Recognition of Compassion Fatigue among Medical-Surgical Nurses: The Provision of Education to Manage the Effects

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Recognition of Compassion Fatigue among Medical-Surgical Nurses: The Provision of Education to Manage the Effects

Kandace Woodruff DNPe, MSN, RN

DNP Project submitted to the faculty of the University of San Francisco in partial fulfillment of the requirements for the degree of Doctorate of Nursing Practice in Healthcare Systems Leadership December 2012
This project is dedicated to my loving parents, it is through your example that I learned the meaning of compassion, empathy and respect for others. I have the deepest appreciation for your support and encouragement to pursue my dreams.

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The Institute of Medicine (IOM) (2010) recommends that healthcare organizations make the “recruitment and retention of qualified nurses a priority”. The ability to comply with the recommendation is fraught with challenges. Nurses are required to care for patients across the age span with varying medical complexities. There are work related stressors which are inherent to the care of a more acutely ill patient population. The tenuousness produced by this type of environment can predispose the nurse to a stress induced phenomenon known as, Compassion Fatigue. The literature is abounding with information related to compassion fatigue among various nursing specialties. However, previous discussions have effectively disregarded this discussion in the context of medical-surgical nurses. The following is a description of a Compassion Fatigue project with an emphasis on the medical-surgical nurse. The project demonstrated a correlation between work-related stressors and compassion fatigue among medical-surgical nurses. It also revealed that medical-surgical nurses are challenged by numerous encounters precipitated by their hectic work environment. Many nurses have the fortitude to overcome environmental stressors, thereby, affording them a deep sense of satisfaction. Conversely, unsuccessful coping can lead to dissatisfaction and an exodus from the profession. The project shed light on the significance of understanding the prevalence of compassion fatigue and the need to be proactive. In response to the findings, an educational intervention was developed and implemented as a resource for the nurse to proactively attend to their own self care needs. The promotion of self care is a sound strategy in the reduction or prevention of compassion fatigue. It creates a positive benefit for the nurse and can ultimately accomplish the goal of the IOM (2010) to maintain a viable nursing workforce.
TABLE OF CONTENTS

Acknowledgements.........................................................................................2

Abstract .............................................................................................................3

Section I
Table of Content..............................................................................................4
Introduction ........................................................................................................8
Significance of the Problem................................................................................9
Scope of the Problem ......................................................................................10
Relevance ...........................................................................................................10
Theoretical Framework ....................................................................................13
Figley’s Compassion Fatigue Model.................................................................13
Project Goals/Outcome ..................................................................................15
Operational Definition......................................................................................15
Assumptions .....................................................................................................16
Limitations

Section II
Criterion for Evidence Search ........................................................................17
Literature Review .............................................................................................18
Compassion Fatigue ......................................................................................18
Burnout ..........................................................................................................19
Empathy .........................................................................................................20
Empirical Studies ...........................................................................................20
Compassion Fatigue ......................................................................................20
Project Intervention.........................................................................................30

Section III
Design .............................................................................................................31
Methodology ...................................................................................................31
Sample ............................................................................................................32
Protection of Human Subjects .......................................................................33
Instrumentation ..............................................................................................34
Procedure .......................................................................................................36
Results ............................................................................................................37

Section IV
Project Evaluation ...........................................................................................42
Patient Impact .................................................................................................42
Clinical Impact ...............................................................................................43
Healthcare Impact .........................................................................................45
List of Tables

Table 1: Description of Project Participants ................................................. 91
Table 2: Participants Educational Level ....................................................... 93
Table 3: Participants Years of Experience .................................................... 94
Table 4: Compassion Fatigue Self Test Results ............................................. 95
Table 5: Compassion Fatigue Descriptors .................................................... 96
Table 6: Manifestations of Compassion Fatigue .......................................... 97
Table 7: Compassion Fatigue Differentiation .............................................. 98
List of Figures

Figure 1: Figley’s Compassion Fatigue Process…………………………………………99
Section I

Introduction

There are approximately 2.9 million registered nurses employed in the United States. This represents the largest segment of the healthcare workforce (US Bureau of Healthcare Statistics, 2010). Unfortunately, this number is not adequate to ensure the country’s projected health care needs. Hospitals are becoming increasingly complex environments due to developments in medical technology, more sophisticated treatments, and an aging, dependent population of patients. Advances in medicine and technology have enabled organizations to accommodate patients with more complex medical issues, co-morbidities and chronic illnesses. All of these factors contribute to the vital role of nurses in healthcare.

Nurses are one of the healthcare system’s greatest assets because they are an integral part of the patient’s treatment and recovery. Therefore, nurses must be prepared to care for patients across the age span that present with varying clinical challenges (Johnson & Johnson, 2009). It is with the desire to care for others that many nurses enter the profession. They have not only acquired the knowledge base to enact care they typically have a compassion, stamina and a willingness to assist others in their struggle to maintain a quality life. This strong dedication does not come without a consequence. The impact can produce a negative effect on the personal and professional life of a nurse.
Compassion Fatigue

Significance

Nurses have an unenviable position of witnessing the patient’s personal battle with acute illness. They often experience negative repercussions when caring for the ill, which predisposes them to the effects of the patients' physical or psychological distress (Sabo, 2006). The human cost of caring can produce a toll such as, the development of “Compassion Fatigue”, which is a negative empathetic response that is insidiously compared to “Burn Out”. The victims of compassion fatigue have a perception of helplessness and hopelessness regarding their ability to provide care.

Nurses who inherently demonstrate compassion and express empathy are at the greatest risk for compassion fatigue (Figley, 2002). According to Schwam (1998) nurses often become physically and emotionally overloaded when witnessing conditions associated with daily exposure to intense human misery. Nurses share their compassion with the suffering which may lead to unmanageable emotions. The toll of unmanaged stress and the effects of compassion fatigue are identified by Schwam (1998) as leaving a mark on nurses' personal lives. Some of the effects that are documented include substance abuse, divorce, dysfunctional relationships, anxiety and more importantly a loss of compassion.

A nurse with compassion fatigue may lose effectiveness in the provision of care because his/her own symptoms interfere with optimal care delivery (Dominguez-Gomez & Rutledge, 2009). There are prevalent factors commonly associated to the development of compassion fatigue among nurses such as inadequate professional training; low staffing; and an organizational culture that does not encourage, value and recognize exemplary compassion (Hofman, 2009). The nurse’s home life eventually begins to deteriorate and personalities have a
Compassion Fatigue
tendency to undergo small but noticeable changes. Eventually, the extra stressors can lead to an overall decline in general health (Schwam, 1998).

Scope

Nurses who care for patients in any setting face the challenges of confronting situations of life and death and are exposed to humanity in its most vulnerable state. According to Boyle (2006) nurses often enter the lives of patients at a very critical juncture and become a partner throughout the healthcare journey. They develop an empathic engagement with patients and families. This accompanied by the experience of grief, positions them at the epicenter of an environment often characterized by sadness and loss (Boyle, 2006). It is this very interaction which may negatively influence their professional quality of life. Stamm (2009) defines professional quality of life as the quality one feels in relation to his or her work as a helper. Both the positive and negative aspects of doing one's job can influence professional quality of life.

In their professional practice, nurses frequently face a side of life that those not involved in healthcare only see very occasionally. While the average person faces several traumas or tragic events over the course of a lifetime, the nurse witness’ countless tragedies over the course of a professional career.

Relevance

A discussion of the prevalence of compassion fatigue and interventional strategies is important to maintaining a viable workforce in healthcare. The IOM report (2010) recommends that organizations establish the “recruitment and retention” of Registered Nurses (RN), as a high priority in the prevention of a potential healthcare dilemma. This type of statement recognizes the significance of nursing as an asset to the healthcare community. Compassion fatigue is an overarching force opposed to this initiative. The development of compassion fatigue often
Compassion Fatigue

predisposes nurses to vacate the profession. This produces a rippling effect causing experienced
nurses to leave the bedside, which adds to an already strained health care system. The national
average cost of replacing one nurse is estimated at approximately $88,000 (US Bureau of Labor

The psychological costs to the nurse who leaves nursing because of compassion
fatigue and the financial costs to the health care agency of losing a valued employee are
significant. The nurses’ quality of life is influenced by their high levels of exposure to patient
illness episodes and research has demonstrated that this exposure is related to higher levels of
mental health risk (Cicogani et al., 2009). The nursing profession requires nurses to extend
themselves physically, psychologically and emotionally while caring for others. There are
competing priorities for nurses in the fulfillment of patient needs, which can place them at
risk for work related stress. The overall threat of which could lead nurses to an eventual
exodus from the field.

According to Schriver et al., (2003), the profession of nursing, is in a period of
transition which is further exacerbated by the growth in patient census in recent years
Despite this frequent exposure in their daily professional lives, the consequences such as
compassion fatigue, have historically been under-recognized and under-researched in nursing.
There have been previous discussions on the topic of compassion fatigue among nurses in the
areas of Critical Care, Hospice and the Emergency Room; unfortunately there has effectively
been a disregard of the medical-surgical nurses in the context of the discussion. Research is
needed in this area, which focuses on the medical-surgical nurse’s perception of work-related
stress and their experience, in order to assist them to understand and remove the risks for
compassion fatigue.
Compassion Fatigue

The fragile nature of the medical-surgical environment is a medium which can affect the nurse’s ability to cope. The environment is one filled with morbidity associated with diseases and the mortality of death. Medical-surgical nurses often have an inability to relax which is coupled by the emotionally draining experiences associated with their work. The degree to which medical-surgical nurses are emotionally healthy affects the extent to which they can satisfy job expectations. The care of patients and families experiencing progressive illness, death and bereavement can increase the nurse's awareness of their own vulnerability ultimately raising stress and anxiety.

Repar & Patton (2007) suggests ongoing stressors can make the practice of nursing too difficult for a caring professional to sustain long term. Since compassion fatigue has not formally been defined within nursing practice, the phenomenon has not been explored, described, or explained in a manner that would allow nurses to identify and combat compassion fatigue effectively (Coetzee & Klopper, 2010).

While nurses cannot be protected from indirect trauma and its negative effects, they must learn to recognize it, acknowledge it, and develop a network of support. Studies are needed which contribute to the comprehension of the nurses’ experience with compassion fatigue and work-related stress, in order to facilitate development of strategies required to combat the disabling effects. The reward is an increasing awareness of compassion fatigue and ability to impact positive patient care outcomes. The consequence associated with compassion fatigue among health professions is a growing area of research. Although there has been a broad exploration of the effects of compassion fatigue few studies have focused on the medical-surgical nurses as the research subjects. In light of the influential nature of compassion fatigue relative to patient care it is a gap, which warrants further study.
Compassion Fatigue

Theoretical Framework

Figley’s (2002) Compassion Fatigue Model is the theoretical framework used by this project (figure 2). Figley defined compassion fatigue as “a state of exhaustion resulting from exposure to compassion stress”. He acknowledged the tendency of healthcare professionals to disregard their own self-care needs while focusing on the needs of their patients and asserted “healthcare professionals must be objective in evaluating their patient’s needs”. This type of objectivity can facilitate the selection and administration of the best treatment practices for patients. In addition to being objective, healthcare professionals need compassion and empathy toward their patients which can “enable them to perceive the world through the patients eyes; thereby, enabling the adjustment for the most appropriate services” (Figley, 2002).

The model developed by Figley (2002) and subsequently revised over the years was established on the premise that “empathy and emotional energy are interrelated and together work to effectively end suffering, while maintaining a therapeutic relationship”. Figley (2002) further suggests that in viewing the world through the patient’s eyes, healthcare professionals also experience some of the suffering. He recognized that compassion fatigue is associated with a sense of helplessness and confusion in addition to feelings of isolation.

Figley (2002) identified a function of eleven interacting variables in being able to predict the development of compassion fatigue. Six of the variables are functions of compassion stress: empathic ability, empathic concern, exposure to the patient, empathic response, detachment, and a sense of satisfaction. Figley (2002) defines compassion stress as “the stress that is connected with exposure to the sufferer”. In other words, if the healthcare professional is able to detach from the patient’s experience and feel a sense satisfaction in terms of the care that has been given, then the healthcare professional will avoid the development of
Empathic ability is defined as the ability to notice the pain of others which is linked to the capacity to experience the feelings of the patient as a result of the exposure. This notion is equated as having similarity to a feeling of being “swept up” in the emotion of the patient (Figley, 2002). Empathic concern is linked to the motivation to care and, without it, the healthcare professional would be unable to assist the patient despite their good intentions. Exposure to the patient involves experiencing what the patient is feeling through direct contact. As a result of empathic ability, empathic concern, and exposure, the healthcare professional is able to elicit an empathic response, which is the degree to which attempts are made understand the patient’s feelings and perspective (Figley, 2002).

The concepts of disengagement and sense of satisfaction are used as ways to prevent compassion fatigue. Disengagement is seen as a healthy way for the nurse to focus on self-care by letting go of feelings associated with the patient and concentrating on his/her own life (Figley, 2002). The degree to which the healthcare professional is satisfied with his/her efforts and the degree to which the healthcare professional can distance himself/herself from the victim’s suffering explains how much the healthcare professional experiences compassion stress Figley (2002). In other words if compassion stress was allowed to continue without relief, then the outcome of compassion fatigue would be realized.

Three additional variables play a pivotal role in the development of compassion fatigue: prolonged exposure, traumatic recollections, and life disruption. Prolonged exposure occurs when the healthcare professional experiences a constant feeling of responsibility for the care of the patient over an extended period of time and, at the same time, the healthcare professional feels as if he/she has no relief from this obligation. Traumatic recollections are
memories that can trigger symptoms of anxiety whether it is from painful childhood memories or memories from working with a patient that was especially traumatic (Figley, 2002). Work-related stressors can also add to the probability of the development of compassion fatigue. These factors combined with unsuccessful coping techniques can increase the likelihood of the development of compassion fatigue. Figley’s (2002) Model is descriptive of the effects of compassion fatigue from both the healthcare professional and the patient.

**Statement of Project Goals and Outcome**

The purpose of this project is two fold; 1) To acquire recognition of the effects of compassion fatigue among medical-surgical nurses and 2) To provide education with interventional strategies to preserve the nurse’s highest level of functioning. This is of critical importance in order to achieve the recommendation by the IOM to maintain a stable nursing work force.

**Project Questions**

In this project, the following questions were addressed:

1. What is the nature of the medical-surgical nurse’s experience with Compassion Fatigue?
2. How does a negative empathic response such as Compassion Fatigue interfere with the medical-surgical nurse’s ability to provide patient care?

**Operational Definitions**

The following definitions have been operationalized for the purpose of understanding this project:

- Compassion fatigue: symptomatic of prolonged exposure to work-related stress
• Medical-surgical nurse: a graduate of an accredited school of nursing; passed the state board examination for Registered Nursing; currently employed in a Medical-Surgical environment.

Assumptions

Polit and Beck (2004) defined assumption as “a basic principle that is accepted as being true based on logic or reason, but without proof or verification”. The basic assumptions of this project included:

1. The medical-surgical nurse participants in this project were at risk for suffering from compassion fatigue.
2. Medical-Surgical nurses have an interest in knowing their risk for compassion fatigue.
3. The experience with work-related stress is perceived differently by each individual, despite the individual’s self awareness which may similarly resonate.
4. Each Medical-Surgical nurse that participates in this project will complete the survey activities in an open and honest manner.

Limitations

The findings of this project are not generalizable to all Medical-Surgical nurses because the sample size was too small. The project sample population was limited to the Medical-Surgical nurses from two hospitals in the San Francisco Bay Area. Another limitation may have been a lack of awareness regarding compassion fatigue, therefore producing a lack of interest in the project.
Section II:

**Criterion for Evidence Review**

The research criterion was based on use of select research journals, case studies, and other scholarly resources. The informational constructs assisted in the selection of the ten sources and contained the necessary features for answering the clinical question. The strategy used to identify the ten sources for the literature review included, an extrapolation of the variables associated with compassion fatigue.

The culmination of variables facilitated the key word search for: compassion fatigue, burnout, empathy and vicarious traumatization. The search for suitable article selections was sought from a conglomerate of scholarly data bases. The majority of the sources were extracted from CINAHL, Medline, Cochrane Review and Pub-Med. Critical judgment was utilized in order to obtain reliable and informative articles. As with any review publication, a retrieval biases can limit the validity of the results. An attempt was made to control for retrieval bias by using well-defined searches and comparing the retrievals with other reviews. There are a number of quality research studies on compassion fatigue, however, studies related to medical-surgical nurses is very minimal.

The CINAHL search criteria was focused on English research articles from peer reviewed journals, and the search yielded a total of 7 articles; 3 articles addressed the medical-surgical nurse and were descriptive in nature. The Medline search criteria included the MESH terms “compassion fatigue” and “nurses”, and the search yielded 8 articles; the majority of these articles addressed healthcare providers in general. The Cochrane search which included the terms “empathy”, “compassion fatigue”, and “registered nurses” yielded 7 articles, and the search which used the terms “compassion satisfaction yielded four articles. Currently, no
Compassion Fatigue

empirical research has been published which exclusively addresses measurable outcomes associated to the study of medical-surgical nurses (Appendix A).

Literature Review

This chapter contains a review of the literature, which is organized under two headings: Theoretical concepts based upon theories and empirical studies upon which experiments and observations were the basis. The theoretical literature reviewed includes: The Compassion Fatigue Model. Literature review in the area of empirical studies includes: Compassion Fatigue in nursing and other disciplines.

Theoretical Concepts

“Compassion Fatigue” is a term widely used in the discussion of traumatic stress. The term compassion fatigue was initially used to identify work related stress derived from working with the mentally or chronically ill patient populations. The term is more commonly used to describe the impact of work related stress incurred by healthcare professionals. Joinson (1992) was the first investigator to identify the sensation of “burn out” among nurses and was the first to initiate the use of the descriptor “Compassion Fatigue”.

Compassion fatigue is defined as “a state of exhaustion and dysfunction as a result of prolonged exposure to compassion stress and all that it evokes” (Figley, 2002). Rudolph, Stamm, and Stamm (2009) described compassion fatigue as the direct result of the health professional’s response to the patient’s experiences. The inability to counteract or reject compassion fatigue renders a healthcare professional powerless to successfully perform their ascribed tasks. This encourages the healthcare professional to denounce the patient’s experiences in lieu of their own, as an act of self care to overcome compassion fatigue. This is
contemptuous behavior which negatively impacts the person’s cognition and judgment.

A healthcare professional affected by compassion fatigue will be unable to deliver effective and professional healthcare services. The care then ultimately becomes devoid of empathy and objectivity (Stamm, 1997).

**Burnout**

“Burnout” has been defined as “a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (Figly, 2002). Compassion fatigue is often compared to burnout because it also manifests as physical, emotional, and spiritual exhaustion (Pfifferling & Gilley, 2000). Compassion fatigue, like burnout, can test the nurse’s ability to provide effective care and to maintain therapeutic relationships. Although these concepts appear to be similar, there are differences. The onset of compassion fatigue is sudden and acute, while the onset of burnout is a gradual erosion of the nurse’s management of duties (Figley, 2002). While different from compassion fatigue, many view burnout as an important risk factor or precursor to compassion fatigue.

The work on a Medical-Surgical unit is often chaotic and hectic which prevents the nurse’s ability to reconcile the difficulties encountered during their shift and can lead to a perceived loss of control. Medical-Surgical nurses often encounter patients who are seriously medically ill. This can cause them to lose their ability to empathize which is a quality critical in establishing therapeutic relationships with patients and families. Nurses suffering from burnout display a variety of symptoms such as “reduced self-esteem, lack of confidence and inability to keep things in perspective”.

In their study, Gillespie and Melby (2003), found that length of shifts, perceived lack of support from those in management, and poor communication contributed to the emotional
Compassion Fatigue

exhaustion of the nursing staff. The researchers concluded that the effects of stress and burnout have far reaching implications for clinical practice and life in general.

**Empathy**

Another concept closely related to compassion fatigue is empathy. It is an ability to understand the feelings or difficulty of someone else (Figley, 2002). Empathy from a nursing perspective involves assuming another person’s suffering through the act of caring. A correlation exists between the nurse’s empathy and the quality of care they provide (Bellet & Maloney, 1991). It has been suggested that a vulnerability to compassion fatigue is due to the use of empathy. The ability to balance empathy and objectivity is an important component in maintaining a therapeutic relationship.

**Empirical Studies**

Potter et al, (2010) introduced a descriptive, cross-sectional study with a purpose to assess for compassion fatigue from a cross section of hospital employees. The survey was conducted in inpatient nursing units and outpatient clinics in a cancer center. The sample consisted of 153 healthcare providers including RNs, Medical Assistants, and Radiology staff. The 30-item Professional Quality of Life (ProQOL R-IV) scale was used for measuring “compassion fatigue”, “compassion satisfaction” and “burnout”. A series of analyses examined the relationship between participant demographics and the ProQOL R-IV subscales.

The results were tabulated from a rate of 34% of the 153-person sample size. The majority of respondents were RNs. The average compassion satisfaction score among all study participants was 38.3 (SD = 7.2). The average burnout score among the study participants was 21.5 (SD = 6.4). The average compassion fatigue score among participants was 15.2 (SD =
Compassion Fatigue

6.6). The statistical analysis demonstrated the risk associated with each of the ProQOL R-IV subscales based on cut scores. These were compared with the study variables, including the participants’ workplace setting (inpatient versus outpatient), years of healthcare experience, and years of oncology experience, age, and level of education.

The findings were statistically significant for the relationship between compassion satisfaction and work setting (p = 0.008). Staff working on inpatient nursing units had the highest percentage of high-risk compassion satisfaction scores. Interestingly, the percentages of high-risk scores for compassion fatigue were relatively equal among inpatient and outpatient staff, with 37% and 35%, respectively. Although 44% of inpatient staff scored at high risk for burnout compared to 33% for outpatient staff, the difference was not statistically significant.

A significant relationship was not found between years of general healthcare experience and the three ProQOL R-IV subscales. However, staff with 6–10 years of experience had the highest percentage of high-risk burnout and low compassion satisfaction scores. The staff with 11–20 years of general healthcare experience had the highest percentage of high-risk compassion fatigue scores, followed by those with 6–10 years of experience. No statistically significant relationships were found between oncology experience and the three ProQOL R-IV subscales; however, an interesting trend was noted that staff with 11–20 years of oncology experience had the highest percentage of high-risk scores for all three ProQOL R-IV.

Boscarino et al (2009) studied the prevalence of compassion fatigue among Social Workers. The researchers set out to test the hypothesis that social workers involved in counseling trauma victims are at a greater risk for compassion fatigue and that social workers that have a supportive work environment would be protected from compassion fatigue. The
data was based on a survey of social workers with a Master’s Degree in Social Work or higher who were current members of the National Association of Social Workers (NASW). From the membership list, 600 members with New York City mailing addresses were randomly selected and were mailed a questionnaire. A second questionnaire was mailed 2 weeks later and a follow-up letter was sent 2 weeks after that as a reminder to return the survey. Those respondents not engaged in direct practice were asked to indicate this on the survey.

In all, 236 clinically active social workers returned the completed surveys and 38 returned the surveys indicating that they were not working directly with patients and were excluded from the analyses. The overall completion rate was 46% (236+38/600). This project focused on two main outcome measurements: compassion fatigue and job burnout. The items for these scales were derived from the 30-item Compassion Fatigue Scale-Revised. This scale asked respondents to rate each item as it related to their “work/life situation” using a 10-point Likert scale.

Utilizing the sample of social work practitioners, the researchers first assessed the psychometric properties of this scale and found that the original 30-item scale measured seven underlying factors. The advantage of using separate scales is that they contained fewer items overall while they remained highly correlated with the original 30-item compassion fatigue scale. The initial study supported the notion that compassion fatigue is a unique feature of the workplace environment.

The regression findings indicated that the compassion fatigue 30-item (CF-30) was a good predictor of psychological distress. In this study, the researcher used the ST-5 scale items (Cronbach’s alpha = .80; mean = 4.80, SD = 5.54. The analyses contained three demographic variables; gender, race/ethnicity, and years working in professional counseling.
The researchers also included four stress-related variables in the analyses.

This survey had 13-items relating to different ways of helping those affected by the September 11 attacks using an ordinal scale: no/little involvement (0-1 ways = 1), low involvement (2 ways = 2), moderate involvement (3 ways = 3), high involvement (4 ways = 4), and very high involvement (5 or more ways = 5). The survey also had seven questions about counseling people, categorized as yes vs. no, in order to measure exposure to other traumatized patients, the researchers also asked participants what percentage of their patients were survivors of violence.

Respondents were divided into low exposure, if less than 20% of their patients were victims of violence, and high exposure, if 20% or more of their patients were victims. The researchers also asked about personal experiences with trauma which used an ordinal scale: no traumatic events = 1, one traumatic event (low = 2), two traumatic events (moderate = 2), three traumatic events (high = 4), and four or more traumatic events (very high = 5). The researchers also assessed an important dimension of the work environment: having information to work effectively with patients, which was the sum of two items on the survey. The response options available were based on a 5-point Likert scale where a higher score indicated a more supportive work situation.

The researchers utilized a regression analysis with the demographic, stress, and resource variables. They developed two multivariate regression models to test their hypotheses. The researchers log was used to calculate the outcome of the variables due to skewed results. A regression analysis and descriptive statistics were conducted in addition to the hypothesis testing. The researchers compared the prevalence of cases in this project by both low vs. high September 11 involvement and counseling, in order to examine the predictive value of the
defined cut-off point. All p-values were based on two-tailed tests.

The demographic information indicated that most of the sample was female, white, and over 50 years old. Also, more than 50% reported being exposed to two or more traumatic events in their lifetime and 19% were currently seeing a substantial number of patients who were victims of violence. Additionally, 38% were extensively, involved with the WTC recovery efforts and 67% were extensively, involved with counseling persons affected by the WTC disaster. The major finding was that compassion fatigue among WTC counselors was significant (p<.05).

This research supported the concept that a group of mental health professionals working with traumatized victims were at greater risk for compassion fatigue. The researchers also suggested that the important variables in predicting compassion fatigue include degree of exposure, personal history, social support, and environmental factors. As was shown in this project, the work environment appears to have an impact on the outcome. This was the first project to validate the concept of compassion fatigue.

In a study by Hooper 2010 the concepts of compassion satisfaction, burnout, and compassion fatigue among emergency nurses and nurses in other selected inpatient specialties were explored. The purpose of the study was to identify the prevalence of these outcomes from the target population. Emergency nurses and nurses from the Oncology, Nephrology and Intensive Care Unit were selected for participation in this cross-sectional survey. Participants completed a Sociodemographic Profile and the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV. Scores were summed for compassion satisfaction, burnout, and compassion fatigue for emergency nurses and compared with those of the nurses in the other specialties.
The results found that approximately 82% of emergency nurses had moderate to high levels of burnout, and nearly 86% had moderate to high levels of compassion fatigue. Differences between emergency nurses and those working in the Oncology, Nephrology, and Intensive Care, on the subscales for compassion satisfaction, burnout, or compassion fatigue did not reach the level of statistical significance. However, the scores of emergency nurses evidenced a risk for less compassion satisfaction, while intensive care nurses demonstrated a higher risk for burnout and oncology nurses reflected a risk for higher compassion fatigue.

Dominquez & Rutledge (2010) chose a descriptive-survey design for their study of Emergency Department (ED) nurses and doctor’s attitudes and experiences of stress in the workplace. A questionnaire was devised and copies were sent to 150 ED nurses and doctors working in three EDs. The mean age of the 103 respondents was 33.4 years. The number of years’ experience since respondents’ first professional qualifications ranged between one and 35 years, with a mean of 11.4 years, while the number of years’ experience working in the ED ranged between three months and 26 years, with a mean of 6.9 years.

Thirteen per cent of respondents were doctors (n=13), of whom 62 per cent (n=8) were male. Nine per cent (n=8) of the nurses were male. The typical respondent was a female registered nurse (n=90, 87 per cent) aged between 23 and 59, who worked full time and had been married or in a relationship for a long time.

The results were conclusive that 52% of the respondents had experienced stress at work ‘frequently’ or ‘very frequently’, while 37% of the respondents indicated that they had on occasion experienced work-related stress. The most commonly identified stressors in EDs were ‘aspects of the work environment’, including workload, overcrowding, traumatic events, shift work, frequency at which doctors rotate, inter-staff conflict, lack of teamwork and poor
managerial skills. Other commonly identified stressors included aggression and violence from patients, and the death or resuscitation of a young person or child.

Bride (2007) studied the prevalence of secondary traumatic stress among a group of 282 Social Workers in the Southern United States. The study focused on the rate and degree of secondary traumatic stress symptoms as well as the rates of Post-Traumatic Stress Disorder (PTSD) among the target population. A questionnaire was administered to each of the participants, which contained clusters of symptoms which are indicative of PTSD.

It was found that 70.2% of the Social Workers experienced at least one symptom of secondary traumatic stress, 55% met the criteria for at least one of the core symptom clusters, and 15.2% met the core criteria for a diagnosis of PTSD. The study demonstrated that the intrusion criteria were endorsed by nearly half of the respondents and most reported symptoms of intrusive thoughts, avoidance of reminders of clients, and numbing responses. Due to these findings, a description could be formulated about secondary traumatic stress as a significant occupational hazard for social workers that work directly with clients exposed to trauma. Social Workers in child welfare engage primarily with children and thus are exposed to children’s pain and trauma on a regular basis. According to the researchers, specific events may potentially lead to secondary trauma for social workers in child welfare. These events include: the death of a child on one’s caseload; investigation of horrific child abuse allegations; ongoing exposure to a child’s description of trauma and abuse; visual exposure to a child’s physical injuries or emotional pain; and ongoing interactions with families who have experienced severe abuse, neglect, and domestic violence (Siegfried, 2008). In light of this data, it appears that social workers that work particularly in the field of child welfare are potentially at an elevated risk for developing secondary traumatic stress as compared to the general population.
Due to the nature of the work, social workers often experience chronic exposure to trauma and a high number of trauma related clients on their caseloads. Additional stressors such as excessively large caseloads, contentious client interactions, limited resources, and difficult working environments only further complicate the experience of social workers in the child welfare system and increase their vulnerability for distress and emotional difficulties (Siegfried, 2008). Bride went on to state a belief that “the experience of secondary trauma is one reason why many child welfare professionals leave the field prematurely”.

Blomberg & Sahlberg 2007 study was interested in understanding how care team members caring for patients with advanced cancer handle difficult circumstances arising from their daily work. The sample size was 77, which included Nurses, Nurse Assistants, Psychologists and Occupational Therapists. The chosen setting included: the Oncology, Palliative Care and Outpatient departments. The study was conducted utilizing 16 focus group discussions with the care team members. The procedure for data analysis was inspired by the phenomenological method.

The results demonstrated that the care team members handled difficult situations by balancing between being close and distancing themselves. In most situations their choice of strategy seemed spontaneous rather than being a conscious decision, although it was sometimes described as a more conscious approach. Variations of closeness and distance that were identified were Identity, Meaning, Limit-setting and touching, Prioritization, the Team and the Organization. These could also be seen as tools that could facilitate or impede the use of closeness and distance.

A need to reflect over the daily care and to become aware of what governs different care actions was also demonstrated by the care team members. If the experienced difficult situation is
unresolved, it is apparent that it can lead to distress, burnout and most importantly a lack of optimal care. It is well established that nursing can be a stressful occupation. Pediatric oncology, as a setting, is perceived as both personally and professionally demanding, due to additional stressors that are unique to its specialty. The additional stressors that are specific to the pediatric oncology field include, grief, loss, ethical dilemmas regarding treatment and the management of professional boundaries in regard to relationships with patients and their families.

The study’s intent was to determine if there were strategies in use, which promoted resiliency with work, related stressors. These findings highlight the possibility of resilience being present among pediatric oncology nurses. However, the literature fails to explore the concept of resilience among pediatric oncology nurses at this time. Blomberg & Sahlberg (2007) assisted in the understanding of how nurses currently cope. They are in favor of the development of strategies, which can enhance coping ability. Abendroth, (2006) conducted a study in order to 1) understand the complex relationships among Compassion Satisfaction, Compassion Fatigue and Burnout within the hospice and palliative care workforce and 2) explore how key practice characteristics, practice status, professional affiliation, and principal institution interact with the measured constructs of Compassion Satisfaction, Compassion Fatigue and Burnout.

The study utilized measures of “Self - Report” of Compassion Satisfaction, Compassion Fatigue and Burnout, using validated scales. The study also administered a survey questionnaire to describe socio-demographic profiles and key practice characteristics. The participants were healthcare professionals comprising clinical, administrative, allied health workers and volunteers. The total number of participants was 630 (n = 630). The participant’s were from a variety of settings, which included hospital, community based and
Compassion Fatigue

home care.

The study results indicate a significant negative correlation between Compassion Satisfaction and Burnout ($r = -0.531$, $p < 0.001$) and between Compassion Satisfaction and Compassion Fatigue ($r = -0.208$, $p < 0.001$), and a significant positive correlation between Burnout and Compassion Fatigue ($r = 0.532$, $p < 0.001$). Variations in self-reported levels of the above constructs were noted by key practice characteristics. Levels of all three constructs are significantly, but differentially, affected by type of service provided, principal institution, practice status and professional affiliation. The results further indicate the impact health care systems could have on increasing the prevalence of Compassion Satisfaction through engagement in policy changes and through development of supportive programs for their healthcare professionals (Appendix B).

**Summary**

The literature provides support for the notion that a stressful environment produces varying effects on people. There are some that escape the impact and others in which the impact produces psychological or physical problems which are severe. Stamm (1999) argued that there are healthcare professionals that suffer varying degrees of impact which is related in part to the motivation that drives their satisfaction for helping others. The act of demonstrating compassion for the traumatized can have harmful effects among the care givers (Figley, 2002).

The concepts of “burnout”, “vicarious traumatization” and “empathy” are directly related to the concept of compassion fatigue. The effects of stress can leave its toll on the body and mind predisposing the nurse to the development of compassion fatigue, which interferes with the ability to provide care. Section III includes the methodology utilized in this project to
explore compassion fatigue among Medical-Surgical nurses. The discussion will include the project design, sample, and instrumentation, protection of human subjects, procedure, and data analysis.

**Project Intervention**

An aim of this project was to assess compassion fatigue among medical-surgical nurses. The planned intervention consists of the development of an educational program, which has been implemented. It involved the initial training of the Nurse Educator as the future facilitator of Compassion Fatigue education for the staff within healthcare organization A. The first of four series was initiated and included a 45-minute training session, which was designed to assist RNs to recognize compassion fatigue and to develop a self care plan. The program was presented to a group of RNs at both of the facilities, which were involved in the project.

Pre-and post-intervention evaluation will be conducted over six months and will involve use of the ProQOL R-IV, a nursing satisfaction measure, and a qualitative evaluation of program features. The program will be conducted as a mandatory educational session allowing time for group participation and discussion among the attendees and the Nurse Educator. This will facilitate an opportunity for a didactic with and among the nurses related to the concerns and deficits that pose barriers to the provision of quality care. Upon successful implementation of the education program the findings will be shared with the corporate administration and a recommendation will be made for corporate wide program implementation. Applying internal evidence in the design of the program will prepare the nurses to attend to their own self care needs that of the patients and families they serve.
Section III:

Project Implementation

Design

The project utilized a quantitative exploratory format designed to elicit information about a relatively sparsely studied topic. In fact, few studies have looked at the experience of the medical-surgical nurse, rather, most have focused on the experiences of Intensive Care, Hospice, Oncology and Emergency Room nurses. Subsequently, the data gathered can provide a basis for further study and the need for intervention techniques. The focus of the project will delve into the precipitating factors of compassion fatigue.

According to Polit and Beck (2004), the goal of most studies is to “develop a rich understanding of a phenomenon as it exists in the world and as it is constructed in the context of that world”. The type of design construct used for the purpose of this project was appropriate as a means to adequately support the discovery and meaning of the Medical-Surgical nurses’ experience with compassion fatigue. Inclusion criteria Medical Surgical nurses whom fit the criteria.

Methodology

The project contends that knowledge concerning the symptoms of Compassion Fatigue may inspire the development of interventions to prevent or deter its existence. The impetus for this project arose from an observation of a chronic display of apathy in the performance of providing care to the patient and their families in the medical-surgical department.

There were two hospitals chosen for project participation. Each hospital is a member of the same larger Northern California healthcare conglomerate. The first hospital chosen for
Compassion Fatigue

the project will be referred to as Hospital A. It is located within 10 miles of the second hospital. It is a 16 bed acute care hospital with an Ambulatory Care Center and Physiatry services. Hospital A is located in a Northern California community with a total population of approximately 32,148 of which approximately 4.8% of the residents are African-American, 70.2 % are Caucasian, and 25% are of other ethnic or racial origin (U.S. Census Bureau, 2011).

The second hospital selected for the project, which will be referred to, as hospital B is also located in a Northern California city. The population of the community is approximately 21,158 and approximately 1% of the residents are African-American, 76 % are Caucasian, and 23.1% are of other ethnic or racial origin (U.S. Census Bureau, 2011). Hospital B is a 450-bed acute care hospital, which was selected for the project due to its high volume of patients treated in the medical-surgical units. The researcher contends that the large patient volume increases the exposure to work related stressors, creating a predisposition for Compassion Fatigue. This hospital was also selected, as it was the only other acute care hospital in the area which is owned by the targeted healthcare organization.

Sample

The participant populations were selected from the two targeted acute care hospitals. A total of 50 Medical-Surgical registered nurses were recruited for participation in the project. Approximately 35 participated in the project. The participant population consisted of all Registered Nurses (RNs). The registered nurse participant’s met the following inclusion criteria: a) Graduates of a school of nursing and having passed the board of registered nursing examination as a registered nurse, and b) at least 18 years of age or older, b) currently employed as Medical-Surgical nurses in an urban hospital in California and c) interacts directly with patients and families.
Protection of Human Subjects

An application was completed and submitted to the IRBPHS Research Institute governing the target hospitals. An approval was received by the Research Institutional Review Board governing the corporation of the two target hospitals (Appendix C). An application to the Institutional Review Board Protection of Human Subjects (IRBPHS) was completed and submitted to the University of San Francisco IRBPHS prior to initiation of data collection. An exemption was received in the implementation of this project from the University of San Francisco Institutional Review Board (Appendix D).

An approval letter was received from the Chief Nursing Officer of organization A (Appendix E) and the Vice President of Patient Care Services from organization B (Appendix F). Project participants were recruited through a letter distributed online through the nurses secure work web mail address (Appendix G). There was no scripting by this researcher, in order to limit any inconsistencies that could be created by any impromptu presentation to the nurses prior to completion of the project.

The recruitment letter was accompanied by an Informational Statement (IS) to inform the participant of their rights during the course of the project (Appendix H). The researcher’s telephone number and web-mail address were contained in the IS. Additionally, the telephone numbers and web-mail addresses of the faculty advisors from the University of San Francisco were included. Each Medical-Surgical nurse was informed of their right to voluntarily choose to participate in this project. They were also informed of the right to withdraw from the project at any time. The IS statement addressed that no monetary awards would be offered in exchange for participation in the project. Potential risks were discussed including fear and apprehension over describing uncomfortable and/or stressful events. The potential benefit for participation was
described as a potential self-awareness and opportunity to help nurses to relieve their suffering from CF, through the sharing of experiences.

The IS explained the confidentiality process in which there would be no personal identifiers associated with participation in the project, therefore, the identity or information would remain strictly confidential. Data collection in this project would be managed and stored on the secure encrypted desktop computer in the researchers locked office. All documents pertinent to the project would be destroyed no later than May 31, 2013.

Instrumentation

Validity – An extensive review of research did yield quantitative surveys addressing compassion fatigue, however, it was not specific to medical-surgical nurses. The survey instruments utilized for this project were validated instruments. The project yielded a minimal threat to internal validity because the project was completely devoid of personal contact by the researcher. The contact with the participants was avoided in order to not lose objectivity.

Reliability – All of the participants in this project were at risk for or have already developed compassion fatigue. All of the participants in this project indicated this was the first survey they’ve taken targeted to Compassion Fatigue; however, if the group took the survey a second time the measurements could yield the similar results, therefore demonstrating test-retest reliability.

Quantitative data was obtained from three different survey tools, which included: a Demographic Profile, Online Questionnaire and the Compassion Satisfaction/Fatigue Self-Test for Helpers.

The first tool selected for use was the Online Questionnaire, an assessment
tool of current employment status (Appendix I). It consists of a series of 9 questions designed to elicit each nurse’s individual experience with CF and work-related stress. Since many nurses are not familiar with the term CF, the questions were formatted with a series of choices in which to guide the sharing of experiences related to CF. Each of the 9 questions offers a choice from multiple answer selections. The purpose of the questionnaire was to determine whether there are any links between factors such as income and the development of compassion fatigue.

The second tool selected for use was the Demographic Profile (Appendix J). The demographic Profile assists to identify any pattern or trend, which exists that, can create a predisposition for compassion fatigue. There were 13 questions in the Demographic Profile with multiple-choice answers. The data was collected from three tools because according to Polit and Beck (2004) it is preferable to use data from multiple sources in order to be able to validate the conclusions and enhance the credibility of the results obtained and a 5-point Likert scale was used.

The final tool selected for use was the Compassion Satisfaction/Fatigue Self-Test for Helpers was developed by Dr. C. Figley and Dr. B.H. Stamm (1996) (Appendix K). This is a 25-question tool with scoring on a 0 to 5-likert scale. The lowest score selection a “1” represents a response of “never” and the highest score selection a “5” represents a response of “very often”. The purpose of the Compassion Satisfaction/Fatigue Self -Test for Helpers was to gauge compassion status as well as the risk for CF. The potential alpha reliability of this test is compassion satisfaction at .87; burnout .72 and compassion fatigue .87 Figley & Stamm, 1996. It also assess’ the risk level of compassion fatigue and degree of satisfaction with helping others.
Compassion Fatigue

**Procedure**

This project involved the recruitment of Medical-Surgical nurses to participate in a survey designed to facilitate articulation of their feelings and experiences with CF. Upon receipt of permissions from the respective Institutional Review Boards for the Protection of Human Subjects the project commenced. A letter was e-mailed to the Vice President of Clinical Services and the Chief Nursing Officer of the targeted hospitals, to explain the purpose of the project as well as to ascertain agreement for nursing participation.

Upon confirming the agreement, the next step was preparation of Survey Monkey, a secured, encrypted website to serve as the survey engine. A consent outlining the rights of the participant as a subject of the project was uploaded to Survey Monkey. Next the Online Questionnaire, Demographic Profile and the Compassion Satisfaction/Fatigue Self-Test for Helpers accompanied by answer choices were uploaded.

Consent to participate in the project was implied as soon as the participant logged on to the confidential website to participate in the survey activities. The recruitment letter contained the Information Statement (IS) outlining the rights of the individual participant with an emphasis placed on the protection of the participant’s identity. This was a means to facilitate the candid expression of each participant’s experience with CF and work-related stress.

The time parameters were also explained in the IS and were estimated to be approximately 45 minutes length of time for completion. The estimated length of time for completing the demographic profile (approximately 10 minutes), the estimated length of time for completing the interview questions approximately 15 minutes and the estimated length of time for completing the Compassion Satisfaction/Fatigue Self- Test for Helpers...
Compassion Fatigue

approximately 20 minutes.

Upon completion of all survey activities, the data was initially complied through Survey Monkey. The data was analyzed and the results maintained on the secure encrypted computer locked in the researcher’s office. The researcher and the researcher’s committee members are the only persons who will have access to the results of the project. The comments made by the project participants will allow the researcher to fully capture the experiences with CF and work-related stress.

On October 13, 2012 a lecture was given on the concept of CF which included the Nurse Educator who will host future trainings. The lecture was held during the hospital wide “Competency Day” in order to educate the entire nursing staff. Interventional Strategies, which have been designed by the researcher, were given as an aspect of promoting self-care among the entire hospital staff.

On October 19, 2012 the strategies designed to prevent or reduce the effects of CF were fully implemented to include additional mandatory training which will include a four series training initially and will be hosted twice a year, thereafter. The training will serve as a forum for the nurses to talk about stress reduction strategies and the challenges faced in provision of quality care. The data collected through the successful implementation of this program will demonstrate its usefulness in averting combat fatigue. There will be recommendations made based on this success to offer the training corporate wide to all staff.

Results

Prior to analysis, there was an examination for outlying and missing data. Descriptive statistics were used to analyze demographic information, including age, number of years as a
Compassion Fatigue

nurse, number of years working in the medical-surgical area and educational background. Although Figley (2002) recommended reporting summed scores for the subscales, this researcher preferred to rely on the raw scores to indicate relative risks.

The project response rate was a total of 35 nurses for a rate of 70%. The majority of respondents were female RNs (see Table 1). The average compassion satisfaction score among all study participants was 20, which were lower in comparison to an average score of 22 reported by Stamm (2009). Conversely, the average compassion fatigue score among participants was 22, which were higher in comparison to the average score of 13 reported by Stamm (2009). Figley’s Compassion Stress and Fatigue Model (2002) was the framework, which directed and assisted to conceptualize the project. The sample of nurses included full time, part time, and per diem nurses. A triangulation was produced by the quantitative data from Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers and assisted to confirm the project’s objective.

The number of nurses who reported being married was 51% (n = 18); reported a divorce, 26% (n = 9); were single 14% (n=5), and separated from their spouses 9% (n =3). Nurses with four children living at home, 3% (n=1); had 3 children living at home, 17% (n =6); had two children living at home, 20% (n = 7); had one child living at home 17% (n=6); had no children at home 43% (n=15). Sixty nine percent (n =24) received an associate’s degree in nursing, 17% (n=6) received a bachelor’s degree in nursing, and 14% (n =5) had a Master’s degree in nursing (Table 2). There were 31% (n =11) of nurses who earned a yearly income of $70-80,000 8%; Nurses who earned a yearly income of $81-90,000 were 49% (n =17); Nurses who earned a yearly income above $90,000 was 20% (n =7).

The number of years of experience as a registered nurse ranged from 0 years to
Compassion Fatigue

34 years with the mean number of years of experience as a registered nurse of 17 years. The number of years of worked in the Medical-Surgical ranged from 0 years to 23 years with the mean number of years worked in the Medical-Surgical of sixteen years (Table 3). Fifty-four percent \((n = 19)\) were employed full time at the current facility and 46\% \((n = 16)\) were employed on a part-time basis. Forty-six percent \((n = 16)\) worked day shift (7 am to 7 pm), 28\% \((n = 10)\) worked night shift (7 pm to 7 am), and 26\% \((n = 9)\) worked variable hours to include both day and night hours. The mean number of hours worked per week was 37.5 hours. Eighty-two percent \((n = 29)\) did not work in another facility and 17\%, \((n=6)\) indicated they worked at other areas/facilities, which includes Medical-Surgical and long term care. Analysis showed no significant correlations between age, gender, marital status, employments status, number of years as a nurse, education level and/or previous medical-surgical nursing experience.

Compassion Satisfaction/Fatigue Self-Test for Helpers results were compared to the quantitative data obtained from the online survey questionnaire. Figley’s Compassion Satisfaction/Fatigue Self-Test for Helpers evaluates compassion status. It is a tool, which measures the risk for developing compassion fatigue as well as measure level of satisfaction with helping others. The scores are broken down into two sections: potential for compassion satisfaction and risk for compassion fatigue.

The scores indicated that 26\% \((n =9)\) of the project participants had an extremely high potential for compassion satisfaction; 28\% \((n = 10)\) had a high potential for compassion satisfaction; 20\% \((n = 7)\) had a good potential for compassion satisfaction; 17\% \((n =6)\) had a modest potential for compassion satisfaction; and 8\% \((n = 3)\) had a low potential for compassion satisfaction. In examining the risk for compassion fatigue, 3\% \((n = 1)\) had an extremely low risk for developing compassion fatigue; 11\% \((n = 4)\) had a low risk for
developing compassion fatigue; those with a mod risk were 23% ($n=8$) those with a high risk for developing compassion fatigue; and 37% ($n=13$); those with an extremely high risk for developing compassion fatigue were 26% ($n=9$) (Table 4).

The results of these scores validate the number of nurses with compassion fatigue experiences. The scores indicated that more than half of the project participants had a high to extremely high risk for developing compassion fatigue. The responses given by the project participants’ provides evidence that work-related stressors can affect the nurse’s ability to cope and to provide the compassionate care that the patient deserves.

The coping measures indicated in the responses demonstrated that the project participants are attempting to be mindful regarding their own self-care. Further exploration is needed in order to understand how the work stress specifically impacts the ability to provide care. While the scores indicated that a greater number of the project participants were at risk for developing compassion fatigue, the scores also indicated that a majority of the project participants had an excellent chance for developing compassion satisfaction.

Stamm (2002) indicates that caregivers can derive compassion satisfaction while simultaneously being at risk for compassion fatigue. This explanation is evident throughout the project participants’ responses to the relationship of their sense of accomplishment and a stressful work environment. Many of the project participants demonstrated that they have a sometimes overwhelmingly stressful workload and environment.

Medical-Surgical nurses encounter numerous stresses on a daily basis, the main work-related stressors according to project participants relate to feeling a lack of support from
managers and team members and also the increased patient acuity, and lack of qualified nursing staff. These project participants demonstrated resourcefulness in their use of internal coping measures, and perseverance as a way to manage their stress. It is evident that a work related stress negatively impacts care. The project participant’s responses in some cases signified an uncaring attitude toward the patients.
Section IV:

Project Evaluation

The project on compassion fatigue was evaluated through review of objective and subjective measures which impacts: the patient; clinical environment and healthcare.

Patient Impact

Objective measure

The Online Questionnaire was the objective measurement regarding the nurse’s experience with compassion fatigue and the affect on the ability to care for the patient. Item number six on the questionnaire was designed to elicit a description from the project participants in terms of how their experiences with compassion fatigue interfere with the ability to provide care (Table 5).

Subjective measure

The responses from the questionnaire offered emergent themes, which were that of anger, lack of care and lack of time. 

*Anger* seemed to be pervasive among the participants as they responded regarding the effect of stressors. Many of the respondents seem to lack a sense of support and are seemingly angered by that notion. Many of the participants have managed to identify angry feelings and use appropriate coping instead of projecting their feelings onto the patient.

*Lack of caring* was an attitudinal problem expressed among the participants in their plight to cope with work-related stressors. The recognition of this theme is important as it creates an
Compassion Fatigue

understanding of the negative influences on the environment when there are work related stressors.

*Lack of time* spent in patient care was a common theme that seemed to produce the greatest amount of frustration among the project participants. The lack of time spent with patients is a delicate subject and a perception which if allowed to continue can lead to mounting disappointment and feelings of defeat. This can also produce barriers, which threaten the delivery of quality and safe care. If left unattended, it is a factor, which can ultimately lead to an increase in errors of judgment which can be catastrophic to an organization.

Clinical Environment Impact

Objective Measure

The Online Questionnaire was the objective measure used to establish the existence of compassion fatigue among Medical-Surgical nurses’ and the impact to the clinical environment. Online questions one through five and seven through nine were purposed to direct the project participants in their familiarity with descriptors regarding compassion fatigue. There were consistent themes noted in the results related to the experience working in the medical-surgical clinical environment (Table 6).

Subjective Measures

The participant’s responses were the subjective measures. The project participants’ descriptions focused on the themes of lack of control, disempowerment, dissatisfaction, and a negative environmental influence. Multiple project participants reiterated loss of control. Loss of control is demonstrated by an overpowering inability to meet obligations. The recognition of this vulnerable impact demonstrated that the
Medical-Surgical clinical setting can be extremely taxing and therefore in need of processes and systems with which to manage work responsibilities and avert patient safety issues.

Some of the participants were acutely aware of the contributing factors of their compassion fatigue, yet, indicated an inability to manage the effects while delivering responsible care. The demands of the job seem to produce a sense of helplessness which resulted in the nurse becoming out of balance. As was mentioned previously, Medical-Surgical nurses need balance in order to effectively and efficiently provide quality care. They need a capacity to multi-task, however, the issues with loss of control can undermine the confidence to maintain.

Disempowerment was a re-occurring theme throughout the responses regarding the effect of work-related stressors. Feeling disempowered often occurs when not feeling like the resources are available to accomplish the work load. These nurses are in a precarious situation as the lack of empowerment disallows them to independently address conditions, which precipitate safety issues. The participants responses demonstrated how difficult it is for them achieve the mission within the Medical-Surgical area, given a perceived lack of support and scant resources.

Dissatisfaction was another theme used to define the feelings associated with the clinical environment. The project participants seem to recognize the impact of their dissatisfaction on their ability to provide therapeutic care.

Negative environmental influence was often pointed out as a key factor for many stressors. The setting is often comprised of a heavy workload and patients with health problems of varying complexities. This leads to competing forces in the division of care and ultimately an environment plagued by staff negativity. These issues affect the nurse and jeopardize the
Compassion Fatigue

welfare of the patient, which compounds the nurse’s feelings (Table 7).

There are continuous quality improvement measures in place at each hospital to thwart issues that impact the medical-surgical environment. This includes regularly scheduled monthly meetings, which facilitates a discussion with and between the nurses regarding topics which affect their practice. An example can be noted at hospital A in which there are in-services which focus on working with Breast Cancer patients.

There are also activities, which are scheduled routinely which elicit knowledge pertinent to care, while simultaneously promoting team work. The managers and supervisory personnel also engage in the activities in order to demonstrate solidarity with the staff since the influence of the environment starts with the leadership. These are worthy measures, however, a continuous quality improvement project such as the education regarding compassion fatigue and its control cannot be over emphasized.

Over time the most effective measures are those, which impact positive change in the environment. If the nurses aren’t feeling comfortable to adequately and safely perform it is a subject, which must be broached. Education is not the only method to address compassion fatigue however; it extends far beyond most interventions which influence change.

Healthcare Impact:

Objective measures

The information that seems to have the most profound effect on healthcare globally is the discussion of encounters with work-related stressors. The project participants’ descriptions centered around two themes: workload and lack of support. The overall impact for healthcare is largely related to the ability of nurses effectively copes with work-related stressors.
Subjective measures

In their discussion of strategies used to cope with work-related stressors, the project participants focused on the themes of interaction with support systems, self resolve and internal control measures. The type of interaction with support systems seems to impact the nurse’s ability to cope. Each project participant’s responses were indicative of some form of angst when dealing with daily stressors. Many indicated a choice to take a time out as a method to counter their anxiety, while others indicate suppression of their anxiety in order to complete their usual tasks without incident. Some of the project participants indicated that they share their work related difficulties with close family members and friends as an outlet. Other project participants indicated they leave their difficulties at the work place while still others used coping measures not listed in their choices as a means to manage a stressful day.

Internal control measures were utilized by some of the participants such as activities at work or outside work in order to cope with the stress. One of the most stunning aspects were those participants that seemed to rely on unhealthy choices such as, drinking or smoking to counter a stressful day. There were some participants that use exercise or relaxation as an outlet after completing a stress filled day at work. The use of internal control measures was a more positive method by which participants coped with work related stressors. Finally, and not surprisingly, most of the project participants utilized a sense of accomplishment, which was vital to raising a level of satisfaction for the work they perform.

There is oversight by the Centers of Medicare and Medicaid (CMS), the California Department of Public Health (CDPH) and the Joint Commission (TJC) just to name a few who have an interest in the provision of quality care at the micro level. The intent is to protect healthcare delivery through initiatives designed to encourage organizations to address barriers
Compassion Fatigue

to safe and responsible care.

One such initiative utilized by hospital A is the participation in the Collaborative Alliance for Nursing Outcomes (CALNOC). They are providers of information and research on nursing sensitive quality indicators. CALNOC’s database registry of nursing sensitive indicators converts the reported outcome data into information which the hospital administration uses to guide decisions that advance patient care.

The imperative for quality patient care has never been stronger. With nursing sensitive indicators linked to reimbursement, there is now a direct effect on the impetus to change issues in the environment, which have a global impact on care. Each hospital participates in continuous quality improvement through participation in a national patient satisfaction database (PRESS GANEY), which gathers data regarding the patient’s perception of their overall experience. To evaluate and improve the quality of care provided is of vital importance in the context of nursing care. Patient satisfaction is a significant indicator of the quality of care. Consequently, there are processes that provide information from the patient’s perspective on whether quality is being performed. It also maps out patient satisfaction with nursing care.

To improve the quality of nursing care, the nurse needs to know what factors influence patient satisfaction. Each hospital has an interest in the survey items which specifically address the patient’s perception of their care and of their care providers. The feedback from the survey has a powerful influence. Upon identifying a concern continuous quality improvement efforts such as performance improvement teams are established in order to determine which improvements are needed. Each of the themes that are reported by patients is categorized and an action plan is developed. That is why it is essential to address the issue of compassion fatigue before it evolves to a level, which impacts the patient’s perception of care. The level of
Compassion Fatigue

awareness and impact of compassion fatigue has not been fully realized. Education regarding the condition and prevention will assist to ensure that patients desires to have their needs met adequately and compassionately are fulfilled.

The Compassion Fatigue project was executed under the premise of the quality tool of FOCUS-Plan-Do-Check-Act (PDCA). This is a research-based structure model which provides the tools to continually self monitor. The key steps of FOCUS-PDCA were implemented to first identify the profound impact of compassion fatigue on patient care as well as the recruitment and retention of nursing personnel. The compassion fatigue project proved to be meaningful in the discovery of an opportunity to improve the phenomenon. Compassion fatigue is a troubling concept with implications for provision of quality care. A plan to alter this disturbance clearly involves the collaboration of an organized team of nurses, administration and other key stakeholders whom are the closest to and have ownership of the problem.

The clarification needed for process improvement will include education regarding the information pertinent to understanding compassion fatigue. Facilitating an understanding will essentially provide a framework for understanding how compassion fatigue interferes with care practices. The “Plan” was accomplished through writing the education plan, data collection and the vital few opportunities for improvement identified in the process of conducting the compassion fatigue project. The “Do” was accomplished through the implementation of staff education. The “Check” will be accomplished through a baseline monitor, which will occur 6 months after the plan implementation. The “Act” will be monitored and the results adjusted as needed based on the results of the baseline monitor. The PDCA process will be utilized for all performance improvement activities within the facility and its entities.
Sustainability

The sustainability of methods to mitigate or reduce compassion fatigue was designed to assist the nurse to implement and maintain strategies of functioning that have been compromised due to Compassion Fatigue. The proposed education program as an intervention would include an integrated approach to self-care in order to enhance resiliency to compassion fatigue. In addition to addressing the deficits, which prevent the nurse from performing at an optimal level, there will be the opportunity to learn, by experiential participation, steps that can also be utilized by the patient. Compassion Fatigue has an ability to deter the nurse’s sense of well being, purpose, identity and empowerment, all of which are important qualities. The education program will strive to instill a sense of hope in the nurses professional and person life.

The educational program protocol is designed in four series and will be directed to assist the nurse with the achievement of the following major objectives; Identify and understand the experiences which trigger symptoms of compassion fatigue in their lives; Review of present personal methodologies of addressing these difficulties; develop a maintenance self-care plan which incorporates: specific skills and a connection with others. The purpose of this is to enable the nurse to identify resources (external and internal) to assist with resiliency to compassion fatigue. The program will also assist in boundary-setting and conflict resolution.

**Series One** will involve the completion of a nurse individual self assessment in order to explore professional and personal life experiences. Although this might be intimidating, a reminder about confidentiality will be acknowledged. Each nurse will have an opportunity to develop their own self care plan with skills to acquire regarding internal conflict and making a connection with others.
Series Two will include an introduction of a variety of relaxation technique taught by the Nurse Educator including safe place visualization. The intent would be to relax the nurse in order to inspire the same hope and empowerment created at the beginning of the nursing career.

Series Three is to develop professional and personal goals and to start reframing the nursing experience. There will also be a review of situations, which are difficult, accompanied by a review of strategies for modulating feelings.

Series Four: The nurse will be assisted to identify new skills to practice and master boundaries and self care which will include and a review of the goals of the compassion fatigue program.

Options for Further Work

It is possible that a problem may develop to which a resolution is beyond the scope of the education program, in which case the nurse will be referred to the Employee Assistance Program (EAP) in order to explore individual treatment.
Section V

Project Summary

The occurrence of compassion fatigue within the health care professions has undergone significant investigation. However, the prevalence of compassion fatigue among Medical-Surgical nurses has gone practically unnoticed. Work in the Medical-Surgical is often described as a “death zone” (Badger, 2001). Medical-Surgical nurses endure numerous work-related stressors as a result of their work environment. These nurses are at risk for developing compassion fatigue as a consequence of the stressors that they encounter.

The intent of this project was to assist the Medical-Surgical nurse with recognition of compassion fatigue and work-related stress and its impact on patient care. An understanding of this phenomenon will allow others such as those in administration to become more acutely aware of the detrimental effects of compassion fatigue. It will also facilitate the nurse’s ability to plan for self-care as a means to improve patient care and safety.

Medical-Surgical nurses encounter numerous work-related stressors as a result of their hectic work environment. These nurses must adapt to the demands produced by a high patient acuity. These are circumstances which predispose the Nurse to conditions which compromise the health and safety of patients. The responses to the survey questions are not a surprise as they allude to the frustration associated with feelings of loss of control.

It is imperative given these circumstances that Medical-Surgical nurses establish and maintain order which is needed to provide care which is efficient and effective. A loss of control is frequently experienced when the nurse believes that patient needs have not been met. The feelings related to this can induce pressure which creates unmanageability. Some
nurses are simply overwhelmed when there is high acuity because they believe it disallows their time spent providing patient care. When nurses lack control in their environment it has a tendency to diminish their self-confidence and ability to perform their duties.

A loss of control is tantamount to feelings of disempowerment in the work setting. Medical-Surgical nurses view the lack of time available to spend with patients as disempowerment. High acuity patients or those with a severe episode of illness, require more nursing time thus taking away from the care needed by other patients. Nurses have a tendency to want to be all things to all people. There is a tendency to become easily upset and short tempered which can be taken out on the patient. The participants in the project demonstrated varying degrees to which they manage their feelings when the workload is perceived as burdensome. In their descriptions a recurring theme seemed to relate to the amount of workload and lack of support. The trend in increased patient volume, high patient acuity, and lack of adequately trained nursing staff seemed to also factor into the stress.

The lack of support from management, hospital nursing staff, and co-workers was perceived as a work-related stressor. These nurses had perceived feelings that the department managers were not aware of nor understood the stressors they face. Teamwork is essential within the Medical-Surgical because of the enormous work load. Lack of support from co-workers who do not complete their share of the work was also perceived as a work-related stressor.

Despite the prevalence of work-related stressors in the environment it seems that many of the nurses have attempted their own methods of coping. Their internal control measures of coping relate to their support network and self-endurance. It is through use of their own devices that some nurses are able to process their feelings of anxiety. An ability to
appropriately modulate feelings facilitates a progression to task completion. If work related stressors are not dealt with appropriately they become a barrier which has negative implications for patient care and the tasks at hand. Some of the project participants seem to have a strong ethic which allows them to persevere despite the obstacles.

Measures of internal control were often implemented when the nurses responded that they perceived a lack of support from others. There are coping strategies utilized by some on the job such as snacking and smoking, which are considered among their tools of stress reduction. Taking breaks are an exceptional means of self care which allows the nurse to reconstitute prior to performing the many challenges required throughout the shift. It appeared through the responses that many of the nurses could see the benefit of activities that produce relaxation whether alone or with others.

When the nurse doesn’t engage in healthy coping strategies it appears they are more apt to engage in negative thoughts such as feeling a loss of control and frustration due to the barrage of work related stressors encountered daily. The nurses with successful coping seem to suggest a greater sense of self worth and accomplishment. These nurses tend to have what it takes to be able to provide compassionate care and manage to have a good perspective at the end of the day. For some nurses being able to overcome the barriers throughout the shift is support of their sense of accomplishment.

The Medical-Surgical nurses with compassion fatigue are those who have been bombarded with work-related stressors. Medical-Surgical nurses like others derive pleasure from helping others, it’s generally the impetus that keeps them committed to nursing. The experience with compassion fatigue and work-related stress has a direct correlation to the nurses’ ability to provide care to the patients. The mounting stressors are a direct result of
their attitude toward patients. The consequences which are many are derived from a lack of caring. Some of the nurse respondents described feelings that display a lack of tolerance or empathy for the patient. This type of callousness is precipitated by the chronic exposure to work-related stressors.

The themes discussed by the project participants were supported by the scores on the Compassion Satisfaction/Fatigue Self-Test for Helpers (Table 7). The scores indicated that one-half of the nurses had a high to extremely high risk for developing compassion fatigue. The scores also indicated that the nurses had an excellent chance for developing compassion satisfaction from their patient care interactions. The ability to experience compassion satisfaction is directly related to the nurse’s ability to adequately cope with the work-related stressors. The nurses described feeling a sense of satisfaction if they felt that they coped well with the stressors and if they felt that the care they gave was beneficial to the patient.

Much has been written about compassion fatigue and the negative impact that it can have on health care workers (Lamendola, 1996; McCann & Pearlman, 1990; Rudolph, Stamm, & Stamm, 1997; Pfifferling & Gilley, 2000; Figley, 2002; Vander Zyl, 2002). Additionally, the literature has revealed several pieces addressing the work stress endured by Medical-Surgical nurses (Derlet & Richards, 2002; Velianoff, 2002; Hart, 2003).

The nurses that participated in this project have frequent encounters with work-related stressors such as increased patient volume and high patient acuity which was echoed by Derlet and Richards (2002) who wrote how the trend over the last several years has seen an increase in the numbers of patients on the Medical-Surgical unit as a result of the aging population and overflow. The project finding that repeated exposure to work-related stressors can affect one’s ability to cope was echoed by Badger (2001) who noted that despite the
Compassion Fatigue

resiliency of and vast range of coping techniques used by Medical-Surgical nurses, the stress of the environment can compromise the ability to cope.

The nurses in this project described feeling exhausted and abandoned, which contributed to their inability to cope with work related stressors. This finding was further supported by Hageness, Kreitzer, and Kinney (2002) who noted that self-care is usually not a top priority during a busy shift which makes Medical-Surgical nurses more susceptible to the effects of work-related stress. Several of the nurses in this project explained that if they did not have time to deal with the work stress, they simply pushed through the stress and dealt with it later. This is a strategy, which can only result in feelings of fatigue.

There were also reported feelings of a sense of accomplishment when the nurses perceived success, as evidenced by an improvement in the patients’ condition resulting from their nursing interventions. This finding is supported by Hageness, Kreitzer, and Kinney (2002) who reported that when nurses take the time to care for themselves, nursing becomes a more enriching experience. Many nurses in this project stated that when they were able to vent to their co-workers, they were able to let go of their feelings of anger and frustration, which enabled them to continue with their care giving efforts. However, if they were unable to express their feelings, the negativity of their encounters affected their patient interactions throughout the rest of the shift.

In this project, the nurses reported feeling anger, cold and callous toward their patient's as a result of their frequent exposure to work-related stressors. This finding is supported by Vander Zyl (2002) who noted that loss of a caring attitude toward others is often the consequence of compassion fatigue and can result from a stressful work environment. Many of the nurses in this project reported feeling more short-tempered toward their patients
Compassion Fatigue

especially if the shift was particularly stressful and felt that they were unable to provide compassionate care to their patients.

This is echoed by Rudolph, Stamm, and Stamm (1997) who found that if a caregiver suffers from compassion fatigue, then the ability to deliver effective health care services and to maintain professional relationships become inadequate. Additionally, Gillespie and Melby (2003) found that frequent encounters with work stress can cause nurses to lose their ability to empathize which is a critical quality in establishing therapeutic patient relationships.

Gaps in the literature exist because there were no studies found that investigated the prevalence and effects of compassion fatigue on Medical-Surgical nurses. However, several studies reported that Medical-Surgical nurses encounter work related stressors which makes them vulnerable to the effects of these encounters (Adali & Priami, 2002; Hagness, Kreitzer, & Kinney).

Figley’s Compassion Fatigue Model was the theory integrated to form the conceptual framework used in guiding the project. Stress can lead to compassion fatigue and, thereby, affect one’s ability to provide therapeutic care to the patient. Figley (2002) provided an understanding of how one’s encounters with work stress and the inability to cope with it can lead to compassion stress and fatigue, and as a result, hinder one’s ability to provide care. In his model, Compassion Fatigue was defined as “a state of exhaustion resulting from exposure to compassion stress”.

The model is based upon the assumption that empathy from the caregiver is necessary in order to deal effectively with the patient’s needs as well as to establish a therapeutic relationship with the patient. However, the caregiver is at risk for developing compassion fatigue if the caregiver is not able to adequately cope when in contact with the patient’s
suffering. If the caregiver is able to detach from the patient’s experiences and feel a sense of satisfaction in terms of the care that has been given, then the caregiver will avoid the development of compassion fatigue.

Several of the variables contained in Figley’s (2002) model were evident in the project participants’ experiences with work-related stressors, their coping mechanisms and effect on the process of providing care. The variables of concern, empathy, prolonged exposure, sense of satisfaction, and compassion fatigue are notable throughout the project participants’ responses.

Concepts from the theory of Figley were combined with concepts derived from the data in this project in order to form the Medical-Surgical Nurses’ Compassion Fatigue Experience Model (shown below figure 1). In this model the nurse innately possesses qualities required in the provision of care through a demonstration of caring interactions and empathy. Nurses normally respond to the patient’s needs by delivering compassionate care. The nurse exercises their unique individuality by promotion of their own self-care and through use of healthy coping strategies.

External stressors such as loss of control, disempowerment and an environment fraught with negativity can infringe upon the healthy nurse to patient relationship. The preservation of a good self image can be impacted by daily stressors when the nurse is has compassion fatigue. The consequence of the development of compassion fatigue is mind, body, and soul discord within the caregiver in which the caregiver becomes emotionally dead. Not only does the caregiver suffer as a result of compassion fatigue, but the patient suffers as well because the caregiver has lost the ability to nurture and care for patients.

Healthy coping strategies such as a support network and internal control mechanisms
Compassion Fatigue can have a measure of success with diverting compassion fatigue. It can also be taken a step further by creating compassion satisfaction with the nurse-patient relationship. Figley (2002) Compassion Fatigue Model depicts the consequence of compassion fatigue as mind, body, and soul discord within the caregiver. The patient and the caregiver suffer due to the caregivers lost ability to nurture and care for the patient.
Compassion Fatigue

Medical Surgical Nurses Compassion Fatigue Model (Figley, 2002)

Loss of control
Negative environment

Caregiver
Patient

Caring
Empathy

Interaction with support systems, Internal control measures

Compassion Stress
Compassion Satisfaction

Compassion Fatigue
Mind/Body Affect
Medical-surgical nursing is a stressful venue for caregiving. Nurses in this area encounter numerous work-related stressors as they attempt to deliver quality care to their patients. Medical-Surgical nurses often give a lot of themselves and in putting the patient first, they often neglect their own self care needs. In doing so, they are frequently at risk for emotional distress and other negative consequences. Ineffective coping strategies and a lack of self care is a recipe for the development of compassion fatigue. Unresolved compassion fatigue evolves into a hopeless despair and an inability for the nurse to continue in the profession. Increased nursing shortages, lends to the decrease in the quality patient care.

This project’s findings can increase an awareness of compassion fatigue and the impact on provision of care. Through increased self-awareness, nurses may be able to configure self care strategies that will enable them to overcome compassion fatigue, in order to help them continue to meet superior standards of care for their patients. The knowledge of the existence of compassion fatigue would also enable nurses to become aware of the prevalence of the condition and to facilitate the development of peer support in dealing with the deleterious effects of compassion fatigue.

Advanced Practice Nurses (APN’s) play an important role in assessing the risk factors of compassion fatigue; implementing strategies designed to reduce the prevalence and in evaluating the success and usefulness of the interventions. This project’s findings would enable the APN to understand and recognize early signs of compassion fatigue. The APN’s advanced education in conjunction with clinical experience, would allow the APN to demonstrate the mastery needed to improve the coping of potential sufferers with the effects of compassion fatigue.

The knowledge from this project would also provide the leverage for the APN to advocate and enact educational changes with offerings on compassion fatigue and its effects on nurses and patient care. Changes such as the ones proposed by the APN may increase the administrative leadership’s awareness of the existence of compassion fatigue as well as the need for policies to acknowledge assistance with this phenomenon. The implementation of the appropriate policies and availability of resources such as counseling, are the means by which the profession can begin to prevent the occurrence of compassion fatigue.
It is essential that nurse administrators thoroughly understand the phenomenon of compassion fatigue and its potential effects on the care delivery process. This understanding would effect policy changes that would ultimately improve the ability to recruit and retain nurse in the promotion of a healthy and viable organization. The provision of quality patient care would also be enhanced in the process. Increased knowledge and understanding of compassion fatigue would also enable nurse administrators to be aware of the signs and symptoms of compassion fatigue as well as the risk factors for its development. Nurse administrators would become more vigilant in their observations and intervene when the risk factors or signs of compassion fatigue are exhibited.

**Nursing Education**

The main focus of the Nurse Educator is to provide information to nurses on issues that affect nursing practice. Compassion fatigue is one such issue that could potentially have negative implications for the nurse and patient. It is the responsibility of the Nurse Educator to communicate evidenced based practices. The nurse educator has been tasked with sharing the results of the compassion fatigue project and its effects on healthcare delivery. In February of 2013 the researcher and the nurse educator will host Nursing Grand Rounds which will be another opportunity to delve into the prevalence, risk factors, and interventions for compassion fatigue.

The knowledge gained through the project on compassion fatigue will enable the Nurse Educator to initiate policy changes, increase understanding of the associated risk factors of compassion fatigue, and develop intervention strategies to prevent or overcome its effects. The nurse educator has an opportunity and a duty to share knowledge with others through educational opportunities such as continuing education and seminars. The Nurse Educator will become the trainer for the Compassion Fatigue program which will be offered bi-annually as a mandatory component of staff competencies and training. This distribution of knowledge would expand the knowledge base of other health care professionals which would hopefully prevent the spread of compassion fatigue.

**Higher Education**

It is imperative that information regarding compassion fatigue and its associated risk factors be imparted to nursing students at the Baccalaureate and Graduate levels of education. Undergraduate nursing students in particular are often unaware of the stressors that await them,
therefore, they need to be armed with pertinent information that will facilitate their ability to manage work related stressors in their practice. Awareness of compassion fatigue and the effects while a student can have a great impact on nursing practice and assist new nurses to navigate the healthcare environment. This will increase their cognizance regarding compassion fatigue within themselves and also among their co-workers, which will deter adverse patient events.

Graduate level nurses are preparing to become leaders within their respective fields, therefore, it is essential that these students become adequately prepared with evidenced-based information regarding compassion fatigue and the effects it can have on self care and the care of the patient. This information will assist future nurse leaders to recognize the development of compassion fatigue within the work environment and to develop strategies to cope with compassion fatigue. Graduate nursing students also have the responsibility as leader of promoting further projects on the phenomenon of compassion fatigue.

**Future Recommendations**

It would be beneficial to expand further study into the phenomenon of compassion fatigue, utilizing Medical-Surgical nurses from other bay area hospitals. This approach would capture an aerial view of the experience with compassion fatigue since other Medical-Surgical departments may have different patient populations and factors that uniquely impact the perception and prevalence of compassion fatigue.

Additionally, qualitative studies should be used to investigate the risk of compassion fatigue within the population of Medical-Surgical nurses. These studies would be useful in predicting the risk and prevalence of compassion fatigue and would enhance the growth of policymaking and programs designed to combat this debilitating phenomenon. Furthermore, qualitative studies should also be conducted comparing the risk and prevalence of compassion fatigue within medical-surgical to other high stress areas such as Oncology.

**Conclusion**

This project investigated the experience of Medical-Surgical nurses with compassion fatigue. The investigation of this phenomenon gave the researcher insight into the perspectives and experiences when a Medical-Surgical nurse has compassion fatigue and the impact of the consequences precipitated by those experiences. The literature reviewed for the project revealed that compassion fatigue and its effects on health care workers is not a new
phenomenon. However, Medical-Surgical nurses have not been the focus or specifically targeted for a study. The framework guiding this project was Figley’s Compassion Fatigue Model. It offered a sociological perspective, which linked it together with other components of the conceptual framework.

The project discovered that the compassion fatigue experience can have a negative impact on patient care and a physical and emotional effect on the nurse. This project provided a starting point for recognizing the Medical-Surgical nurses’ experience with compassion fatigue. There are gaps prevalent within the literature which demonstrates that there are other areas in need of investigation such as the prevalence and risk of compassion fatigue and a comparison to larger groups of Medical-Surgical nurses’ experience with compassion fatigue. It is clear that if there is an aim to accomplish the recommendations of the IOM, the issue of compassion fatigue will need to be addressed at all levels of care.
References


Compassion Fatigue


Schwam, K. (1998). The phenomenon of compassion fatigue in Medical-Surgical

Stamm, B. (2002). Measuring compassion satisfaction as well as compassion fatigue:

Developmental history of compassion fatigue and satisfaction test. In C. Figley (Ed.)


http://factfinder.census.gov.

Appendix A

**PICO Worksheet and Search Strategy**

**Population:** Medical-Surgical Nurses

**Intervention:** Education to reduce or prevent Compassion Fatigue

**Comparison:** Didactic educational activities vs. Negative behavior patterns

**Outcome:** Reduction or prevention of the symptoms of compassion fatigue

**Question:** Will compassion fatigue be reduced or prevented when education is implemented?

**Main Topics and Search Terms**

Compassion fatigue, burnout, empathy, vicarious dramatization, secondary traumatization, medical-surgical nursing, nursing, self care, self help skills, nursing didactics, stress management programs, mentors

Check any limit that may pertain to your search:

- **Age**: 27 - 66
- **Language**: English
- **Year of publication**: 2002-2012

Type of study/publication you want to include in your search:

- X Systematic Review or Meta-Analysis
- X Clinical Practice Guidelines
- X Critically Appraised Research Studies
- X Individual Research Studies
- _ Electronic Textbooks

Check the databases searched:

- X Cochrane
- _ Joanna Briggs
Compassion Fatigue

(Appendix A cont’d)

_X_ PubMed

_DARE_

__Clinical Evidence__

_X_ AHRQ Evidence Reports

__Guidelines Clearinghouse__

__ACP Journal Club__

__Evidence-Based Journals__

_X_ CINAHL

X PubMed Clinical Queries

__UpToDate__

__MD Consult__

CINAHL yield the research article that mostly helped answer my question. The results are below.

*Utilizing CINAHL the search terms were entered. Fifteen articles were retrieved from the search. The articles were peer reviewed and available in full text. Approximately one half of the articles consisted of compassion fatigue among nurses, one fourth consisted of articles regarding compassion fatigue related to healthcare providers and one fourth of the articles consisted of compassion fatigue among emergency workers. The majority of the articles were journal articles with a study. Many of the studies had a phenomenological approach which utilized live interview and or audio. One of the studies reviewed was longitudinal to measure the risk for compassion fatigue at different points over time.
Appendix B

PICO Evidenced Based Literature Evaluation Tool

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<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparative Data</th>
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<td>Potter 2010 study</td>
<td>aimed to determine the prevalence of compassion fatigue or burn out in the emergency room. “Compassion Fatigue and Burn Out Among Oncology Nurses”. Clinical Journal of Oncology Nursing</td>
<td>The participants were administered the ProQOL R-IV to measure the risk of burn out or compassion fatigue.</td>
<td>The overall completion rate was 46% (236+38/600). The research sought to determine which healthcare provider group is more at risk for burn out or compassion fatigue.</td>
<td>The response rate was 34% of the 153 person sample size. The majority of respondents were RNs). The average compassion satisfaction score among all study participants was 38.3 (SD = 7.2). It was reported that an average score among previous users of the Pro-QOL R-IV was 37. The average burnout score among the current study's participants was 21.5 (SD = 6.4), which compared with an average score of 22 was reported. The average compassion fatigue score was 15.2 (SD = 6.6), higher than the average score of 13.</td>
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Compassion Fatigue

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<td>Dominquez &amp; Rutledge (2010)</td>
<td>Study was to examine compassion fatigue across specialties and in varying emergency departments to detect differences.</td>
<td>A questionnaire was devised and copies were sent to 150 ED nurses and doctors working in three ED's</td>
<td>The participants worked in the ED between three months and 26 years, with a mean of 6.9 years. Thirteen per cent of respondents were doctors (n=13), of whom 62 per cent (n=8) were male. Nine per cent (n=8)</td>
<td>Fifty two (51 per cent) respondents had experienced stress at work ‘very frequently’, while 37 per cent indicated stress occasionally. The most commonly identified stressors in EDs were ‘aspects of the work environment’.</td>
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<td>Hooper (2010)</td>
<td>The purpose of the study was to explore the prevalence of compassion satisfaction, burnout, and compassion fatigue among emergency nurses and nurses in three other selected inpatient specialties.</td>
<td>Participants completed a socio demographic profile and the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV. Scale scores were summed for compassion satisfaction, burnout, and compassion fatigue comparing the nurses from each of the three groups.</td>
<td>Differences between emergency nurses and those working in Oncology, Nephrology, and Intensive Care, on the subscales for compassion satisfaction, burnout, or compassion fatigue. The differences did not reach the level of statistical significance.</td>
<td>Approximately 82% of ER nurses had moderate to high levels of burnout, 86% had moderate to high levels of compassion fatigue. The ER nurses evidenced a risk for less compassion satisfaction when compared to ICU nurses and oncology nurses.</td>
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Compassion Fatigue

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<tr>
<td>Bride (2007) study aim to understand the impact of the Social Workers care of victims of trauma. “Reflecting on the Concept of Compassion Fatigue and Secondary Traumatization”. Journal of Clinical Social Work</td>
<td>Sample Selection: Bride studied the prevalence of secondary traumatic stress among a group of 282 social workers in the Southern United States. In particular, the rate and degree of secondary traumatic stress symptoms as well as the rates of Post-Traumatic Stress Disorder were studied.</td>
<td>A survey questionnaire was administered to the participants with questions which allowed them to endorse their own symptoms relative to the PTSD and Compassion Fatigue criteria</td>
<td>The data demonstrates evidence that Social Workers in the field of child welfare are potentially at an elevated risk for developing secondary traumatic stress and vicarious trauma when compared to the general population. Due to the nature of the work, social workers often experience chronic exposure to trauma and a high number of trauma related clients on their caseloads. In addition, social workers in child welfare engage primarily with children and thus</td>
<td>According to the findings, 70% of social workers experienced at least one symptom of secondary traumatic stress while 55% of social workers met the criteria for a complete group of symptoms. In addition, Bride found that 15% of social workers met the full criteria for a diagnosis Post Traumatic Stress Disorder, twice the national average of PTSD in the general population. Due to these findings, Bride describes secondary traumatic stress as a significant occupational hazard for social workers who work directly with clients exposed to trauma.</td>
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Compassion Fatigue

are exposed to children’s pain and trauma on a regular basis. According to researchers, specific events may potentially lead to secondary trauma for social workers in child welfare. These events include: the death of a child; exposure to a child’s description of trauma and abuse; visual exposure to a child’s physical injuries or emotional pain; and ongoing interactions with families who have experienced severe abuse, neglect, and domestic violence.

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<td>Boscarino (2009)</td>
<td>Sample Selection: 600 Social Workers in the city of New York</td>
<td>A questionnaire was mailed to the respondents and a second questionnaire was mailed two weeks later. The questionnaires focused on two main outcome measurements: compassion fatigue and job burnout.</td>
<td>The data was collected from question items from the 30-item Compass Fatigue Scale-Revised. This scale asked respondents to rate each item related to their “work/life situation” using a 10-point Likert scale. The researcher’s assessed the psychometric properties of the scale and found that the original 30-item scale measured seven</td>
<td>The researchers utilized a regression analysis with the demographic, stress, and resource variables. They developed two multivariate regression models to test their hypotheses. The researchers log was used to calculate the outcome of the variables due to skewed results. The statistics demonstrated that the hypothesis was supported and that the concept of compassion fatigue is a unique feature of the workplace environment.</td>
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## Compassion Fatigue

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<td>Hallin &amp; Danielson</td>
<td>Sample Selection: The sample for this study was 15 Swedish Registered Nurses 6 years after their graduation.</td>
<td>Interviews were conducted using a conversational strategy in order to alleviate stress from the process as a method to reduce the potential for skewed results</td>
<td>The data collection and content analysis were used to handle the interview texts. Data was collected in 2003 from an in-depth interview and then again in 2009 which was 6 years after their graduation. The purpose was to measure the before affect of the work environment and then at a point where the nurse has been acclimated to the environment and stressors. The interviews were semi-structured and analyzed with interpretive content analysis.</td>
<td>The findings resulted in two main themes one to balance strain and the other stimulation in the environment. There were related to stress in the work environment. The nurses perceived an inability to meet work demands which created a lack of confidence and control. A pattern emerged throughout the themes, which showed that due to the increasing number of patients RNs' capacity for management, planning team work, and care had diminished significantly.</td>
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<td>Abendroth (2006) aimed to: 1) understand the complex relationships among Compassion Satisfaction, Compassion Fatigue and Burnout within the hospice and palliative care workforce and 2) explore how key practice characteristics -</td>
<td>Sample: There were 630 Healthcare workers comprised of clinical, administrative, allied health workers and volunteers. They were from the hospital, community-based and home</td>
<td>A survey questionnaire was administered which included questions to elicit information across each profession of the presence of Compassion Fatigue or Burn Out among each group of professionals</td>
<td>The data was collected through a “Self-Report” measure of Compassion Satisfaction, Compassion Fatigue and Burnout, using validated scales, as well as questions to describe socio-demographic</td>
<td>The findings indicate a significant negative correlation between Compassion Satisfaction and Burnout ($r = -0.531$, $p &lt; 0.001$) and between Compassion Satisfaction and Compassion Fatigue ($r = -0.208$, $p &lt; 0.001$), and a significant positive</td>
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Compassion Fatigue

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<td>Blomberg &amp; Sahlberg (2007)</td>
<td>The sample size was 77 which included Nurses, Nurse Assistants, Psychologists and Occupational Therapists. The chosen setting included: the Oncology, Palliative Care and Outpatient departments.</td>
<td>The study was conducted utilizing 16 focus group discussions with the healthcare team members</td>
<td>The procedure for data analysis was inspired by the phenomenological method.</td>
<td>The findings demonstrated that the healthcare team members handled difficult situations by balancing between being close and distancing themselves. In most situations their choice of strategy seemed spontaneous rather than being a conscious decision. Variations of closeness and distance that were identified were Identity, Meaning, Limit-setting and touching, Prioritization, the Team and the Organization. These could also be seen as tools that could facilitate or impede the use of closeness and distance. If a difficult situation is unresolved, it can lead to distress, burnout and most importantly a lack of optimal care resilience being present among pediatric oncology.</td>
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Study Design:
quantitative study


Professionals and key practice characteristics were obtained. Correlation between Burnout and Compassion Fatigue ($r = 0.532, p < 0.001$). Variations in self-reported levels of the above constructs were noted. All three constructs are significantly, but differentially, affected by type of service provided, principal institution, practice status and professional affiliation. Results indicate that health care systems could increase the prevalence of Compassion Satisfaction through both policy and institutional level programs.
nurses. However, the literature fails to explore the concept of resilience among pediatric oncology nurses at this time. Blomberg & Sahlberg (2007) assisted in the understanding of how nurses currently cope. They are in favor of the development of strategies which can enhance coping ability.
Appendix C

Palo Alto Medical Foundation Research Institute

Institutional Review Board 795 El Camino Real, Ames Building Palo Alto, CA 94301 FWA00000089 IORG0000015 IRB00000019

New Protocol Approval Letter

To: Kandace Woodruff, R.N., Principal Investigator
From: Rita French, Ph.D., IRB Chair
Date: October 11, 2012
Re: Protocol #12-09-167: "The Prevalence of Work Related Stress Induced Compassion Fatigue among Medical-Surgical Nurses"

The full Committee reviewed and approved the initial submission of the above referenced protocol at its meeting on October 11, 2012. This protocol and the informed consent(s), and if applicable, questionnaires or other attachments, have been approved for a period of 12 months.

Expiration Date of approval: October 10, 2013

Sponsor/ Funding Agency: None

If this proposal is used in conjunction with any other human experimentation, or if it is modified in any way, it must be re-approved for these special circumstances. Note that the following should be reported to the IRB: 1) all serious adverse events occurring here or at other institutions, regardless of whether or not the events are thought to be study related; 2) any unanticipated problems in the data collection process potentially affecting patients; and/or 3) any injuries to subjects enrolled here.

All continuing projects and activities must be reviewed and reapproved at least annually by the Committee. If this project is to continue beyond the expiration date, the investigator must submit a renewal request for approval by the Committee prior to the expiration date. In any event, no new patients may be enrolled in a study for which the approval date has expired. The completion of the project or study, a discontinuation report (IRB From #13) must be submitted to the IRB.
Appendix D

September 19, 2012

Dear Kandace Woodruff,

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study. Your study has been deemed to be exempt from IRB review based on the following conditions:

Unless otherwise required by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

1) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

This application does not require IRB review.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Terence Patterson, EdD, ABPP
Chair, Institutional Review Board for the Protection of Human Subjects

IRBPHS – University of San Francisco
Counseling Psychology Department
Education Building – Room 017
2130 Fulton Street
San Francisco, CA 94117-1080
(415) 422-6091 (Message)
(415) 422-5528 (Fax)
irbphs@usfca.edu
Appendix E

Hospital Administration Approval Letter

Marjorie Eckford RN
Chief Nursing Officer
Menlo Park Surgical Hospital
570 Willow Road
Menlo Park, CA 94025

Dear Marjorie,

Thank you for the permission to recruit the Medical-Surgical Registered Nurses at Menlo Park Surgical Hospital, to participate in a voluntary research study, required for the completion of my dissertation. As you are well aware, most nurses enter the field of nursing with the intent to help others and to provide empathetic care for patients with critical physical, mental, emotional, and spiritual needs. Empathic and caring nurses, however, can become victims of the continuing stress of meeting the often overwhelming needs of patients and their families, resulting in compassion fatigue or burn out. Compassion fatigue affects not only the nurse in terms of job satisfaction and emotional and physical health, but also the workplace environment by decreasing productivity and increasing turnover. Based upon this information, it is important that healthcare systems invest in creating healthy work environments that prevent compassion fatigue and address the needs of nurses who are experiencing compassion fatigue.

As you are aware, I am conducting a study to explore compassion fatigue among Medical-Surgical Nurses. The outcome of the study is to assist the nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies, in order to develop a personal plan of care, so as to achieve a healthy work-life balance. The study will be completed under the guidance of Dr. Amy Nichols RN EdD, University of San Francisco, and School of Nursing Faculty Advisor.

I would like to recruit participation from the Registered Nurses working in the Medical-Surgical department for participation in the study. The nurses will be asked to complete a survey online through Survey Monkey, a confidential survey portal. There will be a Demographic Profile, Online Questionnaire and Self-Help Test. A consent form will also be included on the portal. The information collected will be kept secure and protected. All information will remain secure and there will be no information utilized which identifies the nurses and or the hospital. I will be the only person privileged to look at the information that is anonymously completed by the nurses. The information provided by the nurses through this process will provide insight into the effects of the work environment and will facilitate development of evidenced based practices to alleviate or prevent the effects of compassion fatigue or burn out.

A request for participation letter that I would like to distribute to the nurses will be submitted to you shortly. Your assistance with my research study is greatly appreciated.

Sincerely,

Kandace Woodruff  DNPc, MSN, RN
Appendix F

Hospital Administration Approval Letter

Vickie White MSN, RN
Vice President Patient Care Services
Mills Peninsula Hospital
1501 Trousdale Drive
Milbrae, CA 94010

Dear Vickie,

Thank you for the permission to recruit the Medical-Surgical Registered Nurses at Mills Peninsula Hospital, to participate in a voluntary research study, required for the completion of my dissertation. As you are well aware, most nurses enter the field of nursing with the intent to help others and to provide empathetic care for patients with critical physical, mental, emotional, and spiritual needs. Empathic and caring nurses, however, can become victims of the continuing stress of meeting the often overwhelming needs of patients and their families, resulting in compassion fatigue or burn out. Compassion fatigue affects not only the nurse in terms of job satisfaction and emotional and physical health, but also the workplace environment by decreasing productivity and increasing turnover. Based upon this information, it is important that healthcare systems invest in creating healthy work environments that prevent compassion fatigue and address the needs of nurses who are experiencing compassion fatigue.

As you are aware, I am conducting a study to explore compassion fatigue among Medical-Surgical Nurses. The outcome of the study is to assist the nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies, in order to develop a personal plan of care, so as to achieve a healthy work-life balance. The study will be completed under the guidance of Dr. Amy Nichols RN EdD, University of San Francisco, and School of Nursing Faculty Advisor.

I would like to recruit participation from the Registered Nurses working in the Medical-Surgical department for participation in the study. The nurses will be asked to complete a survey online through Survey Monkey, a confidential survey portal. There will be a Demographic Profile, Online Questionnaire and Self-Help Test. A consent form will also be included on the portal. The information collected will be kept secure and protected. All information will remain secure and there will be no information utilized which identifies the nurses and or the hospital. I will be the only person privileged to look at the information that is anonymously completed by the nurses. The information provided by the nurses through this process will provide insight into the effects of the work environment and will facilitate development of evidenced based practices to alleviate or prevent the effects of compassion fatigue or burn out.

A request for participation letter that I would like to distribute to the nurses will be submitted to you shortly. Your assistance with my research study is greatly appreciated.

Sincerely,

Kandace Woodruff  DNPc, MSN, RN
Appendix G

LETTER TO MEDICAL-SURGICAL NURSES

Letter to the Medical Surgical Registered Nurses

My name is Kandace Woodruff and I am a Doctoral student at the University of San Francisco’s School of Nursing. I am currently working on a research study for my Doctorate. You are invited to participate in my research study on Compassion Fatigue among Medical-Surgical Nurses.

As you are well aware, most nurses enter the field of nursing with the intent to help others and to provide empathetic care for patients with critical physical, mental, emotional, and spiritual needs. Empathic and caring nurses, however, can become victims of the continuing stress of meeting the often overwhelming needs of patients and their families, resulting in compassion fatigue or burn out. Compassion fatigue affects not only the nurse in terms of job satisfaction and emotional and physical health, but also the workplace environment by decreasing productivity and increasing turnover.

The purpose of the project is to assist Medical-Surgical nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies, in order to achieve a healthy work-life balance. You will be directed to a computer link on Survey Monkey where you will be asked to complete a confidential Interview Questionnaire, Demographic Profile and a Compassion Satisfaction Self Help test. The study will be completely anonymous. The results will be computed and analyzed. The information that you share will be maintained in a locked file and destroyed no later than May 31, 2013.

My work will be completed under the guidance of Dr. Amy Nichols, University of San Francisco School of Nursing Faculty Advisor. The survey will take approximately 45 minutes of your time.

If you are interested in participating please click on the link https://www.surveymonkey.com/s/KH7CNKQ

Sincerely,

Kandace Woodruff, RN, MSN
Appendix H

Palo Alto Medical Foundation Institutional Review Board
795 El Camino Real,
Palo Alto, CA 94301
FWA 00000089
IORG0000015
IRB00000019

Research Information Statement

Protocol Title: “Prevalence of Work Related Stress Induced Compassion Fatigue or Burn Out Among Medical-Surgical Nurses”
Principal Investigator: Kandace Woodruff RN, MSN USF Doctor of Nursing Practice Candidate

DESCRIPTION: You are invited to participate in a research study on the impact of work related stress on the lived experience of Medical-Surgical Nurses, which can produce a risk of developing compassion fatigue or burn out. The purpose of the study is to assist Medical-Surgical nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies, in order to develop a personal plan of care to assist in the achievement of a healthy work-life balance. You will be directed to a computer link on Survey Monkey, a secure website where you will be asked to complete a confidential Interview Questionnaire, Demographic Profile and a Compassion Satisfaction Self Help test. The study will be completely anonymous. The results will be computed and analyzed by the researcher. The results will be maintained by the researcher on a secure encrypted computer which is locked in the office of the researcher. The information will be destroyed no later than May 31, 2013.

TIME INVOLVEMENT: Your participation will take approximately 45 minutes.

RISKS AND BENEFITS: The risks associated with this study are at a minimal level. The participant might experience anxiety thinking about the work experiences on a Medical-Surgical unit. The benefits which may reasonably be expected to result from this study is that you may develop awareness about your compassion satisfaction level. Also, it may assist other healthcare professionals to gain valuable insight into Medical-Surgical nurses’ feelings of compassion satisfaction or compassion fatigue. You may benefit as a nurse by learning to effectively cope with compassion fatigue. We cannot and do not guarantee or promise that you will receive any benefits from this study. Your decision whether or not to participate in this study will not affect your employment.

PAYMENTS: You will receive no payment for your participation.

PARTICIPANT’S RIGHTS: If you have read this form and have decided to participate in this project, please understand that your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. You have the right to refuse to answer particular questions. Your individual privacy will be maintained in all published and written data resulting from the study.

CONTACT INFORMATION: Questions, Concerns, or Complaints: If you have any questions, concerns or complaints about this research study, its procedures, risks and benefits, or alternative courses of treatment, you should ask
the Principal Investigator (PI), Kandace Woodruff. You may contact her at any time at 650-853-5439. Independent Contact: If you are not satisfied with the way this study is being conducted, or if you have any concerns, or general questions about the research or your rights as a participant, please contact the Palo Alto Medical Foundation’s Director of Quality and Patient Safety at (831) 479-6606.
Appendix I

Compassion Fatigue Project
Online Questionnaire

1.) How do you define a work-related stressor?
2.) What work-related stressors do you encounter on a regular basis?
3.) How do you cope with work-related stressors?
4.) What is the final result for you (at the end of the day) after coping with work-related stressors?
5.) Describe one of the most stressful situations/shifts you can remember.
6.) How has your encounter with work-related stress affected your ability to care for your patients?
7.) What are some positive things about working in the Medical-Surgical?
8.) What are some negative things about working in the Medical-Surgical?
9.) What is most fulfilling in your work as a Medical-Surgical nurse?
## DEMOGRAPHIC PROFILE

2. Ethnicity: Caucasian African-American Hispanic or Latino Asian Other: ___
3. Gender: M F
4. Marital status: Single Married Divorced Separated Widowed
5. How many children do you have? 1 2 3 4 5 6 7 8 9 more than 10
6. How many of your children live with you? 1 2 3 4 5 6 7 8 9 more than 10
7. Yearly income: (Less than $25,000) ($25,000 - $40,000) ($41,000 - $55,000) ($56,000 - $70,000) (Over 70,000)
8. Education level: Diploma Associate’s Bachelor’s Master’s Doctorate
9. Current job level? Staff Manager Director Other Supervisory
10. Do you possess a National Nursing Certification? Yes or No
11. Years of Registered Nurse experience (1-5) (6-10) (11-15) (16-20) (Above 20)
12. Years of experience in Medical-Surgical (1-5) (6-10) (11-15) (16-20) (Above 20)
13. Number of years at current facility in the Medical-Surgical: (1-5) (6-10) (11-15) (16-20) (Above 20)
14. Work status: Full time Part time Per Diem
15. Shift: Day (7a –3p), Evening (3-11), Night (11- 7) or Day (7a-7p) Night (7p-7a)
16. Hours worked per week: (less than 20 hours) (20-39 hours) (40 or more hours)
17. Do you also currently work at another facility? Yes No
18. If yes, do you work in the Medical-Surgical area? Yes No
Appendix K

Figley’s Compassion Satisfaction/ Fatigue Self-Test for Helpers

Helping others puts you in direct contact with other people’s lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with you’re helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am happy.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I find my life satisfying.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I have beliefs that sustain me.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I feel estranged from others.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I find that I learn new things from those I care for.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I find myself avoiding certain activities or situations because they remind me of a frightening experience.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I have gaps in my memory about frightening events.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I feel connected to others.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I feel calm.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I believe that I have a good balance between my work and my free time.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I have difficulty falling or staying asleep.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I have outburst of anger or irritability with little provocation</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I am the person I always wanted to be.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I startle easily.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>While working with a victim, I thought about violence against the perpetrator.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I am a sensitive person.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I have flashbacks connected to those I help.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I have good peer support when I need to work through a highly stressful experience.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I have had first-hand experience with traumatic events in my adult life.</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I have had first-hand experience with traumatic events in my childhood.</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I think that I need to &quot;work through&quot; a traumatic experience in my life.</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I think that I need more close friends.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I think that there is no one to talk with about highly stressful experiences.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I have concluded that I work too hard for my own good.</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Working with those I help brings me a great deal of satisfaction.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I feel invigorated after working with those I help.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I am frightened of things a person I helped has said or done to me.</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>I experience troubling dreams similar to those I help.</td>
<td></td>
</tr>
</tbody>
</table>

(Appendix K) cont’d

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.</td>
<td>I have happy thoughts about those I help and how I could help them.</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>I have experienced intrusive thoughts of times with especially difficult people I helped.</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>I have suddenly and involuntarily recalled a frightening experience while working</td>
<td></td>
</tr>
</tbody>
</table>
33. I am pre-occupied with more than one person I help.
34. I am losing sleep over a person I help's traumatic experiences.
35. I have joyful feelings about how I can help the victims I work with.
36. I think that I might have been "infected" by the traumatic stress of those I help.
37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
38. I remind myself to be less concerned about the well being of those I help.
39. I have felt trapped by my work as a helper.
40. I have a sense of hopelessness associated with working with those I help.
41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
42. I wish that I could avoid working with some people I help.
43. Some people I help are particularly enjoyable to work with.
44. I have been in danger working with people I help.
45. I feel that some people I help dislike me personally.

Items about Being a Helper and Your Helping Environment
46. I like my work as a helper.
47. I feel like I have the tools and resources that I need to do my work as a helper.
48. I have felt weak, tired, run down as a result of my work as helper.
49. I have felt depressed as a result of my work as a helper.
50. I have thoughts that I am a "success" as a helper.
51. I am unsuccessful at separating helping from personal life.
52. I enjoy my co-workers.
53. I depend on my co-workers to help me when I need it.
54. My co-workers can depend on me for help when they need it.
55. I trust my co-workers.
56. I feel little compassion toward most of my co-workers
57. I am pleased with how I am able to keep up with helping technology.
58. I feel I am working more for the money/prestige than for personal fulfillment.
59. Although I have to do paperwork that I don’t like, I still have time to work with those I help.
60. I find it difficult separating my personal life from my helper life.
61. I am pleased with how I am able to keep up with helping techniques and protocols.
62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
63. I have thoughts that I am a "failure" as a helper.
64. I have thoughts that I am not succeeding at achieving my life goals.
65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.

This form may be freely copied as long as (a) authors are credited, (b) no changes are made, & (c) it is not sold. Adapted with permission from Figley, C.R., (1995). Compassion Fatigue, New York: Brunner/Mazel.
Purpose and Background

Ms. Kandace Woodruff, a doctoral candidate in the School of Nursing at the University of San Francisco is doing a study on compassion fatigue among Medical-Surgical Nurses. The researcher is interested in assisting Medical-Surgical nurses to become knowledgeable about compassion fatigue symptoms and intervention strategies, in order to develop a personal plan of care to assist in the achievement of a healthy work-life balance.

I am being asked to participate in the study because I am currently employed as a Medical-Surgical Registered Nurse.

Procedures

If I agree to be a participant in this study, the following will happen:

1. I will complete a demographic profile giving basic information about me, including age, gender, and race and job history.

2. I will complete an Interview Questionnaire about my personal work experience in the Medical-Surgical environment.

3. I will complete a Compassion Satisfaction/Fatigue Self-Test for Helpers which will assist to determine if I’m at risk for compassion fatigue and also the degree of my satisfaction with helping others.

Risks and/or Discomforts

1. There are minimal potential risks for participating in this study. However, it is possible that some of the questions may produce mild anxiety about work in the Medical-Surgical environment, which may make me feel uncomfortable, but I am free to decline to answer any questions I do not wish to answer or to stop participation at any time.
2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files.

3. Because the time required for my participation may be up to 45 minutes, I may become tired or bored.

**Benefits**

The anticipated benefit of this study is an increase in self awareness about compassion satisfaction. The participant will be afforded valuable insight into Medical-Surgical nurses’ feelings of compassion satisfaction or compassion fatigue. This knowledge can assist the participant in the development of methods for preventing and coping with compassion fatigue.

**Costs/Financial Considerations**

There will be no financial costs to me as a result of taking part in this study.

**Payment/Reimbursement**

There will be no reimbursement for my participation in this study.

**Questions**

If I have further questions about the study, I may call the researcher, Kandace Woodruff at (408) 623-4687 or (650) 853-5439.

If I have any questions or comments about participation in this study, I should first talk with the researcher. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with protection of volunteers in research projects. I may reach the IRBPHS University of San Francisco office by calling (415) 422-6091 and leaving a voicemail message, by e-mailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Department of Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, CA 94117-1080.
Compassion Fatigue
Nursing Excellence and Magnet Journey

I Nursing Research - Development of Council
   - First Study is a survey of the attitudes, perceptions, and expectations of all the RN staff at Mills-Peninsula regarding family centered care
   - Poster presented at the UCSF Stanford Research Day
   - External nursing doctoral candidate study on Compassion Fatigue
   - Partnering with PAMFRI to support research and EBP work
   - Participate in UCSF in evidenced based practice staff nurse/coach program - January 2013

II Magnet Activities
   - Organizational Gap Analysis Oct 29 and 30
   - American Nurses Credentialing Center (ANCC) conference

Mills-Peninsula
Health Services
A Santa Clara Health Authority

Reaching for the STARS
Table 1
Description of the project sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Freq. (n)</th>
<th>Percentage (%)</th>
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<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>83</td>
</tr>
<tr>
<td>Age 26 – 35</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>36 – 45</td>
<td>14</td>
<td>40%</td>
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<tr>
<td>46 – 49</td>
<td>7</td>
<td>20%</td>
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<tr>
<td>&gt; 50</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>Ethnicity Caucasian</td>
<td>23</td>
<td>66%</td>
</tr>
<tr>
<td>Hispanic</td>
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<td>6%</td>
</tr>
<tr>
<td>African American</td>
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<td>11%</td>
</tr>
<tr>
<td>Asian</td>
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<td>17%</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Single</td>
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<td>14%</td>
</tr>
<tr>
<td>Married</td>
<td>18</td>
<td>51%</td>
</tr>
<tr>
<td>Divorced</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>Separated</td>
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<td>9%</td>
</tr>
<tr>
<td>Number of children living at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 children</td>
<td>15</td>
<td>43%</td>
</tr>
<tr>
<td>1 child</td>
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<td>7%</td>
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<tr>
<td>2 children</td>
<td>7</td>
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<td>3 children</td>
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<td>4 or more children</td>
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<td>3%</td>
</tr>
<tr>
<td>Education</td>
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<td></td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>24</td>
<td>69%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
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<td>17%</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>&gt; Master’s degree</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Yearly income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$70,000 - $80,000</td>
<td>11</td>
<td>31%</td>
</tr>
<tr>
<td>$81,000 - $90,000</td>
<td>17</td>
<td>49%</td>
</tr>
<tr>
<td>&gt;$91,000</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Years of experience as an RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 10 years</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>16</td>
<td>46%</td>
</tr>
<tr>
<td>&gt; 20 years</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>Variable</td>
<td>Freq. (n)</td>
<td>Percentage (%)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Number of years at current facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>14</td>
<td>40%</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>11 – 15 years</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>Work status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>20</td>
<td>57%</td>
</tr>
<tr>
<td>Shift worked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day (7 am to 7 pm)</td>
<td>16</td>
<td>46%</td>
</tr>
<tr>
<td>Night (7 pm – 7 am)</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>Number of hours worked weekly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 – 16 hours</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>17 – 24 hours</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>25 – 36 hours</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>&gt; 36 hours</td>
<td>19</td>
<td>54%</td>
</tr>
<tr>
<td>Work at another facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>83%</td>
</tr>
</tbody>
</table>
Table 2

Participants’ Level of Education

<table>
<thead>
<tr>
<th>Education</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate’s</td>
<td>24</td>
<td>68</td>
<td>68</td>
<td>8.6</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>6</td>
<td>17</td>
<td>17</td>
<td>57.1</td>
</tr>
<tr>
<td>Master’s</td>
<td>5</td>
<td>14</td>
<td>14</td>
<td>34.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 3

Distribution of Participants’ Years of Experience

<table>
<thead>
<tr>
<th>Years of experience in the Nursing field?</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less 1 year</td>
<td>1</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>1-5</td>
<td>11</td>
<td>31.4</td>
<td>31.4</td>
<td>34.3</td>
</tr>
<tr>
<td>6-10</td>
<td>14</td>
<td>40.0</td>
<td>40.0</td>
<td>44.3</td>
</tr>
<tr>
<td>11-15</td>
<td>9</td>
<td>25.7</td>
<td>25.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4

*Results of the Compassion Satisfaction/Fatigue Self-Test for Helpers*

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Freq. (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely high potential</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>High potential</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Good potential</td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td>Moderate potential</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>Low potential</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Compassion Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely low risk</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Low risk</td>
<td>4</td>
<td>11%</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>8</td>
<td>23%</td>
</tr>
<tr>
<td>High risk</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>Extremely high risk</td>
<td>9</td>
<td>26%</td>
</tr>
</tbody>
</table>
### Table 5

**Descriptors of Compassion Fatigue**

- Borrowed stress
- Compulsive sensitivity
- Disabled resiliency
- Emotional contagion
- Empathic distress
- Empathic strain
- Empathy fatigue
- Empathy overload
- Existential suffering
- Fatal availability
- Indirect trauma
- Secondary victimization
- Soul pain
- Vicarious trauma
- Wounded healer
# Table 6

<table>
<thead>
<tr>
<th>Manifestations of Compassion Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional:</strong></td>
</tr>
<tr>
<td>- Apathy</td>
</tr>
<tr>
<td>- Desensitization</td>
</tr>
<tr>
<td>- Discouragement</td>
</tr>
<tr>
<td>- Feelings of being overwhelmed</td>
</tr>
<tr>
<td>- Attitude of hopelessness</td>
</tr>
<tr>
<td>- Sarcasm</td>
</tr>
<tr>
<td><strong>Intellectual:</strong></td>
</tr>
<tr>
<td>- Boredom</td>
</tr>
<tr>
<td>- Concentration impairment</td>
</tr>
<tr>
<td>- Disorderliness</td>
</tr>
<tr>
<td>- Weakened attention to detail</td>
</tr>
<tr>
<td><strong>Physical:</strong></td>
</tr>
<tr>
<td>- Increased somatic complaints</td>
</tr>
<tr>
<td>- Lack of energy</td>
</tr>
<tr>
<td>- Loss of endurance</td>
</tr>
<tr>
<td>- Loss of strength</td>
</tr>
<tr>
<td>- Weariness, sense of fatigue, exhaustion</td>
</tr>
<tr>
<td><strong>Social:</strong></td>
</tr>
<tr>
<td>- Callousness</td>
</tr>
<tr>
<td>- Feelings of alienation, estrangement, isolation</td>
</tr>
<tr>
<td>- Inability to share in or alleviate suffering</td>
</tr>
<tr>
<td>- Indifference</td>
</tr>
<tr>
<td>- Unresponsiveness</td>
</tr>
<tr>
<td>- Withdrawal from family or friends</td>
</tr>
<tr>
<td><strong>Spiritual:</strong></td>
</tr>
<tr>
<td>- Decrease in discernment</td>
</tr>
<tr>
<td>- Disinterest in introspection</td>
</tr>
<tr>
<td>- Lack of spiritual awareness</td>
</tr>
<tr>
<td>- Poor judgment r/t existential issues</td>
</tr>
<tr>
<td><strong>Work:</strong></td>
</tr>
<tr>
<td>- Absenteeism</td>
</tr>
<tr>
<td>- Avoidance of intense patient situations</td>
</tr>
<tr>
<td>- Desire to quit</td>
</tr>
<tr>
<td>- Diminished performance ability (i.e., medication errors, decreased documentation accuracy/record-keeping)</td>
</tr>
<tr>
<td>- Stereotypical/impersonal communications</td>
</tr>
<tr>
<td>- Tardiness</td>
</tr>
<tr>
<td><strong>Sources:</strong> Aycock &amp; Boyle, 2009; Coetzee &amp; Klopper, 2010; Showalter, 2010</td>
</tr>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td><strong>Etiology</strong></td>
</tr>
<tr>
<td><strong>Chronology</strong></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
</tbody>
</table>
The Compassion Fatigue Process (Figley, 2001)
Compassion Fatigue