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## **Strategies to Increase Compassion Satisfaction and Reduce Compassion Fatigue Among Hospital Nurses**

Christy Morton Secor  
*St. Catherine University*

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Strategies to Increase Compassion Satisfaction and  
Reduce Compassion Fatigue Among Hospital Nurses

Systems Change Project  
Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Nursing Practice

St. Catherine University  
St. Paul, Minnesota

Christy Morton Secor

December 2015

ST. CATHERINE UNIVERSITY  
ST. PAUL, MINNESOTA

This is to certify that I have examined this  
Doctor of Nursing Practice systems change project  
written by

*Christy Morton Secor*

and have found that it is complete and satisfactory in all respects,  
and that any and all revisions required by  
the final examining committee have been made.

*Alcie R. Swan D.M.A., R.N.*

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Name of Faculty Project Advisor

December 2015  
Date

DEPARTMENT OF NURSING



Strategies to Reduce Compassion Fatigue and  
Improve Compassion Satisfaction Among Hospital Nurses

Nursing is one of the most rewarding, but also one of the most difficult professions related to the toll it can take physically, mentally, emotionally, and spiritually on its members. Standards and expectations for nurses are high, as they should be, given the nature of the work and the manner in which nurses interact with their patients and communities. The American Nurses Association (ANA) Code of Ethics for Nurses describes the values, virtues, and obligations of nursing practice in this way:

Nursing encompasses the protection, promotion, and restoration of health and well-being; the prevention of illness and injury; and the alleviation of suffering, in the care of individuals, families, groups, communities, and populations. All of this is reflected, in part, in nursing's persisting commitment both to the welfare of the sick, injured, and vulnerable in society and to social justice. Nurses act to change those aspects of social structures that detract from health and well-being. (ANA, 2015, p. vii)

Both the profession of nursing and healthcare organizations are beginning to recognize and address the personal and professional cost of caring for others. It is a dialogue that is needed not only to protect the workforce, but to promote patient safety.

For individual nurses, the conversation represents recognition for deeper self-awareness and support in order to prevent and to heal from the effects of burnout, secondary traumatic stress, and compassion fatigue. This process is challenging in light of the personal and daily expectations nurses encounter in practice and the calling nurses feel to their profession. The conversation carries with it the recognition of personal limits and the need to seek support in demanding, challenging work environments. It also recognizes, as Native American culture

teaches, that “each time you heal someone you give away a piece of yourself until at some point, you will require healing” (Houck, 2014, p. 455).

### **Review of the Literature**

Nursing can be a hazardous profession. Interacting with patients and their families during times of trauma, illness, and increased stress can lead to negative coping mechanisms for nurses. Compassion fatigue is a term first used by Joinson in 1992 to describe nurses in an emergency department who were ‘worn down’ by the needs of their patients (Flarity, Gentry, & Mesnikoff, 2013). Compassion fatigue is relational-based and can develop suddenly (Boyle, 2015; Maiden, Georges, & Connelly, 2011; Potter et al., 2010). Nurses experience a loss of empathy, compassion, purpose, and self that can affect every aspect of the nurse’s personal and professional life (Grafton, Gillespie, & Henderson, 2010; Harris & Griffin, 2015).

Stamm (2010) describes compassion fatigue as a result of the combined effects of burnout and secondary traumatic stress. Burnout in individuals typically occurs gradually over time and is associated with barriers encountered within the work environment (Stamm, 2010). Working long work hours, being short-staffed, difficulty communicating with managers, learning new equipment and protocols, and meeting regulatory requirements are all examples of barriers nurses may experience within their work environment that can contribute to burnout. Secondary traumatic stress develops within nurses as a result of witnessing and hearing the traumatic events taking place in the lives of others (Stamm, 2010). Nurses are at the center of the trauma and stress taking place in the lives of patients and families. The very nature of a nurse’s work can create conflict with the values, virtues, and obligations described by the profession’s code of ethics (ANA, 2015).

The American Society of Registered Nurses (ASRN) reported in 2008 that 9.6% of nurses will experience at least one major episode of depression during their lifetime. While all of these cases may not be attributed to the work environment, the possible connection to the work environment should be considered given the life and death situations that are a part of a nurse's daily practice. The ASRN also noted that approximately eight out of every 100 nurses has been involved in illegal drug use in the past year (2008). While the overall numbers for substance use within the profession may not differ greatly than the general population, there are certain populations of nurses who are more at risk for abuse such as emergency department nurses, mental health nurses, critical care nurses, oncology nurses, and certified nurse anesthetists (National Council of State Boards of Nursing, 2011). Given the sacred trust nurses hold for the welfare and safety of their patients, the abuse of substances to cope with stress and trauma within the work environment must be addressed. In addition, the rate of suicide among female nurses is higher than the national average of suicide for women with a female nurse being four times more likely to commit suicide than other women (ASRN, 2008).

The impact on the nursing workforce has clear implications for patient safety and employee engagement. Workplace violence is a growing trend within healthcare. The Bureau of Labor Statistics reported that while fewer than 20% of all injuries happen to healthcare workers, these workers will experience 50% of all assaults (Occupational Safety and Health Administration, 2015, p. 3). The rates of workplace violence are especially high for nurses who work in the emergency department. The Emergency Department Violence Surveillance Study which was conducted by the Emergency Nurses Association reported 55.6% of nurses who worked within the emergency department had experienced either physical or verbal violence or both (Thompson, 2015, para. 2). In addition, this same study found that 57.6% of these nurses

rated the overall safety of the emergency department at a 5 out of 10 or lower (Thompson, 2015, para. 2). Experiences like this contribute to a nurse's compassion fatigue and lead to job dissatisfaction and turnover. The National Patient Safety Foundation (NPSF) noted studies indicating 33% of new nurses will seek another job within their first year as a nurse (2013, p. 5). The loss of qualified nurses represents a loss of individuals who are needed to care for an aging population, and a loss of individuals who bring new insights and passion to an evolving profession.

### **Method**

This study used a descriptive longitudinal design evaluating one-group prospectively.

Two research questions were explored:

- How does a mind-body-spirit educational strategy for self-care affect compassion satisfaction and compassion fatigue in hospital nurses and nurse managers?
- How does coaching a nurse manager influence implementation of self-care strategies on nursing unit(s)?

### **Instrument**

The Professional Quality of Life scale (ProQOL) was developed by Stamm (2010). It has good construct validity and has been used in more than 200 published papers as well as in more than 100,000 articles found on the internet (Stamm, 2010). Stamm (2010) notes that the ProQOL has also been translated from its original English version into other languages including Finnish, French, German, Hebrew, Italian, Japanese, Spanish, Croat, European Portuguese, and Russian.

### **Setting**

The setting was a 65-bed acute care hospital located in a Midwestern town of approximately 15,500.



### **Sampling Framework**

Nurses and nurse leaders of this 65-bed acute care facility participate in annual education as part of their Professional Nursing Practice training. This training was offered during March 2015. Nurses had the option of attending one of six sessions. During the one-hour education, each participant was given an opportunity to voluntarily and anonymously complete the ProQOL with the researcher out of the room. After ten minutes, the researcher returned to provide brief demonstrations of different self-care modalities such as meditation, acupressure, guided imagery, and aromatherapy. As part of the second and third quarter learning bundle for the nursing staff, additional in-depth education on self-care topics was provided to the nurses and nurse leaders through an online learning platform known as SABA.

An email was sent to the hospital's nurses and nurse leaders during the months of April, June, and September asking staff to complete the ProQOL. Completed surveys were placed in a specially marked container in unit breakrooms and collected at the end of each month.

In addition to the surveys, the researcher engaged in dialogue with nurse leaders through nurse manager's meetings scheduled during April, June, and September. These conversations looked at how to support the nurse managers and their staff in implementing self-care strategies individually and within their departments. Feedback and discussions from these meetings were gathered by the researcher.

### **Sample and Ethical Considerations**

A convenience sample of 180 registered nurses who worked throughout the hospital was eligible for the study. The study was approved by Quorum, the Institutional Review Board (IRB) used by the hospital system, for this type of research. An additional IRB with the graduate

program the researcher attended was waived due to a pre-existing agreement with the healthcare system where the researcher works.

### **Data Analysis**

The ProQOL provides a scoring guide that aligns specific questions to the concepts of compassion satisfaction, burnout, and secondary traumatic stress. Data were entered by the researcher with a sample of the data entry verified by the researcher's site mentor for accuracy. The verified data were sent to a statistician where descriptive statistical analysis was performed. Scores for compassion satisfaction, burnout, and secondary traumatic stress were graphed using mean scores as well as individual results.

## **Results**

### **Response Rate**

The initial response rate during the face-to-face education in March 2015 was 67% (see Table 1). The response rate decreased significantly for the follow-up surveys which were placed in the nurse's breakrooms to complete. Learnings from this approach will be discussed in the limitations.

Table 1

*Overall Response Rate*

Department	March	April	June	September	Total
Birth Center	3	8	2	3	16
Cardiac Rehab	0	3	1	0	4
Emergency Department	23	0	2	5	30
Medical / Surgical	41	4	6	7	58
Operating Room	8	1	1	3	13
Same Day Surgery	21	2	3	0	26
Oncology	5	5	4	4	18
Miscellaneous	10	3	2	3	18
Managers / Administration	9	8	4	6	27
Total	120	34	25	31	210

**Findings**

**Compassion satisfaction.** Pre-study results for compassion satisfaction were the highest for participating nurses working in the Medical/Surgical department ( $n=41$ ,  $\bar{x} = 42.98$ ), Birth Center ( $n=3$ ;  $\bar{x} = 44.33$ ), and the Operating Room ( $n=8$ ;  $\bar{x} = 45.13$ ) although the total number of participants in two of these departments was small (see Table 2).

The lowest rates of compassion satisfaction were found among nurses in Same Day Surgery ( $n=21$ ,  $\bar{x} = 38.19$ ) and the Emergency Department ( $n=23$ ,  $\bar{x} = 38.26$ ) (see Table 2).

Table 2

*Pre-study Results: Means of Participating Departments*

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Managers / Administration (n=9)	39.89	23.67 ♦	20
Birth Center (n=3)	44.33 †	20.33 †	19.67 †
Oncology (n=5)	39.8	23.4	22 ♦
Operating Room (n=8)	45.13 †	18.38 †	19.25 †
Miscellaneous (n=10)	39.9	20.9	19.8 †
Emergency Department (n=23)	38.26 ♦	23.65	22.52 ♦
Same Day Surgery (n=21)	38.19 ♦	26.1 ♦	20.14
Medical / Surgical (n=41)	42.98 †	20.17 †	20.22

† = highest levels of compassion satisfaction; lowest levels of burnout and secondary traumatic stress

♦ = lowest levels of compassion satisfaction; highest levels of burnout and secondary traumatic stress

Results in the subsequent months following initial education were not statistically significant as a result of poor response rates. However, the results for the nurse managers / administration were statistically significant over time when weighted (see Table 3).

Table 3

*Results for Nurse Managers*

	March 2015	April 2015	June 2015	September 2015
Participants	9	8	4	6
Compassion Satisfaction Scale Mean *	39.89	43.75	42.00	44.83
	* Weighted results $p = .02$			
Burnout Scale Mean *	23.67	21.50	21.75	18.50
	* Weighted results $p = .02$			
Secondary Traumatic Scale Mean	20.00	20.63	21.00	19.50

**Burnout.** The results for burnout taken pre-survey were the lowest for participating nurses working in the Operating Room ( $n=8$ ,  $\bar{x} = 18.38$ ), Medical / Surgical department ( $n=41$ ;  $\bar{x} = 20.17$ ), and the Birth Center ( $n=3$ ;  $\bar{x} = 20.33$ ) although the number of participants in two of these departments was small (see Table 2).

The highest rates of burnout were found among Nurse Managers / Administration ( $n=9$ ,  $\bar{x} = 23.67$ ) and nurses in Same Day Surgery ( $n=21$ ,  $\bar{x} = 26.1$ ) (see Table 2).

Poor response rates did not provide statistical significant results among departments. But as with compassion satisfaction, the results for the nurse managers / administration were statistically significant over time for burnout when weighted (see Table 3).

**Secondary traumatic stress.** The results for secondary traumatic stress taken pre-survey were the lowest for nurses who work in the Operating Room ( $n=8$ ,  $\bar{x} = 19.26$ ), Birth Center ( $n=3$ ,  $\bar{x} = 19.67$ ), and nurses who worked in various, miscellaneous smaller departments within the hospital ( $n=10$ ;  $\bar{x} = 19.8$ ). The number of participants in two of these departments was small (see Table 2).

The highest rates for secondary traumatic stress were found with nurses who worked in Oncology ( $n=5$ ,  $\bar{x} = 22.00$ ) and in the Emergency Department ( $n=23$ ,  $\bar{x} = 22.52$ ) (see Table 2).

Poor response rates did not provide statistical significant results among departments for secondary traumatic stress or with nurse managers / administration when weighted (see Table 3).

### **Discussion**

Equipping nurses to care for themselves is difficult work – both for individuals and organizations. Developing a commitment for self-care calls for a nurse to maintain a deep sense of personal self-awareness as well as openness to communicate to others when additional support is needed. It often involves a change within a department's as well as an organization's culture. Self-care is a life-long process. It does not represent a state of mind where one "arrives." The reality is that life will be filled with disruptions that can be personal, professional, or both. These disruptions have the ability to pull us away from being our true self to our patients, our families, our friends, and even to ourselves.

This study highlighted the need for this work. Being a part of a hospital that is less than 100 beds has given nurses the ability to know one another on a more personal basis. During the time frame of this study, nurses and nurse managers have experienced numerous stresses. In addition to the complex needs of patients, several members of the staff experienced significant medical issues either personally or with a member of their family. Family members passed away; transitions in staffing and leadership took place; staff cared for colleagues who experienced trauma following a motor vehicle accident and for another who died by suicide on the hospital's grounds. Lack of adequate services to meet the ongoing needs of mental health patients taxed staff and left them with difficulty coping.

While these events can contribute to burnout, secondary traumatic stress, and compassion fatigue; they can also represent opportunities for personal learning and growth. One difference between these polarities lies in the perspective or response taken by those involved. For example, do nurses attempt to handle these events individually or with the support of others? Do nurses acknowledge when their “compassion identity” is being challenged (Corso, 2012). Corso (2012) describes compassion identity as “one’s internal global positioning system” that allows the nurse to “regularly and continually reevaluate and reexamine their internal resources” (pp. 448–449). Having a better sense of one’s compassion identity can equip nurses to seek support, communicate issues, or implement additional personal strategies when needed.

Another difference is in the on-going strategies a nurse uses for self-care. Nurses who are better at self-care have more of a reserve when disruptions take place. These individuals approach their work and personal lives from a place of wholeness rather than unmet personal needs. Interactions with coworkers and patients rise from a stronger place of being allowing the nurse to be more present with others.

In reviewing the statistical significance of the weighted results for the nurse managers and nurses in administration, the key difference noted in the interventions carried out between this group and the nurses working in other departments was the additional support and conversations the researcher held with the nurse managers / administrators. Nurse managers began conversations with statements like, “I can’t do one more thing” and feeling overloaded with the amount of email that needed to be answered. One shared, “I feel I always have to be on the defensive to justify the staffing and positions that are needed.”

Nurse managers asked for support and tools on self-care to share with staff that they could also use personally. Weekly self-care toolkits were developed by the researcher and shared

with nurse managers to post in their weekly updates to staff. Group support was also observed and demonstrated among nurse managers and nursing administration during these follow-up meetings. One manager shared she had left work early the day before because she realized she was not in a good place emotionally. Other managers acknowledged the strength of this decision and encouraged this individual for taking care of herself. The group physically applauded her choice. This affirmation was important for the nurse manager involved in the self-care decision, and for the others around the table as well.

Another manager acknowledged the importance of trust with her staff in their interactions with one another and as problems arose. She stated, “It’s okay to let it play out and see how things go.” This ability to allow the members of her department to work through situations without her immediate involvement enabled the nurse manager to prioritize the situations that truly did require her attention. This same nurse manager shared she was also seeing positive changes in her staff as strategies were being shared. For example, the nurses in her department were not picking up extra shifts because they realized it was a higher priority to have the time off. Having a supportive department and organization to work through this type of disruption demonstrated tremendous support and sent an important message to staff.

### **Limitations**

The greatest limitation encountered in this study was the poor response rate experienced by the nursing staff in the follow up months of the study. The protocol called for the surveys to be left in the breakrooms of the staff along with a box where their completed surveys could be placed. Staff breakrooms were often heavily cluttered with not only food and personal items, but internal communication from the hospital. Expecting nurses to complete the survey during their off time when they were trying to get away from the stresses of the floor was unrealistic. A



greater response rate may have occurred by meeting with members of a department during a staff meeting. There may also have been stronger results experienced by following one department over time.

An additional limitation was the inability to follow individuals over time. Did only certain types of individuals participate? Did those doing well or those experiencing difficulty participate or not participate. It would have been helpful to have more demographic information available for those who completed the study. Another option would have been to have followed a cohort of participants who agreed to participate in the study prospectively.

### **Implications**

As a hospital, the need to build self-care and promote resiliency has become a focus for building a high reliability organization. The Joint Commission has described the ability of an organization to bounce back or respond quickly to safety concerns as one component of an organization's internal system that demonstrates a strong safety culture (Chassin & Loeb, 2013; United States Department of Health and Human Services, 2008). The senior team at our hospital believed our organization's strength in responding to safety concerns could only be as strong as the strength of the individuals who make up our workforce.

Self-care has become a part of our everyday practice. Self-care is addressed during critical event reviews in the development of action plans, and part of the strategies being implemented with our site's violence prevention work. Building stronger communication and a sense of team as well as the need to be share personal feelings about the cost of caring led to the initiation of the Schwartz Center Rounds at our site (The Schwartz Center for Compassionate Care, 2015). The Schwartz Center Rounds provides a time for individuals from all areas of the interdisciplinary team to meet and share feelings that arise in the caring of patients. These

sessions have improved understanding and compassion of the unique needs of patients and their families; it has also offered a platform to decrease the feelings of stress for care providers as they give and receive support with one another (The Schwartz Center for Compassionate Care, 2015).

The concepts of self-care and resiliency are now being shared with other departments and hospitals in our healthcare system. Opportunities exist to obtain support from leaders through a growing recognition of the issues being faced by those who work in healthcare. Providing strategies can lead to cultural change and improved care for an over-stretched workforce as well as improve patient safety. In addition, this work is being taken to the community as a way to improve the mental health for each member of the community. Businesses and schools are working in collaboration with the hospital on ways to implement self-care. Communication has also begun with state and national contacts to investigate additional ways to move this work forward.

### **Summary and Recommendations**

Further research is needed to better understand the concepts of burnout, secondary traumatic stress, and compassion fatigue among nurses. In addition, more work is needed to develop programs to address the stress of nurses within the workplace. Having support of leadership is critical to foster the change needed within organizations. Recognizing barriers and implementing strategies to improve the environment of the patient, the workplace, and the individual in a way that does not come across as “more work” can assist in developing new attitudes and behaviors of self-care. This research should also evaluate the effectiveness of interventions designed to reduce the negative effects of caring. Connecting these interventions to measures of improved employment engagement, reduced employee injuries, reduced errors, and

improved patient satisfaction can provide evidence for a strong return on investment to leaders, care providers, and sites who realize the benefit of this work.

Burnout, secondary traumatic stress, and compassion fatigue are realities in today's healthcare environment. But individuals and hospitals do not have to be crippled by nurses who disengage from the care they provide as a coping mechanism. By learning how to influence and create positive cultural change for individuals and organizations, nurses can practice to the fullness of their profession.

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