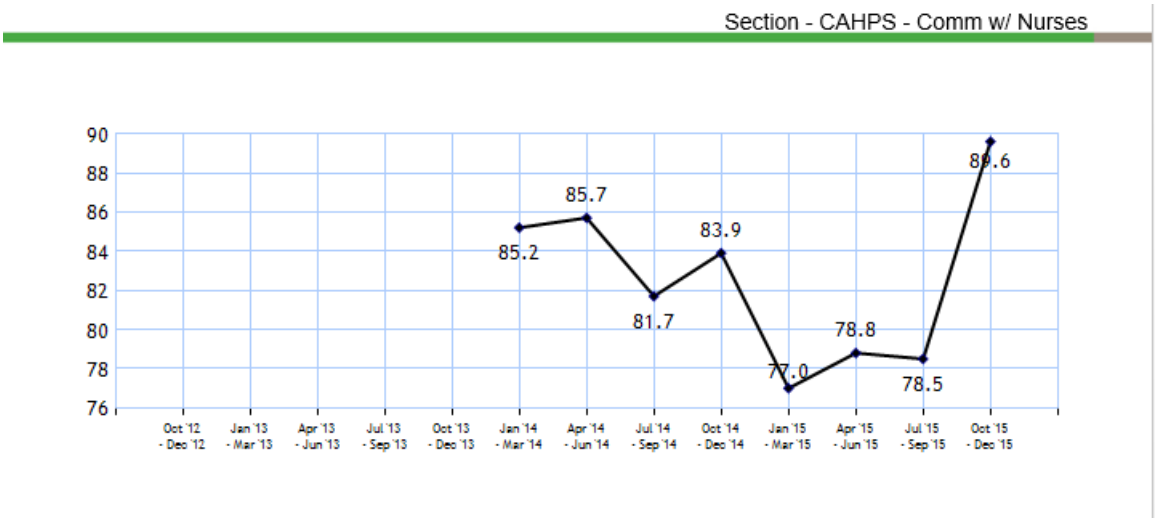
Appendix C

Press Ganey Patient Satisfaction Survey Results



Appendix D

Press Ganey Patient Satisfaction Survey Results



Appendix E

Press Ganey Employee Engagement Scores