Compassion Fatigue Experienced by Nurses in Acute Medical Surgical Settings

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Table of Contents

Abstract

Background: Compassion for others is at the heart of the nurse-patient relationship. Many nurses pursue the profession based on their desire to care for others. The original desire to care for others may be challenged by a difference in population of patients over time.

Objectives: The aim of this project is to decrease nurses' compassion fatigue. 1) Reduce compassion fatigue and improve self-care behaviors through education. 2) Improve nurses' ability to practice techniques that decrease compassion fatigue.

Methods: A pre and post intervention survey was administered using the Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009). All subscales of the survey tool were used to determine the degree of compassion satisfaction, burnout/compassion fatigue and secondary traumatic stress participants might be experiencing.

Results: The education intervention presented in this project resulted in no significant change in compassion satisfaction or compassion fatigue for the participants. The participants' scores showed high levels of compassion satisfaction. Scores for the subscales of burnout, compassion fatigue and secondary traumatic stress were low meaning the participants did not have compassion fatigue.

Conclusion: Nurses should practice and maintain self-awareness of techniques and behaviors that improve compassion satisfaction in order to deliver compassionate care.

Compassion Fatigue in Acute Medical Surgical Settings

Nurses are a major part of the health care service or currently the hospitality industry. Nurses have been educated as service providers, prioritizing skill performance and the delivery of safe and effective care (Kerfoot, 2009). Many individuals may have pursued the profession with a desire to care for others, driven by a compassionate nature. The nurse-patient relationship was born of compassion for people. Today patients expect high-quality nursing care to include caring. Patients want to feel a connection to the nurse and the health care system. According to Keeley, Wolf, Regul & Jadwin (2015, p. 352), "nurses assert, human caring is a central focus of study for professional nurses". Nurses' original motivation to enter the profession is likely the same motivation that will encourage them to engage in activities designed to decrease compassion fatigue.

The movement toward hospitality is in part generated by a payment restructuring, with reimbursement rate calculations from patient satisfaction survey responses. Money is a powerful motivator, and acute care facilities are dependent on third party payment. Hospitals are always interested in patient feedback to improve patient care, and it is only in the last decade that Medicare and Medicaid reimbursement have been linked to satisfaction (Boerner & Hwang, 2010).

One patient population that is vulnerable to the effects of compassion fatigue are those who have a co-morbidity of substance use disorder. National, if not global concern of illicit substance use, misuse of prescription medications and associated behaviors creates an enormous impact on healthcare. Factors within heath care delivery systems, such as severity and recurrence of illness, caregiver compassion fatigue, healthcare recipient satisfaction and financial

reimbursement exaggerate this problem. Solutions to this problem require attention to each of these contributing factors.

Substance use disorder (SUD), particularly opiate use disorder (OUD) often requires hospitalization for conditions such as drug overdose and or associated infections. Conditions requiring hospitalization for this population are associated with painful conditions that necessitate acute pain control. Management of acute pain in this population is a challenge for the health care team particularly nurses who deliver care 24/7. Nurses, not unlike the public, in general, may continue to think of addiction solely as a social problem requiring intervention from the legal system, not the healthcare system (Paschkis, Potter, & Ciesielski, 2015). According to Wachholtz and Gonzalez (2014), patients experiencing acute pain combined with a history of addiction use both legal and illegal drugs as well as alcohol to treat their pain. The magnitude of this societal issue is huge. Research indicates, "all practitioners, regardless of specialty will care for patients with this prevalent, chronic medical condition, including during acute hospital admissions" (Donroe, Holt, & Tetrault, 2016, p. 1232).

Patients with a history of opiate use may have developed a tolerance to pain even after treatment is complete, but sensitivity to pain remains unchanged (Wachholtz & Gonzalez, 2014). During hospitalization, OUD disorder patients "are at high risk of having their pain undertreated" (Vadivelu et al., 2016, p. 4). Prevention of withdrawal symptoms is a motivating force behind patients' seemingly manipulative behaviors. Preventing withdrawal helps to decrease stress on the part of both the patient and the nurse "maintaining a therapeutic relationship" (Donroe et al., 2016, p. 1235). A host of biases exists in both the patient who has a substance use problem and the nurse caring for the patient. Patients are worried they will be labeled as "drug seeking" or "addicts" and their current acute pain will not be treated (Donroe et al., 2016; Vadivelu et al.,

2016). Patients also report negative treatment by nurses such as; not being believed, being treated like a "junkie," and not being respected (Morgan, 2006).

Identification and treatment of pain can improve management of other co-existing medical concerns that precipitated the hospitalization. Having knowledge of the patient's opiate use legally or not, the goal of management of acute pain is to control pain while preventing symptoms of opiate withdrawal (Donroe et al., 2016). When patients are fearful of withdrawal symptoms, they may leave the hospital prematurely. Conversely, when patients believe their pain will be managed they are more likely to stay in the hospital and complete their treatment.

The term "compassion fatigue, first appeared in the literature in 1992" (Nolte, Downing, Temane, & Hastings-Tolsma, 2017, p. 3). Compassion fatigue is a term used to describe a condition health care providers experience when their ability to provide sensitive care is exhausted. As the number of patients with a history of SUD or OUD are increasingly admitted to the acute care setting, the incidence of compassion fatigue experienced by nurses caring for them increases as well. Patients, fearful of judgment as well as legal ramifications of illicit drug use may not be honest in reporting their drug use before admission. Since treatment hinges on assessment including patient report, this inaccuracy leads to negative patient behaviors as patients attempt to receive pain treatment. Nurses have many interactions with patients during the course of delivering care. This patient population is admitted to the hospital repeatedly, which affects the nurses' attitudes when providing care. Individuals with SUD or OUD report a variety of behaviors to obtain relief of pain, many of them perceived as manipulative by health care providers. This ongoing testing of the system is wearing on nurses' innate compassion to care for others.

Providing compassionate care is imperative to patient satisfaction. Patient satisfaction survey scores contribute to the financial reimbursement of many acute care institutions receiving third party payment. Nurses may prejudge patient behaviors as "drug seeking" when they care for the patient who is experiencing acute pain and who also has a history of OUD or SUD (Vadivelu et al., 2016). Nurses report feeling unprepared to accurately screen and treat this population (Morgan, 2006). Careful assessment is needed to determine the cause and type of pain. All too often the assessment is incomplete stopping at pain intensity only. If acute pain is undertreated in this patient population (SUD/OUD) there is an increased likelihood of the patient leaving against medical advice prematurely (Donroe et al., 2016). Premature discharge from the hospital may increase the severity of illness in subsequent admission due to incomplete treatment. Patients who leave the hospital prematurely often do so for drug acquisition.

Nurses report negative attitudes related to behaviors used by the patient with SUD and or OUD, commenting that this patient population needs a lot of attention. Nurses comment that this patient population causes them to be constantly aware of their actions and reactions when providing care (Morgan, 2006). Nurses negatively use the term "drug seeking" when several behaviors are identified such as, going to different emergency departments (ED)s to get opioids, or asking for refills because prescription is lost or stolen (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005, p. 126). It is interesting to note that reports from nurses concerning documentation of the term "drug seeking" indicate that nurses rarely document this in a patient's record (McCaffery et al., 2005).

Negative attitudes by nurses, toward this population, are more prevalent than those of other health care professionals: this is possibly due to the frequent interaction between nurses and patients. It is important to understand that negative attitudes do not necessarily result in

negative behavior on the part of the nurse (Morgan, 2014). The daily stress of caring for patients diagnosed with SUD or OUD is exhausting; one nurse reports, "…I'm trying to find ways because it is hard to give good care, very hard…" (Morgan, 2014, p. 171). Compassion fatigue has far-reaching negative effects. An additional concern is that compassion fatigue affects care to all patients assigned to the nurse as well as the members of the healthcare team interacting with the nurse.

When one member of a nursing staff is experiencing compassion fatigue the function of the team delivering care is affected. An increase in absenteeism has been identified as a symptom of compassion fatigue. A generally tense work setting could negatively impact communication as individuals avoid one another. The project was primarily directed toward registered nurses, patient care technicians, certified nursing assistants, those individuals who have direct patient care responsibility. The nursing staff was assigned to one of three medical surgical nursing units in a community hospital.

Statement of the Problem

The growing population of SUD and OUD patients poses challenges to the health care system. Patients with substance abuse history may be thought of as demanding, or "drug seeking" particularly with respect to pain medication schedules, route, and dose (Vadivelu et al., 2016). Compassionate nursing care is particularly challenged as nurses' experience frustration and exhaustion delivering care to this patient population. Ineffective or untreated acute pain results in negative patient-nurse interactions. Patients report dissatisfaction with care triggering an avalanche of responses generated by financial sanctions.

Purpose Statement

The purpose of this project was to assist nurses to identify their own compassion fatigue and to subsequently improve delivery of compassionate care for all patients the nurse cares for. Identify techniques to increase resilience and improve job performance and satisfaction for the nursing staff. The development of a peer support group for the purpose of maintaining awareness of compassionate care delivery may assist nurses in sustaining caring attributes as this vulnerable population expands

Objectives

The goal of this project is to identify interventions or techniques that will decrease nurses' compassion fatigue resulting in more effective care delivery to patients with SUD or OUD. The objectives of this project are:

Reduce compassion fatigue and improve self-care behaviors through education.

Improve nurses to ability to practice techniques that decrease compassion fatigue.

Project Question PICOT

In what ways do nurses caring for patients with a history of substance abuse disorder or opiate use disorder identify compassion fatigue in themselves and others? Will nurses report a decrease in compassion fatigue after a series of informational sessions?

Population	Nurses experiencing compassion fatigue caring for patients with substance abuse disorders or opiate use disorders.
Intervention	Present a series of articles for review and discussion by nurses caring for SAD and OUD disorders. The articles will focus on outcomes of nurses who may be experiencing compassion fatigue and how the use of caring technique may decrease compassion fatigue.
Comparison	Assess nurses' report of self and peer behaviors indicating compassion fatigue before education focused on techniques to curtail negative behaviors, and reassess nurses self and peer report of compassion fatigue after review of research related to poor patient survey reports.

Outcome	Nurses will report less compassion fatigue in themselves and peers after behavior awareness presentation regarding the negative impact of compassion fatigue.
Time	The entire project from nurses' self-assessment followed by behavior awareness presentation then post-intervention self-assessment can be accomplished in 4 weeks. This project presentation can be measured using a survey tool Professional Quality of Life Scale (ProQOl 5)(survey monkey) after completion of the behavior awareness reading. Semi-structured interviews may also be used to obtain anecdotal reports.

Literature Review

A review of literature for this project involved first developing a better understanding of several concepts. Initially, an understanding of the relationship between nurses and their patients was clarified. Since a specific population of patients was identified, a review of literature was undertaken with a focus on patients with a history of SUD or OUD. Patients' perceptions of their relationships with the healthcare system and especially nurses were reviewed. Next, nurses' perceptions of the patients with SUD or OUD requiring treatment in the hospital were reviewed. Lastly, the theory of compassionate care was included for direction and clarity of the discussion.

A literature review was conducted using CINAHL, ProQuest and OVID for peer reviewed articles published in the last five years. Key words included compassion fatigue, Watson's caring theory, nurses and compassion fatigue, burnout, substance abuse opioid use disorders. The literature review yielded a plethora of research both qualitative and quantitative involving both patients' and nurses' perception of care and their satisfaction with one another. Several authors identified the impact of patient satisfaction ratings on healthcare delivery. Zimmermann (2000), Boerner & Hwang (2010), and Kerfoot (2009) all identified that changes in healthcare reimbursement have created a shift in focus from ensuring positive health outcomes to making sure the patient was satisfied. It has become increasingly important to get into the good

graces of patients, sometimes having to provide hospitality instead of service (Boerner & Hwang, 2010; Kerfoot, 2009). Kerfoot (2009) notes that nurses need to get patients on their side, and in another study the author notes that healthcare providers must "please" the patient (Zimmermann, 2000, p. 175). Patient satisfaction has been linked to perception of being cared for and cared about (Keeley et al., 2015). In an effort to please the patient and increase patient satisfaction rates, nurses are reporting less satisfaction with their jobs (Boerner & Hwang, 2010).

In many instances, the literature reports particular patient populations that utilize health services and report dissatisfaction with the healthcare system, particularly nursing care. Patients may even leave the hospital prematurely because they are not satisfied with care provided. In reviewing the literature, several themes emerged for patients with substance use disorder or opiate use disorder when they were surveyed about their satisfaction with healthcare. Patients were dissatisfied with nurses demonstrating negative behaviors such as labeling patients, passing judgement, lack of attentiveness and discrimination (Ti & Ti, 2015; St. Marie, 2014; Monks, Topping, & Newell, 2012). Patients also report their perception that they are not taken seriously by healthcare providers when they report pain (St. Marie, 2014).

Caring for this particular population may require special education and skill. Nurses caring for a population or in a setting disparate from their caring values may be at higher risk for stress and subsequent compassion fatigue (Nolte et al., 2017). Patients, and in some cases nurses, identified inadequate education of SUD and acute pain management (Monks et al., 2012; Morgan & White, 2009). According to (Nolte et al., 2017) many studies have been conducted with nurses caring for oncology, hospice and pediatric patients identifying triggers, manifestations and coping strategies for compassion fatigue. Several strategies have been

identified to relieve compassion fatigue. According to Nolte et al., (2017), considerations for nursing include:

Providing regular training for nurse-managers to identify and prevent compassion fatigue.

Developing an area where stress relieving practices can be used (consider exercise rooms).

Encourage mindfulness and self-awareness.

In addition, from a research perspective, investigate the occurrence of compassion fatigue in various clinical practice settings.

A prevailing concern identified by patients was inadequate pain relief resulting in difficult to manage patient behaviors. Morgan, 2006 discussed in great detail the specific behaviors patients report just to acquire pain medication. Patients may report allergies to many analgesics, request early prescription refills and use many different health care providers to acquire medications (St. Marie, 2014; McCaffery et al., 2005).

Theoretically, nurses may not have enough knowledge of how to provide care that is perceived to be adequate or satisfactory by this particular population of patients. This knowledge deficit results in patient dissatisfaction and nurses feelings of frustration and job dissatisfaction. Basic distrust may be at the root of this problem. Neither patients nor nurses trust one another. Nurses do not have trust in patient reports of substance use and current pain and patients do not trust the healthcare system to provide them adequate pain relief (Oliver et al., 2012; McCaffery et al., 2005).

Compassion fatigue, a term used to describe dissatisfaction with the job, or when a job causes more distress than satisfaction (Sheppard, 2014; Bao & Taliaferro, 2015). Compassion

fatigue has been identified by the inability to provide care that is perceived as caring by others. As nurses interact with patients for long hours each work day, they are at risk for developing compassion fatigue. Compassion fatigue has a negative effect on the nurse, the employer and the patients cared for by the nurse. Compassion fatigue can lead to increased time missed from work, and poor patient nurse relationships. Several factors have been identified as contributing to the development of compassion fatigue. Sheppard (2014) and Hunsaker, Chen, Maughan, & Heaston, (2015), identified a lack of manager support as a factor in increasing compassion fatigue. Compassion fatigue can also be a result of unrelenting pressure from a variety of sources. Usually, compassion fatigue is the culmination of multiple stressors from work and private life that overwhelm the person's coping ability.

Research has been conducted to identify strategies to combat compassion fatigue. Rosa, 2014 proposes that nurses take the same approach to maintaining their "game" as athletes do. Rosa suggests daily rituals that maintain health and a balance of life and practice. Rosa (2014) pins his conceptual, "nurse as athlete" on Watson's theory of human caring applied to the nurse as self-caring. The idea that healthcare agencies consider creating and maintaining a "healthy" work setting was offered by one author (Lombardo & Eyre, 2011). According to Lombardo & Eyre (2011) one of the first interventions toward creating a healthy work setting includes talking about the situation. The effectiveness of an education program for identification, prevention and combating compassion fatigue was studied in emergency nurses (Flarity, Gentry, & Mesnikoff, 2013). Flarity et al., (2013) designed a multilevel education intervention starting with a group seminar to discuss resiliency to compassion fatigue. The next intervention provided multimedia resources to study participants. At the conclusion of the study, participants reported positive outcomes in their ability to engage self-help and resolve compassion fatigue (Flarity et al., 2013).

Generally, a review of an institution's available resources, especially the role of the human resources department personnel should be made public. Flarity et al., (2013) identified a multidisciplinary approach to manage stress with the understanding that employees do have access to employee assistance programs. Lombardo & Eyre, (2011) also suggest the human resources department present classes or in-service programs that address the employees identified concerns. Flarity et al., (2013) found that a series of education interventions was successful in decreasing compassion fatigue and increasing compassion satisfaction in emergency nurses. Lombardo & Eyre, (2011) offered suggestion for classes such as stress reduction, balancing work and home life and even financial planning. Several authors discuss developing self-care strategies; rituals including healthy eating, sleeping and exercise (Lombardo & Eyre, 2011; Rosa, 2014). Schwartz rounds have also been identified as a technique or intervention that successfully improves nurses' satisfaction and therefore improves patient satisfaction (Thompson, 2013). Taking care of one's self (self-care) as an intervention toward improvement in self-compassion, originates in the theory of human caring by Watson (2008). Several authors note the interdependence of nurses caring for themselves and effectively caring for patients (Mills, Wand, & Fraser, 2015; Lombardo & Eyre, 2011; Hunsaker et al., 2015).

Jean Watson offers; caring science as a foundation for nursing and its' approach to caring-healing-person-nature-universe (Watson, 2008). Watson builds on her own basic assumptions of caring with specifics about how caring can be accomplished: interpersonally, human-to-human and that caring promotes health and healing (Watson, 2008). In Watson's subsequent work identifying Caritas Processes she identifies nurses "developing and sustaining a helping-trusting, authentic caring relationship" (Watson, 2008, p.31). Further, Watson states assumptions to her Caritas (Latin for love) "learn how to offer caring, love, forgiveness,

compassion and mercy to ourselves before we can offer authentic caring and love to others" (Watson, 2008, p. 41). It is clear the theory of human caring is well developed and easily applied to caring compassion to ones' self and others. From compassionate care, the concept of fatigue of providing and exuding compassion is easily understood.

Theoretical Framework

Caring for others has the potential to exhaust the care giver. Jean Watson (2008) sates; "caring begins with being present, open to compassion, mercy, gentleness, loving kindness, and equanimity toward and with self before one can offer compassionate caring to others" (Watson, 2008, p. xviii). Watson's caring theory will be the framework for this work. Watson's theory supports that real caring by healthcare providers creates an environment where the best recovery can occur (Desmond et al., 2014). When nurses care for a population that has both behavioral and physical health concerns, the stress to the care provider is a challenge that may result in perception by the patient of uncaring healthcare provider attitudes.

Jean Watson's theoretical framework of caring science supports the understanding that caring for others has an impact on the self. Watson describes this as a fundamental beginning for nursing as a profession with nursing's emphasis on ethical, moral focus on human being (Watson, 2008). Bailey (2009) explains Watson's Theory of Human Caring evolved from the science of caring Watson professes the caring science "informs the profession and serves as the moral-philosophical-theoretical foundation starting point for nursing education, patient care, research and even administrative practices" (Watson, 2008, p. 16). Caring as a science includes both self-care and care of others. The ten (10) Clinical Caritas Processes offered by Watson describe caring actions easily applied to nursing care with a more spiritual identity (Bailey, 2009). "Caritas" comes from the Latin word for charity or love. The very term; "caritas"

indicates a theory of love that is motivated by charity. Ryan, (2005) writes about integrating Watson's caring theory into clinical practice using Watson's original theory of the ten carative factors which later evolved to the ten-clinical caritas (Ryan, 2005).

A theory that focuses on caring is integral to the work of nurses. Often, the words "caring for people" are offered as the original reason individuals seek the profession of nursing and engage in nursing practice. However, caring for others day after day can take a toll on the nurses themselves. As healthcare delivery has increased in complexity, nurses have experienced increased stress and fatigue. This condition has come to be understood as compassion fatigue. Maintaining self-care physically and mentally is part of Watson's human caring science noting that in fact, nurses are human too. Gustin & Wagner (2012) identified that self-compassion results in compassionate care. (Gustin & Wagner, 2012)

The caritas that have been chosen for this work are:

> #4. Developing and sustaining a helping-trusting relationship.
>
> #8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity and peace are potentiated.
>
> #9. Assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiate alignment of body-mind-spirit, wholeness in all aspects of care. (Norman, Rossillo, & Skelton, 2016, p. 402)

The chosen caritas will become the guiding framework for this work. A focus will be placed on providing a caring environment for all persons; nurses and patients as well as family support systems and non-nursing healthcare providers. One of the most fundamental principals in providing care is the development and maintenance of a trusting relationship. Nurses need to

have trust in their coworkers and the healthcare team. An expectation of trust must be extended to patients as well. Nurses should be able to trust that patients are truthful especially if safe care is to be delivered. Patients should feel safe enough to trust that healthcare providers are providing competent care. For healing to take place, both patients and nurses need to expect and provide care to a whole being, the mind-body and spirit of a person. Dignity is a fundamental expectation as well. Simple expectations of privacy and honesty are the foundations of care. Care that is provided in a genuine caring fashion will foster healing. The concept of mutual goal attainment is more easily accomplished with an environment of safety. Honest exchanges between individuals, the nurse and patient, are more likely to result in positive sustained relationships.

It is vitally important for nurses to be able to deliver care that is perceived by their patients are caring, since caring has a positive influence of healing outcomes (Desmond et al., 2014). Desmond et al. (2014) describe the importance of positive patient perceptions of care as having an impact on reimbursement for care provided. The Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) scores query points of care such as courtesy and respect from nurses when third party payment is awarded (Desmond et al., 2014).

Project Design

Description of the Project

This project aims to decrease compassion fatigue through the implementation of a quality improvement project. The project focuses on increasing nurses' awareness of the signs, symptoms and complications of compassion fatigue. The FADE model will be utilized as the framework for this quality improvement project. FADE is an acronym for focus, analyze, develop, execute and evaluate (Moran, Burson, & Conrad, 2017)

Focus for change is the nurses' delivery of compassionate care. The data was analyzed by the project lead who consulted with a statistician to ensure the data collected corresponds with the objectives measured for this project. (K. Durkin, personal communication, August 10, 2017). Data was collected from a pre/post intervention survey using the Compassion Satisfaction and Compassion Fatigue self-assessment ProQOL Scale (CSCFS) (APPENDIX A). The pre-intervention surveys will be administered via Survey Monkey. The tool will be delivered to the email address provided by the participant. Participants' email addresses were collected at the time of the pre-survey. Post intervention surveys were delivered via email in Survey Monkey format. A plan for development of the project included a time line for each step of the process as well as which assessment tool(s) will be used. Evaluation of the project came from the post-intervention survey results.

The population of interest for the planned project was the nurses working in medical-surgical units. Over the past decade, the medical surgical units have noted a high population of patients with substance use disorder. The following demographic information will be collected from the participants: age, gender, years of nursing, shift worked (0700-1930 or 1900-0730) the participant unit and, the highest level of education the participant has achieved.

The proposed project included a pre-intervention survey and post-intervention survey of nurses' self-assessment of compassion fatigue, an information presentation using PowerPoint during a 30-minute lunch and learn session. Lunch and learn sessions took place over one week. Two sessions per day over a three-day period includes one day and one-night shift session each day. Sustainability of awareness of compassion fatigue was accomplished through a "touchstone" or "grounding object" reminder chosen from options provided by the project lead or identified by the participant. Data was gathered from a pre-intervention survey distributed at

the time of the education session paired with a post intervention survey distributed by email 2 weeks after the intervention. If the post intervention survey was not returned within 1 week, the participant was reminded via email to complete a link to a survey monkey survey will be provided. The pre and post intervention survey are identical. The statistical package for social sciences software (SPSS) was used to analyze the findings. The sample size planned is greater than 30 medical surgical nurse participants allowing for a 2-tailed t-test to be performed. Participants' information was, and continues to be kept confidential through an online survey completion. However, their attendance at the "lunch and learn" will not be confidential for obvious reasons. Incentive to participate was noted through the participants' interest in the topic, and distribution of "touchstone grounding" items.

Population of Interest, Stakeholders, Setting, Methods of Recruitment

Population of Interest

The population of interest for this project were medical surgical registered nurses employed in a medical surgical setting for a health care system in New Jersey. There are approximately 882.39 direct patient care full time equivalent positions for nursing throughout the chosen health network. The medical surgical units care for patients with a variety of diagnosis.

Stakeholders

Stakeholders include the nurses of the medical surgical unit, the unit managers, supervisors, nursing administration chief nursing officer (CNO) and nurse educators. Nursing management of the medical surgical units as well as the nurse educator have been supportive of this project. The administration was not able to support mandatory nurse participation due to collective bargaining agreement. Support was evident in the scheduling of conference room space.

An agreement to perform the project was been signed by all necessary parties, and is available in the office of Director of Research and Nursing Quality. The nurse managers of the medical-surgical units where the project will take place have agreed to support the project.

Setting

The project took place at three acute care facilities in the health care network in southern New Jersey. The practice site is a comprehensive health network with 3 acute care facilities. There are a total of 674 acute care inpatient hospital beds and 882.39 direct patient care full time equivalent positions in the network.

Methods of Recruitment

Participants were chosen for this DNP project through convenience sampling technique. A paper flyer announcing the education intervention was posted on each nursing unit. No monetary incentive was used in recruitment.

Tools and Instrumentation

The tools used in the collection of data were a matching pre/post intervention survey. Professional Quality of Life Scale (ProQOL5) is a 30-item survey tool (Appendix A). There are three subscales within the tool: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (CSBSTS). Each subscale has been tested for reliability, and has been found to be reliable using Cronbach Alpha scores. Reliability scores for the subtests are: Compassion satisfaction 0.88, burnout 0.75, secondary trauma (a secondary component of Compassion Fatigue) 0.81. Permission to use this tool was been obtained. Permission to use this tool is in appendix A.

Demographic information was gathered on age, gender, and years of nursing experience of the participants. A sign-in sheet was completed before the education intervention. The sign-in sheet and surveys will be confidential with no personal identifiers. Participants created a

unique personal identifier (5 digit number of their choice) on the sign-in sheet. No names were collected on the sign-in sheet. The link to the survey tools was provided to all participants. Attendance sign in sheet and all intervention materials continues to be maintined in a secure location accessible only by the project lead.

Data Collection Procedures

Pre-Implementation

Participants completed the ProQOL 5 from a Survey Monkey link emailed to the email address provided by the participant on the sign-in sheet. The tool was completed before the education intervention. It was expected that the survey completion takes no more than 10 minutes. Participants used their own electronic devices to access the survey.

Post Implementation

During the post implementation period, the ProQOL 5 was completed electronically through Survey Monkey. The Survey Monkey link was emailed to the email address provided by the participant during the initial sign in process. Surveys were associated to matching pre-intervention surveys. The survey link was emailed to participants up to three weeks after the intervention. If the participant did not respond, a follow-up reminder was emailed. A statistician was available for assistance with codebook development and design of appropriate statistical testing. Data was entered by the project lead. Paired t-tests and mean scores for subscales on the ProQOL 5 Scale tool were performed and reported.

Intervention Project Timeline

Week to accomplish task	Activity
Week 1: 11/27/17-12/5/17	IRB application
	IRB anticipated less than 4 weeks

Week 2: 12/26/17-1/2/18	Search and acquire touchstones and grounding reminders. Plan presentation as New Year Party. Acquire supplies.
Week 3: 1/3/18-1/7/18	Announcements to nurse managers provided by project mentor at all three facilities.
Week 4: 1/8/18-1/14/18	Education intervention provided. 2 sessions will be provided at each of the 3 acute care hospitals. Participants perform a pre-intervention ProQOL survey tool. Begin data entry from pre-intervention Survey Monkey into Excel-SPSS
Week 5 & 6: 1/23/18- 1/30/18	During these two weeks the post intervention assessment tool will be delivered using Survey Monkey
Week 7: 1/30/18-2/6/18	Data collection from surveys, input into SPSS Analysis with statistician.
Week 8: 2/7/18-2/14/18	Evaluation

The anticipated project timeline was 8 weeks after institutional review board review and approval. Before the actual project was implemented, an application was submitted to the facility research council for approval. It was anticipated that institutional review board approval would take less than 4 weeks. Preparation of the application took approximately one week. After the project received approval, one week was dedicated to announcing the education sessions. The project was also announced and briefly described to staff by unit managers. One education intervention session was scheduled at each acute care hospital in the network system over a 3-day period. Each session lasted approximately 30-45 minutes during which time the pre-education intervention survey tool, ProQOL 5 Scale will be completed by the participant, followed by a brief slide show presentation including two videos. One video explains Watson's theory of caring and the second video is a practice meditation track from Watson's caring meditation. Following the intervention, 2 weeks were allowed for post implementation survey tool completions. A link to the post assessment survey tool was delivered electronically to the email provided by the participant. A two-week period followed the post implementation survey

period for downloading survey data and inputting information into SPSS. The final two-weeks were dedicated to analyzing the data and evaluating the project.

Ethics and Human Subjects Protection

The practice site required completion of an application to conduct research that is completed with the director of research and nursing quality. Consent to participate forms are included in this process. Participants took part in the project voluntarily. There is no identifiable risk to participants now. No personal identifiers were collected during the process. Data was retained in a locked location separate from the nursing units accessible only by the project lead.

Plan for Analysis/Evaluation

The project lead used SPSS statistical package for the social sciences software for analysis of the following items:

Demographics

To evaluate the demographics of the participants' descriptive statistics was used. The project lead analyzed the age, gender, years of nursing, shift being worked, and highest degree earned. The findings were presented in a chart listing measures of central tendency (range and mean).

Compassion Satisfaction and Compassion Fatigue (PROQOL) Version 5

To evaluate the change in compassion fatigue and compassion satisfaction, a paired t test was performed. A two-tailed t test uses the same participants at two different time frames using the same tool. This tool was completed before and after the compassion fatigue educational sessions.

A two tailed-t test was used to evaluate the changes in self-caring behaviors. A two tailed-t test is used when the same participants, using the same scale are assessed at two different times.

A meeting with a statistician was scheduled and completed to determine the appropriateness of using a 2 tailed-t test comparing pre-and post-intervention compassion fatigue. Consideration to getting a complete sample size greater than 30 participants particularly in the post education session necessitated using non-parametric test for comparison. The non-parametric test used for sample sizes less than thirty would be the Mann Whitney U test. This test is indicated when there are unequal sample sizes. It has been suggested by the director of research and nursing quality at the practice site that ordinal data which is what is being collected is better suited to a Mann Whitney U test.

Survey items were entered in an excel spreadsheet to facilitate extrapolation to parametric test, paired t-test or if indicated the non-parametric Mann Whitney U test. Analysis of survey results will include tests of reliability, Cronbach alpha. Currently there are no open-ended survey items to tabulate and summarize for theme responses.

Significance for Nursing

The significance to nursing for this project is simply, reducing nurses' compassion fatigue will the improve nurses' quality of life as well as job satisfaction.

Caring for others can be a stressful experience. Ongoing and or unrelieved stress can result in poor quality of life or poor job satisfaction. Unfortunately, either of these conditions can cause declining health that in turn may affect the length of time a person is able or even willing to work. Another possible negative affect of compassion fatigue is an imbalance

between work and private life activities. With a well-documented nursing shortage occurring, it is important to keep nurses in condition to remain in the workforce.

Analysis of Results

The statistical package for the social sciences (SPSS) version 24 was used to analyze the data collected. Four matched pairs of pre-intervention and post-intervention responses were entered into the statistical system for analysis. The mean scores for the Compassion Satisfaction and Compassion Fatigue Scale (CSCFS) (PROQOL 5), and three sub scales of compassion satisfaction, burnout and secondary traumatic stress were calculated after conducting tests of normality or Shapiro-Wilk (Pallant, 2013). Paired sample t-tests were used to compare the means of subscales found to be normal and Wilcoxon Signed Rank test were used for data found to be non-normal (Gray, Grove, & Sutherland, 2017).

In preparing the data for analysis, the project lead reviewed the data for missing responses and items that required reverse scoring as described by the CSCFS. (Gray et al., 2017). One item was missing from one post-intervention survey and was assumed to be unintentionally omitted by error by the participant. The omitted item was replaced by a neutral score as indicated by the survey tool direction (Gray et al., 2017). All items requiring reverse coding were performed by project lead when entering data.

Sample

Of the 4 participants, 100% were female (n=4) with 50% (n=2) of nurses holding a BSN and 50% of nurses holding a MSN (Table 1). The largest number of participants 50% (n=2) had more than 20 years of experience, 25% (n=1) had between 16-20 years of experience and 25% of the participants (n=1) had less than 1 year of experience.

Table 1

Demographic Statistics		
Education	n	%
ADN	0	0
BSN	2	50
MSN	2	50
DNP, PhD, EdD	0	0
Years of Experience	n	%
Less than 1	1	25
1-5	0	0
6-10	1	25
11-15	0	0
16-20	1	25
More than 20	1	25

Normal Distribution of Data

The project lead conducted tests of normality to assess meeting the assumptions of parametric testing. None of the survey subscales met the criteria for parametric testing. For all three subscales not meeting the assumptions of parametric testing, the project lead used the non-parametric equivalent, or Wilcoxon Signed Rank Test.

Comparison of Measures of Central Tendency-Parametric and Non-Parametric

The decision to use one statistical test for comparison of means over another is based on the participant sample size and scale used to collect data and assessment of the data is meeting the assumptions of parametric testing (Pallant, 2013). For this data set, the sample size of 4 was too small to have reliable T-test results. The paired T-test was however completed for each of the three sub scales. The mean scores were found to be statistically significant for all three subscales, though the T-test is not reliable with a sample size less than 30.

Paired Sample t-tests

Evaluating all three subscales for normal distribution, a two-tailed paired sample t-test was conducted to evaluate the impact of the education intervention on the perception of

compassion satisfaction, burnout, and secondary traumatic stress. Each of the three subscales scored a $p < 0.05$, indicating there is a significant difference between the pre-and post-survey data gathered. The compared means of the paired sample T-test of the three subscales were examined for the direction of the difference. The compassion satisfaction pre-and post-data comparison of means shows a difference in the direction of the pre-survey data meaning the participants reported a significant decrease in mean in pre-intervention compassion satisfaction MEANCompSatPRE (M = 43.75, SD = 1.89) to the mean of MEANCompSatPOST (M =37.75, SD 3.59), $p < 0.05$ at .007. The mean decrease is 5.81 with a 95% interval ranging from 3.095 to 8.905. Data analysis for the Burnout subscale, from MEANBurnOutPRE (M = 20.00, SD = 4.082) to MEAN BurnOutPOST (M=20.75, SD = 2.63), with a $p>.05$ demonstrates no significant change from the pre to post intervention perceived burnout subscale. The mean increased 0.75 with a 95% interval ranging from -4.519 to 3.010. Analysis of the Secondary Traumatic Stress sub scale was an increase in the identification of secondary traumatic stress. MEANTraumStressPRE (M = 18.75, SD = 2.062) to MEANTraumStressPOST (M = 21, SD 3.74). The significance is greater than, $p < 0.05$. The mean decrease is -2.25 with a 95% interval ranging from -4.968 to .468.

Wilcoxon Signed Rank Test

The Wilcoxon Signed Rank Test is utilized for comparison of median measure of central tendencies when data not normally distributed (Gray, et al., 2017). According to Pallant (2013), the Wilcoxon Signed Rank Test is "the nonparametric alternative to the repeated measures t-test. The Wilcoxon Signed Rank Test uses a rank order from time 1 & time 2 to compare samples rather than mean scores. None of the three subscale tests showed any significant change between the pre-and post-survey administrations. For the compassion satisfaction subscale, $p > 0.05$

(0.068). The median score for the compassion satisfaction score was (0). The rank score for the Secondary Traumatic Stress scale was $p > 0.05$ (0.109) with a median score of (0). The rank score for burnout had a $p > 0.05$ (.705) and the median score burnout subscale was (0). No significance was noted in any of the three subscales with the Wilcoxon Rank Test.

Discussion of Findings

The education presentation of this topic to the medical-surgical nurse participants did not result in any significant difference in the amount of compassion satisfaction or compassion fatigue identified by the participants. According to the project findings the following two project objectives were not met: reduce compassion fatigue and improve self-care behaviors through education and, to improve the nurses' ability to practice techniques that decrease compassion fatigue. The pre-intervention scores on the CSCFS for compassion satisfaction of 43.75 with the average scale score of 50 is interpreted as having high compassion satisfaction. This finding indicated the participants were mostly satisfied and able to deliver compassionate care. The findings suggested that the participants are deriving satisfaction from the workplace. Scores from the two subscales measuring compassion fatigue; burnout and secondary traumatic stress were low, generally indicating the participants did not have compassion fatigue. For the burnout scale, the participants mean score of 20.00 on the pre-intervention survey and 20.75 on the post-intervention survey scored in the lower 25% according to the CSCFS. Scores less than 22 are interpreted to have low burnout. The findings indicated that the participants have gained positive feelings about the workplace along with the ability of job effectiveness. The second subscale for compassion fatigue, the secondary traumatic stress score was also low for participants with a mean score of 18.75 during the pre-intervention and 21 on the post-intervention survey indicating a very low rate of secondary trauma.

It is likely the objectives of the project were not met since the pre-intervention survey revealed low compassion fatigue scores and improvement might not be needed. It is still important to measure the scores periodically to assure nurses are not experiencing compassion fatigue.

During the education intervention, the participants were engaged and several revealed examples of self-care practices to maintain emotional health. The participants volunteered verbally that even though the job is sometimes overwhelming due to many tasks, the job, workplace and camaraderie remains enjoyable. Without exception, the participants identified that job satisfaction was positively influenced by coworkers.

Implications for Nursing

The project has significance to nursing as a profession as it is charged with caring for others. Nurses must maintain an ability to provide care that is perceived by the patients as compassionate, for that care to be effective. It is important to periodically assess nurses' level of compassion satisfaction and compassion fatigue to maintain a thriving effective workforce. The ability to sustain an effective workforce is imperative to the profession since people will continue to become ill and require the skill and compassion of nurses.

Nursing has been identified as a caring profession. Jean Watson, a nursing theorist identifies the consequences of caring for others more than caring for oneself. This over expenditure of caring behavior leaves the nurse in a state of compassion fatigue, a condition that could cause an inability to provide care that is perceived by others to be caring, and or dissatisfaction with a job such as when a job causes more distress than satisfaction (Watson, 2012). Nurses are expected to not only provide care that is safe, but to provide genuine caring to be effective (Norman et al., 2016).

Compassion fatigue may be manifested by illness, (physical or behavioral), increased absence or tardiness from work and expressions of negativity. Effective nursing requires teamwork and collaboration based on communication. Those experiencing compassion fatigue have negative effects on coworkers and the delivery of care. With emphasis being placed on patient satisfaction, it is important that employers assist their employees to regularly assess risks as well as manifestations of compassion fatigue. A shift from measuring positive care outcomes to one of ensuring patient satisfaction for third party payment has been identified by Zimmermann (2000), Boerner & Hwang (2010), and Kerfoot (2009).

As the measure of success in the nurse patient relationship has changed, more pressure has been placed on nurses' attitudes and conveyance of empathy. The patient population, and cause for hospitalization has also changed. An increase in the number of patients admitted with SUD and comorbidities has further challenged nurses' caring behaviors. There is little time spent in prelicensure nursing curricula to assist nurses to accurately and genuinely care for this population. Nurses may feel unprepared in how to meet the multidimensional needs of this population. Several authors have reported patients being unhappy with nurses' behaviors. Specific discouraging behaviors are: labeling patients, passing judgement, lack of attentiveness and discrimination (Ti & Ti, 2015; St. Marie, 2014; Monks, Topping, & Newell, 2012).

The future of the nursing profession must respond to the change in the patient population and provide care that is perceived by the patient as caring. Healthcare systems are experiencing more competition for fewer dollars in healthcare reimbursement. Healthcare systems that are able to improve patient satisfaction through compassionate care delivery will be successful. Maintaining the compassion satisfaction of nurses employed by a healthcare system is key to sustaining its' success.

Limitations

Several limitations have been identified with this project. The project design used a handwritten sign in sheet that could not always be interpreted. During the participant recruitment and data collection phase, familiarity with the site did not allow for aggressive recruitment of participants. Implementing the project was scheduled during weather related challenges to staffing, and each of the three implementation sites presented technology challenges.

Project Design

The project was designed for quality improvement using a pre and post questionnaire following the intervention. The questionnaire time intervals were separated by 2 weeks and this was too short a time to actually measure a difference in compassion satisfaction or compassion fatigue and any change is more than likely contributed to the training intervention which was used in the implementation of the project.

This project used self-reporting of feelings about caring in the pre and post questionnaires. In addition, an established survey tool, CSCFS was used. The surveys were delivered electronically through a link to Survey Monkey. Confidentiality of survey responses was maintained through use of individual participant chosen 5-digit identifiers. The participants did not use their name or any identification other than their chosen 5-digit code when responding to both the pre and post questionnaires. Participants used an email address of their choice which was matched to the 5-digit identification code. The sign-in sheet was maintained by the project lead in a secure location though no identifiers were included on the sheet. The electronic copy of the surveys has been maintained on the application site. As a result of this design the use of the

hand-written email address became another project limitation as the handwriting was illegible at times which made it difficult to reconnect with the participant as part of the project. An electronic sign-in on a computer might have eliminated this limitation.

Data Recruitment and Collection Methods

The most significant limitation to the project occurred in participant recruitment and data collection. The project leader was not able to aggressively recruit participants due to unfamiliarity with the facility. Also, participants were solicited at 3 separate facilities within the health network. The project lead provided a recruitment poster to the practice site mentor who posted this electronically and physically through the unit managers. The project was implemented at each of the 3 facilities in one week. Unfortunately, the scheduled week saw severe weather conditions (snow and ice storms) that limited participant availability due to short staffing related to absenteeism. Six education sessions were held with a total of 18 participants completing the hand-written sign in and pre-education questionnaire. Two weeks later, the post-intervention questionnaire link was sent to the email addresses provided. Several of the email addresses were invalid and the link was undeliverable. Permutations or guesses at the handwriting were not successful. Ultimately, only 4 pairs of pre and post education questionnaires were obtained.

Still more limitations were encountered during each education session site. The education was delivered at three sites and each presented unique challenges: inability to achieve internet access, lack of projector sound system and lastly inability to project the presentation onto a presentation screen. The project lead was able to improvise using a personal laptop computer achieving as much consistency as possible between all presentation sessions. Fortunately, small participant numbers allowed for presentation viewing from a laptop monitor.

Data Analysis

The very small number of matched pairs for the pre and post education questionnaires was a limitation. Data was analyzed using SPSS but could easily have been reported using simple descriptive statistics and measures of central tendency. Survey data was maintained electronically through Survey monkey links. The use of software programs such as SPSS and Microsoft excel was a possible limitation to the project again due to the very small sample size.

Dissemination

The project findings were of interest to the practice site and to the project leader. The project leader will continue to disseminate the project findings into the community. The DNP leader has a responsibility to professional practice to share the project with others especially those who participated in the project. The practice site is in the process of magnet status renewal and will include the project as part of the reaccreditation documentation. The project leader will also disseminate the findings through poster presentation at the practice site where quality improvement and research projects are presented in the spring. In addition, the project leader will provide a PowerPoint presentation to her place of employment, a school of nursing site. The PowerPoint will be presented during an advisory meeting with area stakeholders including the project site educators. Lastly, the project will be presented as a PowerPoint to the Touro University Nevada colleagues and faculty.

Project Sustainability

Although the project was not statistically significant there was a clear trend towards interest in the topic by the participants and the practice site. To sustain this topic within the practice site the project leader will develop two-to three slides on compassion fatigue that will be

used in the annual "skills review" presented by the staff education at the practice site. The information will also be used at the site with a campaign for an awareness of compassionate care and will be provided through a periodic running home screen on the nursing portal. Dissemination of the project findings and the information on compassion fatigue to nursing students through a poster presentation as well as PowerPoint narrative would help to also ensure the sustainability of the project. Lastly the project leader has an opportunity that will occur in the summer of 2018 and will interact in an education session with third year medical students beginning their first clinical rotation.

Conclusion

Identification and prevention of compassion fatigue for all nurses continues to hold importance for the individual as well as patients and employers. The looming shortage of professional nurses cannot be ignored. Increasing retention of nurses in the profession is one strategy to stave off the shortage. Nurses who experience compassion satisfaction are better able to extend their professional career lives. Nurses who are satisfied in their work miss fewer work days and are more effective in their work.

Though this project did not show compassion fatigue in the participants, an ongoing awareness of self-care behaviors and practices that reduce compassion fatigue would benefit the profession.

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APPENDIX A

Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL5).

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue

(ProQOL) Version 5 (2009)

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

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

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Scoring the survey will be completed by the project lead. Participants will not be completing the self-assessment scoring.

Compassion Satisfaction _____

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

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

Burnout_____

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

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

Secondary Traumatic Stress_____

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

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

Scoring the survey will be completed by the project lead. Participants will not be completing the self-assessment scoring.

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

Compassion Satisfaction Scale

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

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

Total: _____

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

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

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

Total: _____

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

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

Secondary Traumatic Stress Scale

Just like you did on Compassion 2. ____

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

5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: _____

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

ProQOL.org

MAIN NAVIGATION

- HOME
- THEORY
  - CS-CF THEORY
  - CS-CF THEORY MODEL
  - COMPASSION SATISFACTION
  - COMPASSION FATIGUE
  - BURNOUT
  - SECONDARY TRAUMA
- PROQOL MEASURE & TOOLS
  - PROQOL MEASURE
  - PROQOL MANUAL
  - BIBLIOGRAPHY
- PRESENTATION AIDS
  - PRESENTATION SLIDES
  - HELPER POCKET CARD
  - HANDOUTS
- USE THE PROQOL
  - RESEARCH USE
  - REQUEST USE PERMISSION
- PROQOL DATABANK
  - ABOUT PROQOL DATA BANK
  - DONATE DATA
- RESOURCE LINKS
- FAQ
- ABOUT US
  - PROJECTS OF THE HEART
- CONTACT US
- VOLUNTEER
- DIX

Permission Letters

Thank you for completing the form for permission to use the ProQOL. This page provides access to permission letters. It also specifies the terms of use.

Please read the FAQs if you have questions about use. Most of the time you will find your answer there.

If you wish to use the ProQOL for non-commercial purposes, simply download the Permission to use the ProQOL form below. The form you submitted will be on record with our office so that we will know you requested permission. Make sure to keep a copy of the information you submitted with your use permission form. Together, the information you submitted and this page are your permission. These letters alone are not sufficient without a copy of the use permission form.

In the spirit of helping others, we assume that you will use the ProQOL for good. By submitting your form and downloading the permissions, you agree to the following conditions.

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- You, or someone with whom you work, will not profit directly from selling the ProQOL or products that rest in large part on the ProQOL. The ProQOL can be freely used as part of a school course, training curriculum or in a book or journal when it is not the substantial part of the work.
- We encourage you to review and use the Best Practices Parameters from the International Society for Traumatic Stress Studies. To find more about these, go to the International Society for Traumatic Stress Studies website at www.istss.org. Among others there are parameters for Trauma Research and Teaching and Training about Trauma, and International Training Guidelines.

I wish you the very best as you use the ProQOL. Please do consider donating a copy of your data. You can find more information about data donations at the Donate Data page on the ProQOL site.

Beth Hudnall Stamm
Developer and Director, ProQOL.org

Permission to Use ProQOL --This permission must accompanty any other permissions

Additional Permissions -- Make sure that you have the above *Permission to Use* letter above.

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APPENDIX B

Power Point Presentation

Understanding Compassion Fatigue

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