COMPASSION FATIGUE IN HOSPICE NURSING:

A PROGRAM DEVELOPMENT

by

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Abstract

Hospice nursing is an important aspect of health care. Hospice nursing is a specialized field in which patients are cared for at the end of life and an important aspect of healthcare. Because the care hospice nurses provide comes at the end of life, they are continuously exposed to death, dying, pain and suffering. Numerous studies have documented that continuous exposure to trauma, death and dying may result in compassion fatigue (CF). Compassion fatigue can lead to a physical and emotional toll on nurses resulting in low staff satisfaction, high turnover rates, and reduced quality of care. The purpose of the project was to develop and implement an educational program about CF for hospice nursing staff at Care New England Visiting Nurse Association (VNA). First, a comprehensive needs assessment was conducted and then an educational intervention was developed based on those results and the review of the literature. It was hoped that as a result of the program hospice nurses' knowledge and understanding of CF, its signs and symptoms and prevention interventions that might minimize or prevent the effects of CF would be learned. Sixty-seven percent of eligible nurses (n=8) participated in the intervention. The participants were asked to complete a post program survey and evaluating the program positively and strongly agreed that they benefitted from it. All eight participants stated that there knowledge of compassion fatigue and self-care techniques had improved.

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Background/Statement of the Problem

Nurses have a key role in designing and implementing new models of care and solutions to improve quality outcomes (Weston & Roberts, 2013). The care that a patient receives from nurses is one of the most significant predictors of patient satisfaction and overall healthcare performance (Neville & Cole, 2013). Improving the quality of healthcare involves providing the best care for the patient at the right time. The quality of care provided at a patient's end of life is crucial. Enrolling patients who have been diagnosed with a terminal illness into a hospice program rather than continue aggressive treatments has been shown to improve the quality of care and the quality of life for patient (National Hospice and Palliative Care Organization, 2013). Hospice nursing occupies an important and growing segment of healthcare. The work can be difficult as the work revolves around patients' end of life care. Hospice nurses are continuously dealing with pain, suffering, and loss of life. A nurse who is unable to provide emotional, empathetic, compassionate care at a patient's end of life can adversely affect the patients' and the families' outcomes (Neville &Cole, 2013).

As hospice agencies continue to expand across the country, these agencies must begin to recognize that continuous exposure to death and dying, pain and suffering takes an emotional and physical toll on nurses. These constant exposures frequently results in hospice nurses developing compassion fatigue (CF) which can lead to poor staff satisfaction, high turnover rates, and poor quality of care.

Compassion fatigue is the term used to describe the final result of a progressive and cumulative process which is caused by prolonged, continuous, and intense contact with patients, the use of self and exposure to stress which manifests with marked physical, social, emotional, spiritual, and intellectual change (Neville & Cole, 2013). Compassion fatigue is the emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. It can occur due to exposure to one particularly traumatic case or can be due to a "cumulative" level of trauma (Figley, 1995). Those suffering from CF become physically, mentally, and spiritually exhausted. These symptoms negatively affect the ability of an organization to provide services and maintain personal and professional relationships and may lead to high turnover rates, loss of productivity, and diminished capacity to enjoy life (Showalter, 2010). Hospice nurses in particular are highly susceptible to CF because of their constant exposure to death, dying, and suffering.

In addition to hospice agencies facing an affected work force, they will also be facing a significant challenge. The Patient Protection and Affordable Care Act (PPACA) has directed a decrease in reimbursement for hospice agencies. This reduction of 14% will occur over the next 10 years (National Hospice & Palliative Care Organization, 2015 a). This reduction in financial resources may force increased caseloads for hospice nurses already at risk for CF and will potentially make it more challenging to recruit, orient, and sustain registered nurses. This in turn may further challenge the ability to deliver high quality care at end of life.

This project used the best available evidence available about CF to create an educational program designed to increase the awareness of CF in hospice nursing.

Next, the review of the literature will be presented.

Literature Review

A thorough literature search was performed using CINAHL and web searches of related websites. The search terms used were "compassion fatigue," "secondary stress," "burnout," and "moral distress." The search results were further narrowed more specifically adding "nursing" and "hospice." The texts utilized were of the English language published the last 15 years.

Hospice and Hospice Nursing

The term "hospice" is a term that has been traced back to medieval times when it referred to a place of shelter and rest for tired or ill travelers on a long journey. The name was first used to describe the specialized care for dying patients by physician Dame Cicely Saunders. Dr. Saunders went on to create the first modern hospice, St. Christopher's Hospice, in a residential suburb of London (National Hospice & Palliative Care Organization, 2015, b). Hospice in the United States was based on the model that was established in England. Two organizations in the United States were developed in the early 1970s including New Haven Connecticut and Marin County, California (Wright, 2001).

The first hospice standards of care were created in 1974 by an international committee and adopted by these hospice locations. There had always been care for the dying but no set standard that addressed the medical, social, psychological, and spiritual needs of a patient or their family during the dying process. These standards focused on not only the patient but also the family and loved ones as well as the staff that provided care to the patient (Wright, 2001).

A hospice nurse cares for patients at the end of their lives. The main role of a hospice nurse is to help people live as comfortably and independently as possible and with the least amount of pain. Hospice nursing involves helping patients, and their families feel more comfortable about death and providing them with the emotional support they need (The Campaign for Nursing's Future, 2015). Dr. Dolores J. Wright described hospice as a philosophy of care designed to keep the patient as functional and comfortable as possible until death (2001).

Hospice is unique among other nursing specialties as its main focus is end of life care. Because hospice nurses are consistently faced with end of life situations, pain and suffering both emotional and physical, and bereavement, hospice nurses are highly susceptible to CF (Adenbroth, 2005). Hospice caregivers are especially vulnerable to CF because they sometimes become over-involved, over-invested and are frequently exposed to experiences of loss (Keidel, 2002). Nurses suffering from CF may find themselves unable to provide the needed level of care and support to both the patient and the patent's families at a time when they are at most vulnerable.

Compassion Fatigue: Definition

Compassion fatigue is the emotional residue or strain of exposure to working with those that suffer from the consequences of traumatic events (Figley, 1995). Compassion fatigue can occur due to exposure on one particularly traumatic case or can be due to a "cumulative" level of trauma (Figley). Compassion fatigue is a condition characterized by a gradual lessening of compassion over time. It has been described as "a heavy heart, a debilitating weariness brought on by repetitive, empathic responses to pain and suffering

of others, whereby nurses may absorb and internalize the emotions of patients and, at times, coworkers" (Larowe, 2005, p. 21). Repeated exposure will likely contribute to nurses experiencing negative long-term health effects (Larowe).

Neville and Cole (2013) stated CF occurs due to the intense relationships and experiences one share with their patients. These experiences and relationships result in spiritual, physical and emotional changes in the nurse. Compassion fatigue is the term used to describe the emotional effect of being indirectly traumatized by helping someone who has experienced primary traumatic stress (Edmunds, 2010).

Professor Charles Figley, who has been studying CF in veterans since the Vietnam War, described CF as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress, resulting from helping or wanting to help a traumatized or suffering person (2002). Although Figley worked primarily with psychologists the same principle exists as hospice nurses as they both are frequently exposed to others' stress and trauma. Figley (2002) identified ten variables that form a casual model that predicts CF. These variables include empathic ability, empathic concern, and exposure to the client, empathic response, and compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, and life disruptions. Figley suggested that these variables that make one effective and caring caregivers are the same variables that makes one more susceptible to CF. An example of this is empathic ability. Empathic ability is the ability to recognize one's pain. One could argue without this empathic ability one would be low risk for developing CF. However, without this empathic ability the patient won't be helped.

Showalter (2010) noted that CF is prevalent across all spectrums of the helping professions. Health professionals collect bits and pieces of patients' trauma in the form of pictures in their minds and feelings in their bodies that stays with them. These memories and repeated traumatic experiences stay with an individual and over time begins to not only affect the way the staff are able to provide quality and efficient care but also an individual's personal life and health (Showalter).

Compassion Fatigue: Signs and Symptoms

Compassion fatigue symptoms are normal displays of stress resulting from the care given and may be disruptive, depressive and irritating (Lowenstein, 2013). Symptoms may include excessive blaming, bottled up emotions, isolation from others, substance abuse to mask feelings, compulsive behaviors such as overspending, sexual addictions or gambling. In addition, legal problems, chronic physical ailments and mentally physically tired may be exhibited by those suffering from compassion fatigue (National Hospice & Palliative Care Organization, 2015 b). The American Institute of Stress (2015) further identified signs and symptoms of CF to include regularly waking up tired in the morning and struggling to get to work, individuals become frustrated and irritated easily, everyday events seem traumatic, working harder but accomplishing less, employees feeling bored or disgusted and constantly experiencing aches and pains. Compassion fatigue not only affects an individual but also affects the organization with chronic absenteeism, increasing worker's compensation costs, high turnover rates, friction between employees and friction between staff and management (National Hospice & Palliative Care Organization, 2015).

Showalter (2010) suggested that professional caregivers are normally reluctant to talk about this trauma in the professional setting for fear they will be thought of as "burnt out." These employees keep going and can develop anger and fatigue. They may find brief solace by informally discussing the job with fellow employees who are in a similar situation; however, without digging deep into the true feelings, the positive effects they may feel will be short lived. Employees who suffer from CF can become physically, mentally and spiritually exhausted. Despite this exhaustion the employee continues to give and further neglect self-care. Compassion fatigue can negatively affect the ability to provide care, maintain relationships, both personal and professional, lead to a high turnover rate, loss of productivity, and diminished capacity to enjoy life. The symptoms of CF can be so devastating that they have been known to affect personal lives, professional lives, and break up of families (Showalter).

Compassion Fatigue: Related Terms

The literature revealed that there are several terms that relate to compassion fatigue and are often used interchangeably. Each will be discussed below.

Secondary Traumatic Stress. Secondary traumatic stress is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). An example would be a health care provider that is exposed to a particularly traumatic event or events experienced by their patients.

Moral Distress. Moral distress can be defined as when a situation occurs, one knows what the correct thing to do but institutional constraints make it nearly impossible to pursue the correct course of action (Jameton, 1984). Moral distress is different from the classical ethical dilemma in which one recognizes that a problem exists, and that two or more ethically justifiable but mutually opposing actions can be taken. Often, in an ethical dilemma, there are significant downsides to each potential solution (Jameton). Moral distress occurs when one knows the ethically correct action to take but feels powerless to take that action. Research on moral distress among nurses has identified that the sources of moral distress are many and varied and that the experience of moral distress leads some nurses to leave their jobs, or the profession altogether (Epstein & Delgado, 2010).

Burnout. Burnout is a cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress, not trauma-related. There are several stages of burnout that include enthusiasm, stagnation, frustration, and apathy (American Institute of Stress, 2015).

Many times the terms of burnout and CF are used interchangeably. Although mutually exclusive, sometimes it can be difficult to differentiate between CF and Burnout because of their similarities. Both include emotional exhaustion with a reduced sense of personal accomplishment or meaning in one's work, mental exhaustion, decreased interactions with others (isolation), depersonalization (symptoms disconnected from real causes), and physical exhaustion (American Institute of Stress, 2015). Compassion fatigue is a narrow concept limited to dealing with horrific events in patients' lives. Burnout can be the result of many factors such as an abusive leader, inconsiderate

behavior of physicians, excessive caseload, severe organizational stress, limited resources, unclear expectations, demanding work, or staff shortages. Burnout can often be relieved by finding new employment (Slatten, Carson, & Carson, 2011). Burnout normally occurs and worsens over time while 1CF may happen quickly (Slatten et al).

Compassion Fatigue: Epidemiology

Any occupation that is constantly in the presence of pain and suffering is at risk for CF. Mother Theresa made recommendations to her leadership that her nuns have a mandatory break from their responsibilities every four to five years because of CF (American Institute of Stress, 2015). Research supports that nursing and hospice nursing have a high risk for CF.

Kulbe (2001) examined stressors and coping measures of hospice nurses. Kulbe's research consisted of a convenience sample of 221 hospice nurses from 25 hospices in New Jersey. The Hospice Nursing Census Questionnaire and a demographic questionnaire were utilized. There was reference made to the validity but not to the reliability of this tool in this study. Forty-four percent of the 221 questionnaires were returned. All the participants were female and the mean age was 45.5 years. Survey respondents reported a divorce rate of 20.6%. The major stressors reported in Kulbe's survey were ranked from one to nine in order of severity. The highest frequency of stressors were the amount of paperwork, followed by the number of patients seen in one day, then to too many patients dying in a short period of time, and working with physicians who misunderstand hospice philosophy. Other stressors included poor relationships between nursing staff, the hospice facility environment, and poor

communication among members of the interdisciplinary team. One of the limitations noted was an inadequate amount of statistical analysis that was limited to rank and frequency distribution which did not provide a rich discussion of research results.

Adenbroth and Flannery (2006) conducted a study to measure the risk of CF in hospice nurses. The study was a nonexperimental, descriptive, correlational design. Seventeen of 40 hospice agencies agreed to participate in the study via mailed survey. An additional four agencies participated in the survey during the state's Hospice Symposium. The survey included questions about variables in individual's personal lives such as caring for an elderly parent, difficult finances, and death of a loved one. It also queried about work place variables that included level of education, licensure, and certification, years in the profession and in hospice nursing. The survey assessed exposure to traumatic patient deaths and number of cases of direct involvement with patient deaths per month. Finally, another set of questions measured participants' behaviors that could lead to CF risk. The findings indicated that 80% of the 216 nurses sampled were found to be at moderate to high risk for CF. Adenbroth estimated that 78% of sampled hospice nurses were at moderate risk for CF. In addition, 26% of sampled hospice nurses were at high risk for developing CF. Findings further suggested that 65% of hospice nurses were sacrificing their own personal needs for the needs of their patients. Because hospice nurses are consistently faced with end of life situations, pain and suffering both emotional and physical, and bereavement, they are highly susceptible to CF. Additionally, hospice caregivers are especially vulnerable to CF because they may become over-involved, over-invested and are frequently exposed to experiences of loss (Keidel, 2002). Hospice nurses suffering from CF may find themselves unable to provide the needed level of care and

support to both the patient and the patent's families at a time when they are at most vulnerable.

Neville & Cole (2013) performed a study that examined the relationship between health promotion behaviors and CF in nurses practicing in a community medical center. The purpose of the study was to reexamine the prevalence of CF and to determine if health promotion behaviors impacted CF among nurses. A nonexperimental, descriptive, correlational design was used in the study. Descriptive statistics revealed that nurses in this study were predominantly female (94%; n = 196), had substantial years of experience (50%; n = 93) with 920 total years of experience, were well educated with 49%; (n = 105) obtaining a BSN or graduate degrees, and more than half of the participants were certified in varied nursing specialties 60.2%; (n = 118). Thirty-seven percent (n = 79) of nurses reported engaging in wellness activities sponsored by Hunterdon Medical Center, with 15% (n = 33) of nurses participating at Hunterdon Health and Wellness Centers. The Hunterdon Health and Wellness Centers (HHWC) are fitness facilities where members had access to comprehensive health and wellness services. Membership was open to all employees at a cost of $51.00 per month. Fifty one nurses (38.3%) reported finances as the reason for nonparticipation in HHWC membership. The majority of nurses reported engaging in health promotional activities outside HMC-sponsored programs and wellness centers. Approximately 40% (n = 83) of nurses identified themselves as engaging in holistic practices, which included massage (n = 26), chiropractic (n = 10), meditation (n = 9), herbs/oils (n = 7), and various other complementary modalities. The survey used to measure compassion fatigue was the ProQOL, which consists of: compassion satisfaction; CF, defined as the negative components of the work experience consisting of

burnout; and secondary traumatic stress. The t scores for CF ranged from 48 to 82 (mean t score = 62.53; 6.88). In this study, 73.6% of nurses (n = 145) scored above the established normative data (t score = 57) (Neville & Cole).

Factors Contributing to Compassion Fatigue

Constant or persistent exposure to direct and or indirect pain and suffering of a client and the inability to separate one's self from that of their client have been identified as contributors to CF (Figley, 1995). Other factors include individuals with high standards, high levels of empathy and a high level of compassion for others (Showalter, 2010). Not only does secondary trauma become a causal factor to CF but also an individuals' lack of self-care may are associated with to the high likelihood of experiencing CF. Individual disregard for his/her own needs in favor of the needs of others is detrimental to their health and exposes individuals to higher risk of CF.

Nurses have few systematic supports in place to help deal with their emotional responses to witnessing the tragedy of others and experiencing sadness, grief, and loss. Also, nurses' risk for CF is heightened because they are not only considered first responders but also sustained responders (Boyle, 2011). Nurses' interactions with patients are maintained over time and nurses often cannot leave a situation after bad news is shared or a death has occurred. It is this constant exposure to trauma and pain that makes nurses at high risk for CF (Boyle).

When providers are caring for people on a regular basis, they draw on emotional reserves and if they don't take the time to replenish those they will be running on empty (Mendes, 2014). Mendes pointed out that after a long term patient is discharged or passes

away, another complex long term patient is admitted under the same nurse's care leaving little to no time to decompress in between. Nurses have a tendency to put incredible pressure on themselves to impact or achieve an outcome and may blame themselves when they are not able to meet this expectation. Compassion fatigue is easier to identify in others than oneself. Once an individual is able to identify CF in themselves it is important that individual comes up with a plan to deal with it. This can be incredibly difficult to do when someone has all their reserves depleted (Mendes).

Compassion Fatigue: Prevention

Showalter (2010) provided recommendations for individuals to prevent or minimize the effects of CF. Showalter's recommendations to prevent or minimize the effects of CF include having quiet time, being mindful; participate in an exercise program, prayer, meditation and spending time with loved ones. A healthy diet, a restful night sleep, and time off from work to enjoy hobbies have also been found to minimize the effects of CF. Showalter's recommendations for those actually suffering from CF include refraining from blaming others, ignoring the problem, work harder and longer, make a major purchase, neglect one's own needs, interests, and desires (Showalter).

Organizations also have a role in preventing or minimize the effects of CF that includes understanding that employees need work life balance in order to recharge themselves and function optimally. Showalter also recommended having a counselor with a specialization in CF available to staff in order to help cope and express their feelings.

Slatten, Carson, and Carson (2011) identified the difference between CF and burnout, how to identify individuals at risk, and what to do to prevent and or treat it. The authors provide interventions to combat CF. The authors recommended that managers provide relief by limiting or diversifying caseloads so that the number of traumatic patients is limited. This will help balance the less emotionally challenging cases and more emotionally challenged patients (Slatten et. al). Managers should offer training in holistic self-care. Employees need to learn to recognize symptoms in both themselves and their peers and need assistance with the development of increased personal coping skills that can help prevent or lessen the effects of CF when dealing with crisis (Slatten et al.).

Neville and Cole (2013) performed a study that examined the relationship between health promotion behaviors and CF. The authors used the ProQOL-R-V survey to measure CF. The mean t score was 62.53 with a range from 48 to 82. The results of the data show that nurses' engagement in health promotional activities was inversely related to CF. As health promotional activities increased CF decreased. Stress management, interpersonal relationships, and spiritual growth all had statistically significant associations with CF, providing evidence for the role of health promotion on reducing CF (Neville & Cole).

One intervention that organizations can use is the use of Schwartz Center Rounds. Schwartz Center Rounds are designed to allow nurses and other health professionals to an outlet and debrief about their experiences without fear of retaliation or corrective action (Mendes, 2004). Schwartz Center Rounds is a program that takes place in over 300 health care facilities in the United States, Canada, and the United Kingdom. Schwartz rounds

offer providers' time to openly and honestly discuss the social and emotional issues they face in caring for patients and families (www.the schwartzcenter.org, 2016). Schwartz rounds differ from traditional medical rounds, by focusing on the human dimension of medicine. Providers have the opportunity to share their experiences, thoughts and feelings on topics drawn from actual patient cases. The premise is that caregivers are better able to make personal connections with patients and colleagues when they have greater insight into their own responses and feelings (www.the schwartzcenter.org, 2016). The downside of this program is there is a fee associated with it.

Thielman and Cacciatore (2014) suggested that being mindful can help combat CF. The authors stated that a relationship between being mindful of the present leads to compassion satisfaction, positive results of being able to help others, can be used to protect against CF. This in turn may benefit both the caregiver and the patients they serve. Patients of clinicians that meditate have better outcomes than those that do not (Thielman & Cacciatore).

Reimer (2013) discussed interventions nurses on a 20 bed oncology implemented to help combat CF. Nurses focused on three main themes: creating moments of connection; making moments matter; and energizing moments. The author discussed an event in which a 40 year old male was admitted to their unit and the nurses used the three tier theme to care for him and his family. The staff decided to keep a journal by the patient's bed side so they could record their memories with the patient. The intent was for the patient and his family to read these notes and be reminded of the patient's humanness, his meaningful relationships, and the impact of his life on others. This

helped the staff make connections and moments that matter in the end of life care of this patient (Reimer).

Flarity, Gentry, and Mesnikoff (2013) studied the effectiveness of an education program to decrease compassion fatigue and burnout in emergency room nurses. The education was a four hour interactive group seminar titled "Compassion Fatigue Resiliency" and focused on the five key elements of CF prevention: self-regulation; intentionality; perceptual maturation self-validation; connection and support; and self-care and revitalization. The results of the education showed that organizational prevention programs may help increase caregivers level of compassion satisfaction and reduce the risk of CF. After the intervention, compassion satisfaction improved by 10% with burnout and secondary traumatic stress decreased by 4% and 2% respectively. Although CF was not measured, the authors concluded that organizational programs would be beneficial in decreasing CF by increasing compassion satisfaction and decreasing burnout and secondary trauma (Flarity et al.).

Compassion Fatigue Measurement

There are formal and informal assessments for CF. In an informal assessment of risk of CF, health care managers can ask two questions to assess an employee's likelihood of experiencing CF. The first, does the employee have a high level of empathy? A manager's most empathetic employees are the ones most likely to experience CF. Secondly, is the employee dealing with traumatized children? Individuals who are exposed to the trauma experienced by children have a high likelihood of CF.

The speed of the onset also helps identify whether the problem is CF or burnout (Slatten, Carson, & Carson, 2011).

The Professional Quality of Life Scale (ProQOL) is the most used scale and has evolved from the original Compassion Fatigue self-test (Stamm, 2012). Of the 100 published research papers on CF and secondary stress, nearly half have utilized the ProQol or one of its earlier versions. The ProQOL is composed of 30 statements. Participants are asked to consider each of the questions about themselves and their current work situation. The participants are asked to score the questions that honestly reflect how frequently they experienced these things in the last 30 days. Examples of questions include "I am happy," "I am preoccupied with more than one person I [help]," "I get satisfaction from being able to [help] people," "I feel connected to others," "I jump or am startled by unexpected sounds" (Stamm, p. 26). The validity and reliability of this scale has been demonstrated with over 200 published papers utilizing its effectiveness.

The Secondary Traumatic Stress Scale (STSS) (Lowenstein, 2013) has the participant answer questions about current events in their lives. Each event is assigned a different value such as "Death of Spouse- 100 points," "Divorce-73 points," "Change in recreational habits-19 points." The individuals with a higher score have a higher likelihood of CF than the low score counterparts. A score of 0-149 indicates low susceptibility to stress-related illness. Scoring from 150-299, at the medium range, suggests susceptibility to stress-related illness. It is recommended that the participant learn and practice relaxation and stress management skills and a healthy life style. Scores that are 300 and over reflect a high susceptibility to stress-related illness. When one scores 300 and over, it is recommended that one institutes a daily practice of relaxation.

The goal is to be proactive and reduce stress before it becomes a serious health issue (Lowenstein).

The Secondary Traumatic Stress Scale (STSS) has been determined to be valid and reliable. A sample of 287 licensed social workers completed a mailed survey containing the STSS and other relevant survey items. The results showed reliability, convergent and discriminant validity and factorial validity. The STSS fills a need for reliable and valid instruments specifically designed to measure the negative effects of social work practice with traumatized populations. The instrument may be used to undertake empirical investigation into the prevention and amelioration of secondary traumatic stress among social work practitioners (Bride, Robinson, & Charles, 2003).

In summary, the literature identified that CF is a serious issue in nursing specifically those working in hospice. Hospice nurses have been shown to be at a moderate to high risk for CF. Compassion fatigue may affect professionals in both their personal and professional lives. Those affected by CF may exhibit signs of anger, irritability, and exaggeration over the seriousness of a situation, inability to get out of bed and go to work and loss of compassion. Compassion fatigue has also shown to have an impact on an organization as well. The literature illustrated that workmen's compensation, high turnover rates, inability to recruit staff, and an abundance of sick days have been shown to increase with CF. Compassion fatigue can be combated and prevented by self-help strategies including regular exercise, participate in hobbies, spending time with loved ones, and taking time off of work. Organizations have a role in preventing compassion fatigue by offering employees breaks from difficult cases,

offering organization based health services such as discounted gym memberships and an ability to debrief from their traumatic experiences.

Next, the theoretical framework will be presented.

Theoretical Framework

Three frameworks were used to guide this project: Figley's Compassion Stress and Fatigue Model; Malcolm Knowles' Adult Learning Theory; and W.K Foundation's Logic Model for Program Development.

Figley's Compassion Stress and Fatigue Model (1995) suggested that empathy and emotional energy are foundational and necessary to establish an effective therapeutic relationship with a patient. However, these same traits that make a caregiver effective can also make the caregiver vulnerable to the costs of caring (Figley). Figley noted that there are several factors that either prevent or predict CF. Initially, exposure to the client, empathic concern, and empathic ability lead to an empathic response. This response along with the factors of disengagement and a sense of satisfaction lead to residual compassion stress. Finally, residual compassion stress, prolonged exposure to suffering, traumatic memories, and the degree of life disruptions result in CF. These many components together form a causal model which predicts this clinical phenomenon (Figley).

Hospice nurses are consistently being exposed to patients who are in the final stages of chronic illnesses and have severe symptom management issues associated with these chronic conditions. End of life care can be traumatic for patients, their families and their loved ones. It takes compassion, empathy and caring to help minimize the trauma for patients and families. Repeated exposure to these events, as Figley (1995) pointed out, can lead to CF.

Malcolm Knowles Adult Learning Theory was employed to ensure that the program meets the needs of adult participants. Knowles (1972) wrote that most theories of adult learning are based on the research of how children learn, which in turn is founded upon theories of animal learning. These theories are artificial and not complex enough to apply to adult human beings. Knowles' theory focuses on the concept of andragogy. Andragogy, which is translated as "Man Leading", is the art and science of adult learning (Pappas, 2016). Andragogy includes four concepts that are applied to adult learning. The first concept stated that adults need to have active participation in the planning and evaluation of their learning. Next, it should be acknowledged that life experience, including mistakes, provide the basis for learning. The third concept showed that adults have a high interest in learning if the topics have relevance and an impact in their professional and personal lives. Last, adult learning centers on problems rather than specific content (Pappas, 2016).

According to Knowles as cited by McEwen and Wills (2011) "The single most important thing in helping adults to learn is to create a climate of physical comfort, mutual trust and respect, openness, and acceptance of differences"(p.364). Knowles developed the six assumptions of adult learners. Adult learners need to know the reason why they need to learn a subject. Knowles identified that as people get older and more mature they become much more self-directed than when they were younger students. Adult students have life experiences, and those experiences help as a resource and readiness for learning. Adult perspectives change about learning in which they identify with immediate application with what they have learned and immediate problem solving (McEwen & Willis, 2011).

The Logic model, which was used to guide the program development, will be described in the Methods section under program development.

Next, the methods will be presented.

Method

Purpose

The purpose of this project was to develop an evidence-based educational program about CF.

Design

The program development project employed an educational intervention and a post-program evaluation survey design. The educational program for the nursing staff served as the intervention.

Sample/Participants

The target audience was nurses employed at Care New England Visiting Nurse and Hospice located in Warwick Rhode Island. All hospice nursing staff, including 10 Registered Nurses and two Licensed Practical Nurses, were eligible to participate. There were no exclusions and all hospice nursing staff were encouraged to attend.

Site

The project took place in the conference room at the main office of Care New England Visiting Nurse Agency at 57 Health Lane, Warwick Rhode Island.

Intervention

The intervention was an educational program on compassion fatigue entitled: *Compassion Fatigue: Signs and Symptoms and Prevention Strategies* that was developed by this graduate student.

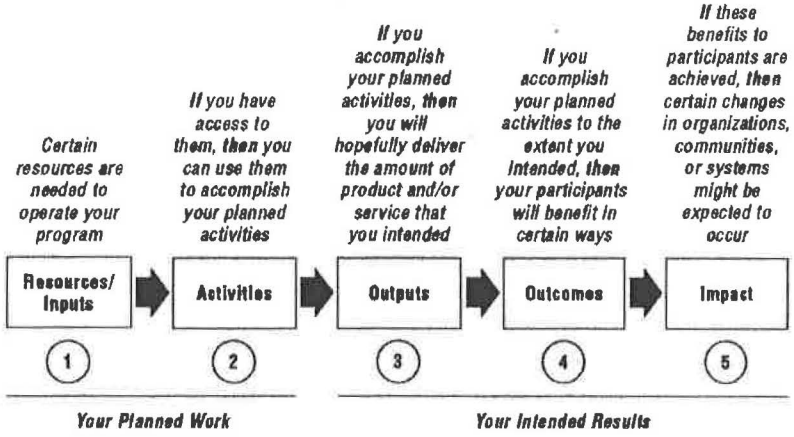
Approval

Approval was obtained by Christine Carpenter, RN Director of Palliative and Hospice care. This project was reviewed by the Care New England's Institutional Review Board (IRB) as well as Rhode Island College's IRB.

Program Development

Framework. The W.K. Kellogg Foundation's Logic Model for program development (Logic Model Development Guide, 2004) was used for the development of this program. The basic logic model shows the connection between planned work and the intended results (Logic Model Development Guide).

The model focuses on five components as illustrated below.



The first component in the Logic Model is resources. Resources include the human, financial, organizational, and community resources a program has available to use for the development and operation of the work. One would need these resources to operationalize the program. Once the resources are obtained they can be used to accomplish planned activities. Activities include the processes, tools, events, technology

and actions that are an intentional part of the implementation of the program. These interventions are used to bring about the wanted changes or results. Outputs are the end product of the program activities. If the program activities are successfully completed, then the desired outputs will be delivered. Outcomes are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. This is where participants will begin to benefit from the program. When the benefits are achieved, the impact is the intended or unintended change occurring in the organization as a result of the project (Logic Model Development Guide).

Resources/Needs Assessment. The needs assessment included review of programs devoted to CF currently being offered by Care New England Visiting Nurses and Hospice. The organization offers an employee assistance program (EAP) which is a resource that is available to staff, free of charge and confidential. Staff may utilize EAP to seek assistance if needed. The EAP offers a variety of services including but not limited to resources for emotional health, care of elders, and assistance with finances. The EAP is limited in its scope in that it does not offer specific services for CF and it is voluntary. If staff members are unable to identify CF in themselves there is virtually no trigger to seek assistance. There are no other formal services available to staff that addresses or assists with treating CF.

This project was reviewed with the Director of Palliative and Hospice Care. It was determined that the proposed program aligned with the goals of improving the patient experience and recruitment and retention of staff, as well as achieving top percentile quality scores such as the reduction of hospital readmissions within 30 days. The

Director was pleased with the concept of the project as she recognized that there was an opportunity for improvement in this area.

Program Activities/Program Design and Planning. The content of this program was developed from the review of the literature as well as input and recommendations from planning meetings with leadership of Care New England Visiting Nurses and Hospice. A detailed content outline is included in Appendix A. The content outline and objectives are illustrated in Table 1 below. The education included a presentation that utilized slides, handouts and discussion with participants. Table 1

Content Outline and Objectives

Content Outline	Objectives of the Content
Introduction to CF: Defining CF	Staff will be able to identify and describe what CF is.
Review the impact CF has on patient care, ones' self, and an organization	Staff will be able to identify and understand the impact CF can have on the care provided, on the organization and themselves
Review related terms that may be confused with CF	Staff will be able to recognize the differences between CF and moral distress, and burnout
Review why hospice nurses are more susceptible to CF	Staff will verbalize why hospice nurses are at higher risk for developing CF
Review signs and symptoms of CF	Staff will recognize and state the signs and symptoms of CF
Review strategies to prevent CF	Staff will verbalize what can be done to prevent CF
Review treatments for CF	Staff will verbalize available treatments for CF

The educational intervention consisted of a 50 minute presentation on CF. The presentation included the definition of CF, the signs and symptoms of CF and why

hospice nursing has a high potential for CF. There was 10 minutes provided after the presentation for questions and answers and to complete the post-program evaluation (Appendix B). The post-program evaluation was developed based on the Rhode Island Nursing Association (RISNA) continued education units survey. The presentation made use of technology including a laptop computer, projector and computer slides including printed materials of the slides for the participants. The slides were created by this graduate student. Handouts included tips on preventing and treating CF as well as contact information for EAP.

Procedure and Program Implementation. Eligible nurses were recruited to participate in the educational program through posting of an informational flyer (Appendix C). The flyer was electronically mailed to eligible participants as well as placed in staff mailboxes. The informational letter (Appendix D) informed staff that participation was voluntary but encouraged. This program was offered during both monthly orientations to new hospice nurses and will be offered annually to current hospice nurses. Staff were informed that the presentation may elicit an emotional response from past traumatic experiences and chaplaincy services were made available to all staff. Contact information for the Employee Assistance Program (EAP) contact information was also provided. Staff were encouraged to ask questions of the graduate student prior to the education.

Evaluation. The expected outcome was for participants to increase knowledge of CF, signs and symptoms of CF. A brief post-program evaluation survey was completed by participants to assess program effectiveness and value in practice. (Appendix B).

Next, the results will be reviewed.

Results

Twelve nurses were eligible to participate and 8 (67%) attended the program. A brief post-program evaluation survey was completed by all participants to assess if the program objectives were met (Table 1), to evaluate the faculty effectiveness (Table 2) and to assess if participants benefitted personally (Table 3).

Table 1

Were the Objectives of the Program Met? (N = 8)

Objectives	Strongly Agree	Agree	Disagree	Strongly Disagree
Identify causes of compassion Fatigue	8			
Identify the differences between compassion fatigue, burnout, and moral distress	8			
Identify strategies to prevent compassion fatigue	8			

As illustrated in Table 1, all participants (N=8), reported that they strongly agreed that all the objectives of the program were met.

Table 2 on the next page illustrates the effectiveness of the program.

Table 2

Was the Faculty Effective? (N= 8)

Presenter	Very Effective	Effective	Somewhat Ineffective	Ineffective
The instructor was prepared in the course content and activities	7	1		
The instructor has an effective presentation style	7	1		
The instructor has knowledge of the subject	7	1		
The instructor used time efficiently	7	1		
Conflict of interest was disclosed	7	1		

The majority of participants (N=7) reported that the faculty was very effective, with one participant (N=1) reporting that the faculty was effective.

Table 3 below illustrates the staffs' personal benefit of the program.

Table 3

Did I Benefit From This Program Personally? (N = 8)

Evaluation	Strongly Agree	Agree	Undecided	Strongly Disagree
I have increased my knowledge base of compassion fatigue.	8			
I will be able to utilize self-care techniques learned in this class.	8			

All participants (N=8) reported they strongly agreed that they benefitted from the program personally. Participants had the opportunity to add comments. Additional comments included:

"Very informative. I didn't know about CF prior to this program; It definitely illuminated some things in my own life and career that I had not noticed before."

"Great job, David, I think it was very well prepared; brought attention to a subject I didn't know much about; It identified and gave a name to something that I have experienced."

Next, summary and conclusions will be reviewed.

Summary and Conclusions

Compassion fatigue can be defined as the emotional residue or strain of exposure to working with those that suffer from the consequences of traumatic events (Figley, 1995). Compassion fatigue can occur due to exposure on one particularly traumatic case or can be due to a "cumulative" level of trauma (Figley). Repeated exposure will likely contribute to nurses experiencing negative long-term health effects (Larowe, 2005). Hospice nurses are especially susceptible to CF as they are exposed to pain, suffering, death, and dying on a routine basis.

Employees who suffer from CF can become physically, mentally, and spiritually exhausted. Despite this exhaustion, the employee continues to give and further neglect self-care. Compassion fatigue can negatively affect the ability to provide care, maintain relationships, both personal and professional, and diminished capacity to enjoy life. The symptoms of CF can be so devastating that they have been known to affect personal lives, professional lives, and the breakup of families (Showalter, 2010). Further, a patient and their family may feel the effects, as the nurse with CF is unable to provide the high level of care that the patient and family requires.

Compassion fatigue has also shown to have an impact on an organization as well. The literature shows that workmen's compensation, high turnover rates, inability to recruit staff, and an abundance of sick days have been shown to increase with CF. The literature demonstrates that CF can be combated and prevented by self-help strategies including regular exercise, participation in hobbies, spending time with loved ones, and taking time off of work. Organizations have a role in preventing compassion fatigue by offering employees breaks from difficult cases, offering organization based health

services such as discounted gym memberships and an ability to debrief from their traumatic experiences.

An educational intervention was developed targeted at hospice nurses in an attempt to enhance their knowledge of CF. Sixty seven percent of eligible nurses (n=8) participated in the intervention. The participants were asked to complete a post program survey. All participants strongly agreed that the objectives were met, that the faculty was very effective (n=7) or effective (n=1) and all participants strongly agreed that they personally benefited from the program.

The program's scope was limited as the intervention was educational only. The project did not include the development of or changes in the agency's policy or procedures. Although the majority of staff participated (67%) the overall number of participants was small. Due to the limited scope and the small number of participants this author recommends further study. The participants' knowledge of CF was not tested pre or post intervention. An assumption was made that knowledge of CF was minimal or none at all.

In conclusion, the educational intervention was determined to be successful. The participants strongly agreed that the objectives were met. Most reported that the faculty was very effective and all benefitted personally from the program.

Next, recommendations and implications for the advanced practice nurse will be discussed.

Recommendations and Implications for Advanced Nursing Practice

The Advanced Practice Nurse (APRN) has the knowledge and skills necessary to critically review the literature, from which they can draw best practice to design, implement and evaluate strategies to identify and prevent CF. The APRN can be a leader of the interdisciplinary team in designing interventions based on best practice and advancing nursing practice through education, research, personal development and organizational leadership (Bryant-Lukosius, DiCenso, & Pinelli, 2004). Functions of the APRN, particularly the Clinical Nurse Specialist (CNS), include clinical expert and change agent, which involve collaboration and consultation with other disciplines in the health care setting. The CNS is in a unique position to create and drive the initiative to improve the quality of care for patients, their families and staff.

Based on the results of this project, it is recommended that an educational program be initiated to engage nurses, particularly those practicing in hospice agencies and those caring for terminally ill patients, in activities that help identify signs and symptoms of CF as well as the management and prevention of CF. Evidence has shown that when CF is identified early, the practitioner, the patient and the agency benefits. The importance of continuing education and training of healthcare professionals cannot be overstated. Informational programs should be implemented to ensure that hospice nurses have the knowledge and skills needed to identify CF. It is further recommended that the training include the screening tools available such as the Secondary Traumatic Stress Scale and the ProQOL.

The CNS needs to be prepared to lobby administration and government agencies for the financial support to develop programs that train staff and leaders how to identify

and manage CF. Political action work through professional organizations and other networks is essential. The ending results of CF can be devastating to staff, patients and the hospice agency. This type of program could benefit an organization by increasing staff satisfaction and patient satisfaction while decreasing turnover rates, loss of productivity, and absenteeism.

Further research is needed to assess the knowledge base required for not only hospice nurses and leaders to effectively identify and manage CF but other disciplines caring for the dying patient as well. This project was limited to nursing staff and did not include certified nursing assistants, chaplains, social workers or rehabilitation staff. Clinicians from disciplines other than nursing also build relationships with patients and their families and could also suffer from CF. Further study to assess the staffs' perception of loss of productivity and a method to measure the actual loss, both financial and productive, to the agency is also indicated.

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Appendix A

Compassion Fatigue in Hospice Nursing; A Detailed Program Outline

A Program Development for Care New England Visiting Nurse

I. What is Compassion fatigue (CF)?
   A. Compassion Fatigue is final result of a progressive and cumulative process which is caused by prolonged, continuous, and intense contact with patients, the use of self and exposure to stress which manifests with marked physical, social, emotional, spiritual, and intellectual change
   B. Compassion Fatigue is the emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. Compassion Fatigue can occur due to exposure on one case or can be due to a "cumulative" level of trauma

II. Significance of CF
   A. Health professionals collect bits and pieces of patients' trauma in the form of pictures in our minds and feelings in our bodies that stays with them.
   B. The most empathetic and the highest standards of care are most at risk for compassion fatigue
   C. Professional caregivers are normally reluctant to talk about this trauma in the professional setting for fear they will be thought of as "burnt out."
   D. These employees keep going and can develop anger and fatigue. The employees may find brief solace by informally discussing the job, "gripe sessions", with fellow employees who are in a similar situation but without digging deep into the true feelings, the positive effects they may feel will be short lived.
   E. Employees who suffer from CF can become physically, mentally, and spiritually exhausted.
   F. Despite this exhaustion the employee continues to give and further neglect self-care.

III. How does CF differ from burnout?
   A. Compassion Fatigue is a narrow concept limited to dealing with traumatic or highly emotional events in patients' lives.
   B. Burnout can be the result of many factors such as an abusive leader, inconsiderate behavior of physicians, excessive caseload, severe

organizational stress, limited resources, unclear expectations, demanding work, or actual or perceived staff shortages.

C. Burnout can often be relieved by finding new employment

IV. How does CF differ than moral distress?

A. Moral Distress is negative stress symptoms emerging in situations involving ethical dilemmas when the healthcare provider feels incapable of protecting all needs and values at stake.

B. Physical or emotional suffering that is experienced when constraints prevent one from following the course of action that one believes is right

C. Occurs when the nurse knows the ethically appropriate action to take but is unable to act on it

V. Why are hospice nurses more susceptible to CF?

A. Constant exposure of suffering and trauma with end of life

B. 78% of sampled hospice nurses were at moderate risk for compassion fatigue. In addition, 26% of sampled hospice nurses were at high risk for developing compassion fatigue.

C. 65% of hospice nurses sacrifice their own personal needs for the needs of their patients

VI. What are signs and symptoms of compassion fatigue?

A. The inability to provide care maintain relationships, both personal and professional

B. High turnover rate

C. Loss of productivity

D. Diminished capacity to enjoy life.

VII. What steps can individuals and organizations take to prevent compassion fatigue?

A. Spending quiet time, being mindful

B. Participate in an exercise program, prayer, meditation, feed your spirit and soul

C. Spend time with loved ones or spiritual advisor, have meaningful conversations

D. Get enough restful sleep

E. Develop and nurture interests outside of work

F. Use your vacation time

G. Personal counselling

H. Identify what is important to you and set personal priorities

I. Take one thing at a time

J. Laugh out loud

K. Follow a familiar routine
L. Maintain a healthy diet
M. Expect to be upset by upsetting events
N. Honor yourself

VIII. What steps can an organization take to ensure their employees do not suffer from CF?
A. Schwartz Rounds
B. Debriefing
C. Limiting or diversifying caseloads
i. The number of traumatic patients is limited to a particular caregiver.
ii. Helps balance the less emotionally challenging cases and more emotionally challenged patients

IX. Recommendations for CNE VNA and Hospice
A. Schwartz Rounds
B. Debriefing after traumatic cases and deaths
C. Organizational sponsored events
i. Eating healthy challenge
ii. 5ks and walkathons
iii. Fundraisers
iv. Staff appreciation and stress reduction program

Appendix B

Program Evaluation

Please complete the evaluation at the end of this program. Thank you.

TITLE: Compassion Fatigue

DATE:

Were the objectives of the program met?

Objectives	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Identify causes of compassion fatigue					
Identify the differences between compassion fatigue, burnout, and moral distress					
Identify how to prevent compassion fatigue					

Was the faculty effective?

Presenter	Very Effective	Effective	Somewhat Effective	Somewhat Ineffective	Ineffective
The instructor was prepared in the course content and activities					
The instructor has an effective presentation style					
The instructor has knowledge of the subject					
The instructor used time efficiently					
Conflict of					

interest was disclosed					

Did I benefit from this program personally?

Evaluation	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I have increased my knowledge of compassion fatigue					
I will be able to utilize self-care techniques learned in this class					

Application:

What did you like best about this course?

_____

_____

What would make this course even better?

_____

_____

Comments:

_____

_____

Recommendations for future programs:

_____

_____

Appendix C

Attention Hospice Nursing Staff

You are invited to attend a one hour education session about Compassion Fatigue which is scheduled for April 6, 2016 at 11AM-12pm

Location: Class will be held in Main Conference room

Attendance: Attendance is voluntary.

Participants will be asked to voluntarily complete a post survey after the education session. If you have any questions please feel free to contact David Carroll at dcarroll_6008@email.ric.edu with any questions.

Thank you all

Yours in Nursing

David E. Carroll, BSN, RN

RIC Graduate Student and program developer

Appendix D

To all Hospice Nursing Staff,

My name is David Carroll. I am a graduate student at Rhode Island College and I will be developing a project in partial fulfillment of requirements of the Masters of Science in Nursing at the Rhode Island College School of Nursing. The purpose of this project is to develop an evidence-based educational program about compassion fatigue.

All hospice nursing staff are invited to participate. Participation in the project is voluntary. If you participate, you will be asked to attend a one hour educational program and complete a brief survey at the end of the program to assess effectiveness of the presentation. The survey is completely anonymous and voluntary. You may decide not to participate and that decision will not negatively impact your employment.

The sensitivity of the information provided may elicit an unintentional emotional response. Chaplaincy service will be available if necessary as well as information on how to access Employee Assistance Program (EAP).

Thank you for your consideration in participating in this program.

David E. Carroll, BSN, RN

Master's Student Program Developer

Rhode Island College

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