Winter 12-15-2019

# Compounding Effects of Reducing Nurse Burnout and How It Can Produce an Increase in Patient Safety and Satisfaction

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## Abstract

The reduction of nurse burnout has shown to have an increase in patient satisfaction and quality of care. It also has shown a decrease in patient-related or sentinel events. Accordingly, with the reduction of nurse burnout, there has also been a reduction of compassion fatigue. This project has illuminated the benefits of acuity-based caseload at the micro-level, including the cost-effective nature of overtime pay, including HCHAPS benefit score. The method of obtaining, planning, and implementing was based on the Plan, Do, Study, Act (PDSA), which required collaboration amongst multiple disciplines, groups, departments, and executives. The process and goals concluded to have increased in HCHAPS scores, reduction in overtime, and the ability to hire additional staff. The most considerable implementation was more patient-centered/driven care, where consumer satisfaction increased. By implementing TEAMSTEPPS, the nursing staff showed to be more willing to adopt change and felt heard as they had "buy-in" in the process as change occurred.

## Introduction

In this report, I will discuss the need and benefit of how restructuring nurse working time and adjustment of the patient ratio can and will help prevent nurse burnout and compassion fatigue. By implementing change, the safety of the patient will improve, including the overall quality and satisfaction of patient care.

## Nature of the project

Currently, for nurses, the constant requirement of overtime has led to suboptimal care to patients and adherence to policies, such as taking short cuts with patient care. Nurse burn out is

highly prevalent due to mandatory overtime and working off the clock to performing patient care duties. Aside from the dangers presented to patient and family but the risks posed to the staff, as many instances of nursing staff falling asleep driving after working a "double shift."

The purpose is for companies to improve nurse work-life balance by reducing nurse burnout. To achieve this, analyzing several factors based on patient acuity, overtime due to increased patient care needs, current patient census, and redistribution of a lower patient to staff ratio. The shortages in the nursing workforce and the high level of nurse burnout are becoming serious global problems due to their potential impacts on the development of the nursing profession and quality and safety of clinical care (Guo. et al., 2019).

Although nurses are expected to do everything they can to care for their patients, there are few expectations concerning how nurses take care of themselves. Florence Nightingale modeled self-sacrifice, caring, and nurturing; she told nurses in training that patient suffering can be relieved through acts of compassion. Burnout can result from a disassociation with managers rather than the relationship between caregiver and patient. Instead, compassion fatigue is a natural response that results from an inability to protect or heal a patient, creating stress and self-blaming (Mattioli, 2018).

## Data that shows the need for the project

Nurses are leaving the profession in part because of burnout, worsening the nursing shortage. Nurse burn-out also contributes to poor patient satisfaction scores and increased infection rates (Brown, 2018). In another study, burn out lead to high emotional exhaustion was found in 31% of the nurses, 24% of high depersonalization, and low personal accomplishment was found in 38% of nurses (Molina-Praena et. Al., 2018).

Kunaviktikul (2015), Nurses' extended work hours: Patient, nurse, and organizational outcomes explain a correlation with patient outcomes, such as patient identification errors, pressure ulcers, communication errors and patient complaints, and with nurse outcomes of emotional exhaustion and depersonalization. This was found to be accurate and staff that worked more than 40 hours per week and or working two consecutive shifts. This not only showed to have a negative impact on the nurse, patient but also impact the company financially due to litigations ascribed from nurse errors or facility-acquired infections. Most notably, a survey performed showed a decrease of 10-11 % in workplace satisfaction and self-evaluation of health.

Rabenu (2017), Understanding the Relationship between Overtime and Burnout. *International Studies of Management & Organization* asserts the effect of long working hours is not linear but rather exponential; the negative implications increase significantly after the threshold of 12 daily hours is crossed. Hence a working hours chart could be drafted according to which, working up to eight hours per day is regular; work lasting more than eight hours, up to 12 hours per day is harmful; and working more than 12 hours per day (which has extremely negative implications) is exceedingly dangerous. As most companies are based on an eight-hour shift working a "double" is exceedingly dangerous, and those companies whose work standard is 10 to 12 hours is already at the threshold of safe practice. Based on the article, overtime produces a less meaningful and lower quality of work, and overtime should be avoided.

Burnout is the sequence of three dimensions: (i) emotional exhaustion; (ii) depersonalization; and (iii) reduced personal accomplishment (Kalicinska, 2012). As emotional exhaustion is defined as a person's experience of being overextended responding to high sensitive demand, which leads to depersonalization as the nurse starts to distance themselves

from personal, work, and patient quality of care; this leads to reduced personal accomplishment as a nurse will work inefficiently with job duties and performance.

The points of each article show over time lead to significant burn out with substantial implications for patient safety and effectiveness of care, including the overall health status and functionality of nurses to perform duties. Both studies suggest a reduction of overtime, by changing standard hours of work based on the job, instituting a work-life balance to allow appropriate rest. Thus, creating necessary rest periods between shifts (i.e., 16-20 hours between variations). As described, a company had given a rest period of 24 hours because an employee worked a 24-hour shift. Both studies concluded burnout to be higher after 40 hours were obtained per week. For example, if an individual works four-10 hour days, they have already met their threshold. Nurses experiencing compassion fatigue frequently suffer from coronary artery disease, diabetes, hypertension, inflammation, and gastrointestinal conditions. Additional effects include apathy, depression, insomnia, and weight gain.

## The goal of the project

The goal is to standardize working hours with shift consistency; it is hard for the by to adjust from 8,10, 12, 16-hour shifts or a variation of shift slot AM, PM, NOC without having an appropriate rest period of 24-48 hours depending on the variable. Doing so helps prevent burn out from exhaustion. Including adapting a lower nurse to patient, the ratio will improve with devoting additional facetime to each patient based on the patient's need; This helps reduce safety issues by having time to assess effects, address concerns, and teach or discuss points with patient or family.

## Assessment

At the current location, we noticed a trend in increased callouts with an up-tick of call-in comments from patients and families regarding dissatisfaction with some aspects of care. The common complaints were slow response time to patient issues or requests, staff not answering the phone after hours. Patients felt they were not listened to on concerns or thought they were not appropriately informed of specific treatments, concerns, or what to expect of the disease progression.

Upon meeting those directly involved with patients who had improvement comments, it was discovered nurses complaining of burnout, working on-call, being overworked, not enough time to complete a task such as documentation, and always in a rush to get to the next patient on time. Many also stated working late at night to complete follow-ups or task. From this we decided to hold staff meetings to determine if this is a local or systemic issue. At the meeting 95% of staff voice the same opinion and concerns regarding the quality of work-life balance and quality of care to patients. 5% of staff didn't mind the overtime and was willing to "tough it out." We then also decided to spot interview current patients of care provided. About 63% raised the same issues and concerns; the others had no problems or no comment about care.

Upon review of the previous quarters, HCHAPS scores were at or above the national average by one to two points. However, although this is an excellent indication of care from a third-party survey, there is always room for improvement and should strive for 100% on scores. After looking at several past quarters, we noticed a downtrend in ratings from the high 90s to low 90s.

We did a review and notice an uptick in the patient census from an average of 280 (+/-10) to 450 (+/-15), with that increase the complexity or acuity of patient type increased. The National Hospice and Palliative Care Organization (NHPCO) guidelines dictate a nurse to patient ratio of

1:35-1:45 based on census, staff, and acuity level. We always implemented a 1:20 ratio. With the nurse case managers (RNCM) team at 25, this would produce a ratio of 1:11.2 at 280 patients; with the uptick of the census, the new ratio increased to 1:18. Although this is significantly below NHPCO and below the company implemented ratio; we now needed to factor in acuity status into care.

Since the staff complained of overtime, we looked into payroll to see the average amount of overtime hours per pay period (labor-intensive process). The findings showed average overtime being 450 to 470 overtime hours per pay period. We further investigated as to how many hours per day and other causes. The determination showed staff working all day, on-call, overnight, or at least 4 hours extra per day. A Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue (ProQOL) assessment was completed (Fig. 1). The evaluation determined that approximately 76% of staff suffered from varying levels of compassion fatigue (Table 1 and 2), and 80% of faculty were exhibiting symptoms of burnout.

## Plan

The plan was going to multifocal, which would require multi-departmental assistance. There would be several phases to the project following periodic review and adjustment. The program would take approximately one year to complete but reviewed monthly and adjusted. Every quarter surveys would be sent out and studied for improvement overall.

### Phase One

It would consist of a patient interview, staff interview and, surveys of work quality, life implications, and patient satisfaction. Each nurse individually and as a group would voice their concerns, comments, but importantly bring their ideas for review to possible implementation. After compiling the data and analyzing the strategic information, planning was done on how to

improve scores, provide better work-life balance. This was completed by also incorporating comments and ideas from staff and patients. We had determined the need to hire on an additional 25 RNs, 7 LPNs, and 40 CNAs in order to adapt the ratio to 1:12-1:15 (acuity based). We also recognized the need to have a dedicated after-hours/weekend team (AHT) as the RNCM were also filling in on these shifts. We also concluded the current AHT was understaffed, and the current schedule was not appropriate. The AHT was working a 7/7 (seven days on seven days off) due to this some days the team was working a 15-hour shift with an 8-hour return to work time followed by an additional 15-hour shift. On other days the staff would work a 36-hour shift with a rest period in between but not enough to work diligently or safely.

**Phase Two**

After compiling and analyzing the data, a business plan would be developed for the board and corporate manager approval. Since the current HCAHP scores are meeting and exceeding national requirements, this proposal would be a hard sell to corporate committee as current policy amendments are done to remain compliant with state and federal requirements. Upon board review and presentation I will present empirical evidence to show how nurse burnout affects scores and profitability. I will also bring financial analysis of overtime cost vs the cost-saving effect to hire additional staff. Several meetings were held to obtain buy-in from corporate approval as the first cases were not strong enough to support the change. At the final assembly, I reduced the evidence data for patient care and presented additional financial savings and profitability. With the data shown, the company was projected to save 125 thousand dollars per quarter by hiring the necessary additional staff and reducing overtime.

## Implement

To implement this project, we decided to start in sections. First, upon reviewing the data, we discovered 60% of overtime hours were attributed to RNCM working after-hours and weekend coverage shifts. We wanted to focus on this first by creating a dedicated after-hours team. Currently, there were only two dedicated RNs splitting coverage alternating seven days on and seven days off. The nurse would also have an RNCM partner as a secondary back up throughout the night. Based on the amount of overtime paid out to RNCM to cover additional shifts it was calculated to hire on an additional 2 RNs to be paired during the AHT, aside from that we were also able to petition for an additional full-time LVN for M-F from 3 pm to 11 pm to assist the AHT RNs. Concurrently the savings cost allowed to hire an additional part-time LNP for Saturday and Sunday shift to cover 12 hours each day. This was a phenomenal change and would have a significant impact on RNCM daily routine as they would be removed from additional shifts and overtime.

The second portion will be hiring an additional 20 RNCMs to help lower the nurse to the patient ratio from 1:20/1:25 to 1:12/1:15 based on acuity. Including two additional full-time LVNs to be support back up to ensure each team has an LVN for assistance. With this, we will also be hiring 30 additional CNAs so that each RNCM will be paired with a CNA for direct reports and plan of care conferencing. This will ensure continuity of care and consistency of staffing; most importantly, it will help prevent miscommunication by removing additional parties. By implementing dedicated staff or minimizing multiple staff members for patients it will help reduce confusion and promote a direct point of communication.

Each portion of the hiring process will consist of grouping five hires at a time to ensure group learning and teamwork approach. The initial onboarding will be done by HR for standards of compliance policies, followed by the Quality Assurance Nurses (QA) training on hospice

philosophy and compliance practices. This will help build and develop a foundation to become a subject matter expert in the field. The next step of the plan will have the orienteers shadow each discipline in the field to know and understand the intricacies of the team members and how they work as a cohesive team for the benefit of the patients and families. The overall training and onboarding will take approximately one month with room to extend training on an individual basis. Each new employee post-training will have a "go-to" staff for questions or additional training needs.

## Review

### Quarter 1

The first quarter was an integral part of the process as it served as the foundation of board approval or dismissal. The information and data collected were researched and compiled to review and business plan development. The initial data showed nurse to patient ratio at 1:20/1:25. We had to get corporate board member approvals to implement the initial business plan, and the proposal was made and approved. Patient satisfaction scored were 90 to 91 with nursing care and communication. Staff reported 76 % to be suffering from compassion fatigue, and concurrently 80 % of staff were exhibiting or voice symptoms of burn-out, less than 10% voice concern for job dissatisfaction. A hiring process and on-boarding/training model was created and reviewed with approval. The first five staff members were hired 2 AH nurses, 1 LVN (AHT), and 2 CNAs within the first two weeks of program initiation. By the first month, an additional five staff were hired 4 RNCM, 1 CNAs. The RNCM were covering 85 % of AH shifts resulting in 284.5 on-call overtime hours and an additional 241 standard over-time hours

### Quarter 2

The second Quarter implemented the same method. The first two groups from Q1 completed training and assumed a dedicated roll. The gap for AHT was filled, and their schedules were readjusted in a conference with the entire team. The new schedule method was ratified. This depicted a five on one-off one on (5+1-1) alternating weeks as pairs. This meant each pair would work five days while the other team was off for five days. They would alternate one weekend day for 24 hours but would have a 24-hour rest period pre and post-shift. For Q2, the onboarding of 2 RNCM and 3 CNAs was completed and placed independently and followed by a second group hired and operational, consisting of 1 RN, 1 LVN, and 3 CNAs. The scores had a slight improvement in patient satisfaction scores increased to 93 %. While staff compassion fatigue decreased to 70 % and burned out decreased to 70 % by mid-second quarter. Job dissatisfaction had no change, so a survey was completed to determine the cause and possible improvements.

Upon review, it was determined the staff felt unappreciated for their hard work and dedication. With that said, we, of course, thanked them and let the team know how valuable they are to the company and the community they serve. This prompted the implementation of employee recognition and awards programs. The additional portion of the plan was also to include company outing events and fairs for staff and families. Like this, we created a weekly “Kudos” acknowledgment, which any positive comment from vendors, patients, families about a staff member would be rewarded with a simple gift card, each time they would be placed into nominations for employee of the month. Which yielded a more substantial gift for thank you; this way, all staff would be placed for employee of the year with the most significant monetary gift. Monthly hiking groups were created, including holiday events, birthday acknowledgment, and celebrations.

The additional changes since the dedicated AHT was up and running had decreased the RNCMs AH overtime down to 40 hours, and this is only due to call off or vacation coverage. Unfortunately, RNCM would still need to step in to cover if the AHT cannot cover their team. There was minimal change to the RNCMs routine overtime 241 to 223 hours per pay period.

**Quarter 3**

Quarter 3 had some setbacks with the loss of 6 RNCMs, 1 LVN, and 3 CNAs. When reviewing the cause of leaving it was determined 60 % left due to military relocation, 20 % left to mainland due to the high cost of living, 10 % left to take care of sick family members, 5 % left the island to experience new opportunities, 5 % retired, and 0% was due to job dissatisfaction.

The updated Nurse to patient ratio as 1:15/1:18 at the current census. This is an improvement but still a distance to the 1:12 goal. However, the patient satisfaction score did improve to 95 % in various sectors. The nurse compassion fatigue dropped significantly to 50 %, nurse burn-out decreased to 55 %, and job dissatisfaction decreased to 9% with an uptick in staff appreciation at 70 %. Although the numbers had marked improvement despite the loss of staff, the changes and oncoming staff have produced a positive effect. During this quarter, the onboarding of new staff in 3 segments comprised 10 RNCMs, 2 LVNs, and 8 CNAs. This was a phenomenal feat of advertising and interviewing multiple candidates.

The RNCMs AH over time significantly decreased from 40 hours to less than 12 hours per pay period. Including a significant decrease in regular overtime hours from 223 to 174 hours worked by RNCMs per pay period.

**Quarter 4**

Quarter 4 has seen significant improvement overall despite the loss of some additional team members. At the beginning of Q4, the loss of 2 RNCMs, 1 LVN, and 2 CNAs. The loss of

these employees was due to relocation off-island to pursue additional opportunities, 0% was due to job dissatisfaction.

During Q4, extensive recruitment and training occurred; the successful placement of 12 RNCMs, 3 LVNs, and 15 CNAs was completed. With the additions to staffing, the nurse to patient ratio has been stable at 1:15 on average based on acuity. During this time, due to growth, a clinical supervisor was added to form an additional team as each team will have a max of 100 patients. After reviewing the new data from surveys, the analysis showed compassion fatigue decreased to 18-20 % while nurse burnout surveyed at less than 10 %. These findings were remarkable. The patient satisfaction scores increased from 97 to 100 % in various categories of communication, empathy, knowledge, clinical response. Work dissatisfaction decreased to less than 2 % with an increase in staff satisfaction scores in the mid to high 80 %

The RNCMs AH over time significantly reduced from 12 hours to less than 4 hours per week. Including a significant decrease in regular overtime hours from 174 to 105 hours worked by RNCMs per pay period.

**Evidence to support the project continuation**

Although the project did not meet the goals of hiring 25 RNs, 7 LPNs, and 40 CNAs in an effort to reduce the nurse to patient ratio to 1:12. Data analysis shows a significant reduction in the cost of overtime pay, including the amount of hour time hours worked. Including reduction of RNCMs off of AHT to almost zero additional hours. The data depicts the need to continue the project in the coming year in an effort to continue to reach the desired goals. As noted, patient satisfaction scores increased into the high 90s with improvement and reduction in compassion fatigue and nurse burnout. With the decrease in overtime and additional staff members, the company was to have a potential cost saving of $147,466.25 (average calculation of projected

high cost [Example. 1]). The actual assumed total from accounting depicted, on average, a total of almost $201,325.00 per Quarter, which these savings can funnel to additional nursing staff, nursing bonuses, pay raise, or back to patient care.

## Conclusion

As a clinical nurse leader (CNL) advocates for the nurses' improvement of work-life balance, the CNL will be advocating for the quality and safety of patient care. This duality is a central point to the CNL as it is multifactorial on many microsystems. For a company to promote every effort to reduce nurse burnout and compassion fatigue by reduction of mandatory overtime and lower the patient-nurse ratio, this will have an exponential effect on the quality of patient care, increased safety for the patient and nurse, including improvements on communication and effectiveness of patient driven-centered attention. Doing so will help to improve HCHAP scores. With the help and utilization of staff input within the committee, staff satisfaction increased by the TeamSTEPPS approach; the staff was willing to “tough it out” as they felt heard and integral to the change. It is imperative for the goals to be measurable, attainable, and have buy-in from staff and management.

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# Appendicies

**Table 1. Compassion Fatigue Process**

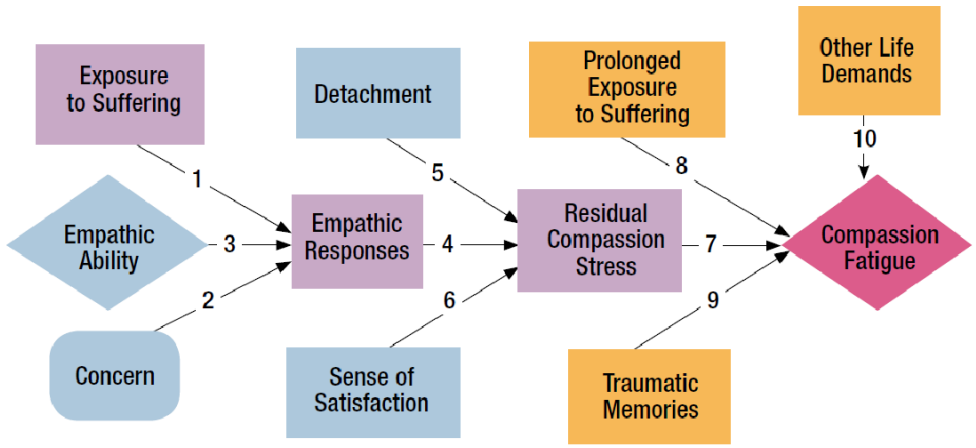


**Table 2. Manifestations of Compassion Fatigue in Health Care Workers**

| Physical | Behavioral | Psychological | Spiritual |
|---|---|---|---|
| • Exhaustion<br>• Insomnia<br>• Compromised immunity<br>• Somatization<br>• Headaches<br>• Stomach aches<br>• Sleep disturbance<br>• Fatigue<br>• Emotional exhaustion<br>• Hypochondria | • Increased alcohol intake<br>• Anger and irritability<br>• Strained personal relationships<br>• Absenteeism<br>• Attrition<br>• Avoidance of patients<br>• Impaired clinical decision making<br>• Compromised patient care | • Emotional exhaustion<br>• Relational distancing<br>• Negative self-image<br>• Depression<br>• Reduced ability to feel sympathy and empathy<br>• Cynicism<br>• Resentment<br>• Professional helplessness<br>• Diminished enjoyment/career satisfaction<br>• Irrational fears<br>• Intrusive imagery<br>• Avoidance | • Lack of spiritual awareness<br>• Disinterest in introspection<br>• Poor judgment<br>• Decrease in discernment |

Adapted from Sinclair et al.[21]

**Figure 1.**
**Professional Quality of Life Scale (ProQOL)**

**Compassion Satisfaction and Compassion Fatigue**

**(ProQOL) Version 5 (2009)**

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

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

___1. I am happy.
___2. I am preoccupied with more than one person I [help].
___3. I get satisfaction from being able to [help] people.
___4. I feel connected to others.
___5. I jump or am startled by unexpected sounds.
___6. I feel invigorated after working with those I [help].
___7. I find it difficult to separate my personal life from my life as a [helper].
___8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
___9. I think that I might have been affected by the traumatic stress of those I [help].
___10. I feel trapped by my job as a [helper].
___11. Because of my [helping], I have felt "on edge" about various things.
___12. I like my work as a [helper].
___13. I feel depressed because of the traumatic experiences of the people I [help].
___14. I feel as though I am experiencing the trauma of someone I have [helped].
___15. I have beliefs that sustain me.
___16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
___17. I am the person I always wanted to be.
___18. My work makes me feel satisfied.
___19. I feel worn out because of my work as a [helper].
___20. I have happy thoughts and feelings about those I [help] and how I could help them.
___21. I feel overwhelmed because my case [work] load seems endless.
___22. I believe I can make a difference through my work.
___23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
___24. I am proud of what I can do to [help].
___25. As a result of my [helping], I have intrusive, frightening thoughts.
___26. I feel "bogged down" by the system.
___27. I have thoughts that I am a "success" as a [helper].
___28. I can't recall important parts of my work with trauma victims.
___29. I am a very caring person.
___30. I am happy that I chose to do this work.

**Source:** Stamm, 2010. © 2009. Reprinted with permission.

**FIGURE 2.**
**Your Scores on the ProQOL: Professional Quality of Life Screening**

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

**Compassion Satisfaction** _____

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

The average score is 50 (SD 10; alpha scale reliability 0.88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason; for example, you might derive your satisfaction from activities other than your job.

**Burnout**_____

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

The average score on the burnout scale is 50 (*SD* 10; alpha scale reliability 0.75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or need some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

**Secondary Traumatic Stress**_____

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

The average score on this scale is 50 (*SD* 10; alpha scale reliability 0.81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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**FIGURE 3.**
**What Is My Score and What Does It Mean?**

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

**Compassion Satisfaction Scale**

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

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

| The Sum of My Compassion Satisfaction Questions Is | So My Score Equals | And My Compassion Satisfaction Level Is |
|---|---|---|
| 22 or less | 43 or less | Low |
| Between 23 and 41 | Around 50 | Average |
| 42 or more | 57 or more | High |

**Burnout Scale**

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

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

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

**Total :** ____

| The Sum of My Burnout Questions Is | So My Score Equals | And My Burnout Level Is |
|---|---|---|
| 22 or less | 43 or less | Low |
| Between 23 and 41 | Around 50 | Average |
| 42 or more | 57 or more | High |

**Secondary Traumatic Stress Scale**

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

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

**Total :** ____

| The Sum of My Secondary Trauma Questions Is | So My Score Equals | And My Secondary Traumatic Stress Level Is |
|---|---|---|
| 22 or less | 43 or less | Low |
| Between 23 and 41 | Around 50 | Average |
| 42 or more | 57 or more | High |

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Example. 1

**On-call Suggestions and Proposal**

**CURRENT STRUCTURE - Primary On-Call Personnel**:
Two 7 on / 7 off RN After Hours and Weekend RNs (alternating weeks) M-F 5 pm-8 am/ Sat-Sun-24 hours each day
One RN Admissions Nurse M-F 4 pm-12:30 am
On RN Weekend RN Sat-Sun 8 am-8 pm

Average visits per day over the weekend: 19.25 per day
Data collected for Sept-Oct: Highest visit weekend – Sat 27 visits / Sun 29 visits (in one weekend)

Average admissions over the weekend: 4.25 admissions Saturday & Sunday (this varies)

**1st, 2nd, and 3rd On-Call Personnel:**
All RNCMs
All LPNs

**NOTE:** Weekly Day Shift RN Case Managers and LPNs are currently being assigned the primary After Hours and Weekend On-Call shifts. RNCMs are struggling and are burnt out.
***LPNs are also covering approximately 160 CNA visits per month.

Data collected for the month of October (thru the 26th):
Regular Day Shift RNCMs and LPNs took approximately 44 after hours and weekend triage calls and made 47 after hours and weekend visits on top of their weekly routine visits.

**Proposed Structure:**

- Remove Weekday RNCMs and LPNs from On-Call Schedule
- **Hire 2 RN and 2 LPNs for After Hours and Weekend Coverage** (more cost-effective)
    - Hawaii provides autonomy for LPNs to pronounce death if needed
- Eliminates RNCM and LPN burn out and loss of qualified/experienced personnel
- Reduces overtime compensation for RNCMs and LPNs
- Utilize Clinical Supervisors for heavy call/visit/admission days

**Pay Period Ending 10/30/2018 284.5 hours of On-Call/Pager hours for RNs and LPNs**
*** Average RN hourly overtime wage is $67.50 per hour x 280 hours = $17,280**
*** Average LPN hourly overtime wage is $43.50 per hour x 4.5 hours = $195.75**
**Total Average On-Call/Pager pay for one Pay Period = $17,475.75** (estimated high)

**Averaged Annually - $448,726.51 (total OT all disciplines – 21 pay periods)**
**Average On-Call Costs Annually (using $17,475.75 for explanation purposes) = $366,990.75**

The average cost to replace an employee is $4000-$5000 per professional employee
(includes advertising, interviewing, hiring and orientation)

**ADD - Approximate Additional Salary Compensation = $142,000 in annual compensation (at 40 hours per week) (estimated high - hourly LPNs may not reach 40 hours per week)**
**$142,000 Annual Compensation - $17,475.75 Over Time Compensation = $124,524.50**
**ADD - Cost of additional Clinical Supervisor for Growth = $95,000 approximately** (utilization of current staff will offset this cost)
**$124,524.50 (additional on-call staff) + $95,000 (additional clinical supervisor for growth) = $219,524.50**

**Average On-Call Costs Annually (using $17,475.75 for explanation purposes x 21 pay periods) = $366,990.75**
**$366,990.75 (on-call/overtime costs) - $219,524.50 (additional staff) = $147,466.25**

**"Potential" estimated savings (deducting potential on-call pay and additional Clinical Supervisor salary for growth – using current staff) = $147,466.25**