RAISING AWARENESS OF COMPASSION FATIGUE AMONG HEALTHCARE PROVIDERS IN THE CORONARY CARE UNIT

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Keri Tifft

Liberty University

Lynchburg, VA

May 15, 2019
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Scholarly Project Chair Approval:

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ABSTRACT

Compassion fatigue is a pressing issue in critical care units across the healthcare field. There is a sincere desire by nurses to give the best care possible to each of their patients; however, many obligations split the nurse’s attention so they do not feel as if they are providing the best care to their patients. When nurses stop viewing their patients as humans and start viewing them as tasks, the compassion that the nursing profession prides itself on, is no longer there to the degree that is needed for quality care. Increasing awareness of compassion fatigue and teaching nurses and staff how to identify and combat this is imperative to the future of nursing. The purpose of this scholarly project was to raise awareness of compassion fatigue among healthcare clinicians in the CCU setting of a community-based hospital and to provide them with strategies and interventions that can be utilized to combat this pressing phenomena of interest.

This scholarly project evaluated existing knowledge surrounding compassion fatigue in a pre-test and a ProQol 5 pre-survey. An educational intervention was conducted to educate staff on compassion fatigue. Two weeks later a post-test and ProQol 5 post-survey was given to determine if there was any improvement in the compassion fatigue scores after the educational intervention. The results showed no statistical difference between the pre- and post-test or the ProQol 5 pre- and post-surveys.

Keywords: compassion fatigue, compassion fatigue clinicians, compassion fatigue intervention, and compassion fatigue critical care
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List of Abbreviations

American Association of Colleges of Nursing (AACN)
American Psychology Association (APA)
Compassion Fatigue (CF)
Doctor of Nursing Practice (DNP)
Evidence-Based Practice (EBP)
Institute of Medicine (IOM)
Institutional Review Board (IRB)
Iowa Model Collaborative (IMC)
Patient Care Technician (PCT)
Registered Nurse (RN)
RAISING AWARENESS OF COMPASSION FATIGUE AMONG HEALTHCARE PROVIDERS IN THE CORONARY CARE UNIT

SECTION ONE: INTRODUCTION

Compassion fatigue (CF) is a pressing issue in critical care units. Hospital personnel are consistently called upon to work with patients and family members who have had a traumatic event, which can be psychologically taxing to the caregivers (Penix, Kim, Wilk, & Adler, 2018). CF is defined as being emotionally exhausted, depressed, having general anxiety, and feeling that one may have failed in their profession; as a result of this they no longer have the capacity to nurture patients (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016; Sinclair, Raffin-Bouchal, Venturato, Mijovi-Kondejewski, & Smith-Macdonald, 2017). An estimated 30-50% of new nurses will change positions or leave nursing completely within the first three years of their career, and the question has been asked, could this be due to CF (Salmond, 2017)?

With the nursing shortage and staffing issues that have been prevalent across the United States, it is important to address reasons that may cause nurses to leave the bedside. Nolte, Downing, Temane, & Hasting-Tolsma, (2017) discuss the possible physical symptoms of CF that may manifest as feeling worn out, fatigue, aches, and pains. The emotional symptoms of CF are described as hopelessness, frustration/despair, feeling incompetent, isolation, and feeling like “opting out” (Nolte Downing, Tenmane, & Hasing-Tolsma, 2017). Increasing awareness of CF and teaching nurses and staff how to identify and combat this is imperative to the future of nursing.

Ledoux (2015) stated CF takes place when nurses perceive themselves as unable to fulfill their moral responsibilities. There is a sincere desire by nurses to give the best
care possible to each of their patients; however, many obligations split the nurse’s attention so they do not feel as if they are providing the best care to their patients. One study documented nurses with CF were not responding quickly to patients and not charting appropriately, which affects how other providers may interpret the patient’s needs (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). An example of this would be if pain is not charted accurately, a needed intervention by another service, such as surgery or pain management might be delayed.

When nurses stop viewing their patients as humans and start viewing them as tasks, the compassion that the nursing profession prides itself on, is no longer there to the degree that is needed for quality care. This can lead to nurses perceiving that they were unable to fulfill a moral responsibility to the patient (Ledoux, 2015). It is imperative for nurses to be able to work in an environment where they consistently feel they are able to meet their moral obligations to their patients. This scholarly project is an evidence-based practice project that aimed to increase awareness of CF among healthcare clinicians, as well as educate them on the strategies and interventions to combat it within the critical care environment.

**Background**

**Compassion Fatigue Defined**

CF is a condition that plagues healthcare clinician’s nation wide. The stress from close relationships with patients and families can increase the strain of the caregivers when the patient condition deteriorates or the patient dies (Aycock & Boyle, 2008). There is also a moral distress that causes CF, when healthcare clinicians are taking care of too many patients at once, or given so many tasks they do not have time to adequately care
for the patient to the best of their ability (Ledoux, 2015). Henry (2014) identifies burnout and job stress, which directly correlates to CF, having increased in nursing, due to of technology, insurance changes and demands, and the vast amount of new education needed to understand current and expanding disease knowledge. Providing nurses with the adequate information needed and evaluating the degree of CF on a hospital unit has the potential to decrease the negative feelings that are responsible for CF.

**Problem**

In 2010, the Institute of Medicine (IOM) released a statement that encourages lifelong learning and advance practice in nursing (Mund, 2012). Currently CF is not measured among registered nurses (RNs) and patient care technicians (PCTs) in the critical care setting. It is important to raise awareness and provide education about CF, as it is noted to impact quality of care and affect nurses nationwide (Sinclair, Raffin-Bouchal, Venturato, Mijovi-Kondejewski, & Smith-Macdonald, 2017).

**Implication for Improvement**

Providing education about CF will potentially increase the knowledge of RNs and PCTs. This increased knowledge will support the identification of CF and further support interventions to combat this phenomenon. The hospital’s code of ethics discusses Jean Watson’s Theory of Human Caring, focusing on the value of all human beings including care for self and colleagues into the model. Jean Watson’s Theory of Human Caring as defined in the mission:

“Care delivery begins with a theoretical framework described in Jean Watson’s Theory of Human Caring. Patient care delivery is founded upon the mission, vision, and values of the Sisters of [blank] and Dr. Jean Watson’s Theory of Caring Science. Caring
expresses the essence of holistic nursing practice within [Bon Secours]. Nursing care at [Bon Secours] Hospital embodies the Sisters’ statement ‘Our ministry is an enduring sign of healthcare rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind and spirit’ ([Bon Secours], 2018).

**Outcomes**

Raising the awareness of CF among RNs and PCTs in the coronary care unit (CCU) was the primary intended outcome for the CF project. Teaching the coronary care RNs and PCTs the strategies and interventions they can utilize to combat CF was also beneficial. Establishing a quality metric to monitor CF among RNs/PCTs in the CCU, via an established tool and implementation across the entire hospital was welcomed.

**Problem Statement**

CF is a noted phenomena of interest and is a pressing issue in critical care units (Jenkins & Warren, 2012). Jenkins & Warren (2012) discuss the implications of prolonged, continuous and intense exposure to patients experiencing life or death trauma, serious illnesses, and sudden critical events in the critical care unit have led to CF. In CCU, the nurses are the primary responders to all in house rapid responses called. This exposes CCU nurses to continuous and intense situations.

There is decreased awareness among healthcare clinicians regarding CF (Sorenson, Bolick, Wright, & Hamilton, 2016). There are many challenges related to this phenomenon of interest such as a standardized definition of CF and multiple contributing factors that healthcare clinicians are exposed to. Poor utilization of appropriate strategies and interventions to support this issue could also be a contributing factor. CF is noted as a determinant of nursing retention in health care systems today; yet, clinicians are often
unaware of the issue (Houck, 2014). Many healthcare clinicians do not utilize strategies recommended CF reduction strategies and interventions (Houck, 2014). This issue must be addressed by healthcare clinicians, as CF has significant ramifications for patients and the healthcare system at large.

**Purpose**

The purpose of the evidence-based scholarly project was to raise the awareness of the challenges of CF among nurses and patient care technicians (PCTs) in a CCU, and to provide them with strategies and interventions that were used in their daily practice. This will further improve the identification of CF in CCU healthcare clinicians and increase their retention rates, which is critical to quality care.

**Significance**

CF has been noted in the research to impact healthcare professionals and the quality of care they give significantly. It is critical that awareness of CF be considered in the critical care settings, as well as the interventions and strategies to combat it. The following statements were used to support this project:

1. There is limited awareness among healthcare clinicians about the challenges that individuals with CF face.
2. CF has been directly linked to nursing retention.
3. Registered nurses in the critical care setting are at an increased risk for CF.
4. Despite the call to action to address attrition rates in the nursing profession, little has been done to address CF.
5. There is poor utilization of recommended strategies and interventions regarding CF among healthcare clinicians.
The significance of the scholarly project was to increase awareness of how to identify and cope with CF. In addition, the project has the potential to establish a CF metric that could be implemented in the CCU setting.

**Clinical Question**

The project addressed the following clinical question: For healthcare clinicians working within the CCU environment, does an educational intervention regarding CF and its proven strategies and interventions for healthcare clinician’s impact their CF awareness and existing practice?

- **Population:** The target population for this study was healthcare clinician’s (RNs and PCTs) in a CCU in a community-based hospital.

- **Intervention:** The intervention was an educational PowerPoint presented during a lunch and learn for CCU clinicians, to raise their awareness of CF, as well as provide them with strategies and interventions to support this pressing issue. The PowerPoint defined CF, addressed the signs and symptoms of CF, and addressed strategies and interventions to support healthcare clinicians who have been impacted.

- **Comparison:** CF awareness among CCU healthcare clinicians was compared via a pre- and post- test, and a pre- and post-survey was used to evaluate clinician’s usage of CF strategies and interventions two weeks after the intervention.

- **Outcomes:** The proposed outcomes of the scholarly project included:
  1) To increase awareness of CF among RNs and PCTs in the CCU.
  2) To provide the CCU nurses/PCTs the strategies and interventions they can utilize to combat CF.
3) To evaluate the utilization of the strategies and interventions, two weeks after the education intervention.

4) To implement a quality metric to monitor CF among RNs and PCTs in the critical care environment

SECTION TWO: LITERATURE REVIEW AND SYNTHESIS

Selection Criteria

To provide current and up to date literature in accordance with the Iowa Model of Evidence Based Practice, a comprehensive review of the literature was conducted using the following search engines: CINHAL Plus, Nursing and Allied Health Collection, and Psychology and Behavioral Sciences Collection. Two search strategies were used to identify articles, a computer assisted search and an analysis of reference lists. The key words used in the search for literature were: compassion fatigue, compassion fatigue clinicians, compassion fatigue intervention, and compassion fatigue critical care. In narrowing the literature, inclusion criteria considered the availability of articles in full text, articles written in the English language, and articles written in the last eight years were most favored.

Quality of Research

The Melnyk Level of Evidence was used to level the evidence for the project. The literature was evaluated and appraised using a leveling scale of one through seven. The Melnyk hierarchy of evidence provides a systematic way for nurses to evaluate and critically appraise literature (see Appendix A) (Melnyk, 2016). A single reviewer reviewed the research. A total of 21 articles were appraised and leveled. The results of the literature review according to Melnyk were as follows: 7 level I articles, 6 level IV
articles, 6 level V articles, and 2 level VI articles. Most of the literature focused on defining CF, its effects on healthcare clinicians, and strategies to combat it. These articles were chosen because of the relevance to the subject matter.

**Compassion Fatigue**

Compassion fatigue is defined as emotionally exhausted, depressed, having general anxiety, and feeling that one may have failed in their profession; as a result of this, nurses feel they no longer have the capacity to nurture patients (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). It is seen as a progressive and cumulative outcome of prolonged, continuous, and intense contact with patients, self-utilization, and exposure to multidimensional stress leading to a compassion discomfort that exceeds nurse’s endurance levels (Zhang, Zhang, Han, Li, & Wang, 2018). Critical care nurses typically work 12 hour shifts; taking care of the same patients. Due to the length of time nurses spend with their patients and families of their patients, close relationships have the potential to form, which may result in an increased stress level and strain of coping with the death of their patients (Aycock & Boyle, 2008). The feelings of being isolated, overloaded, underappreciated, and a decreased awareness of the impact their work has on their emotions may contribute to a higher incidence of CF (Aycock & Boyle, 2008).

Critical care nurses have the potential to take care of individuals who have been involved in traumatic events. Those nurses who are exposed to the same trauma indirectly through their work, may suffer from symptoms that align with CF (Cieslak, et al., 2014). CF is multifactorial and involves different areas of experience, which can be triggered by prolonged professional burdens and lack of support (Nolte, Downing, Temane, & Hasting-Tolsma, 2017). It is important to understand the nature of compassion and its
prevalence and contribution in nursing. Compassion must be represented by measureable data, so that a clear understanding of CF and how to prevent it can be determined (Ledoux, 2015).

Impact on Nurses

CF is a phenomena of interest that can be manifested with physical symptoms such as feeling worn out, fatigue, and generalized aches and pains (Nolte, Downing, Temane, & Hasting-Tolsma, 2017). Emotional symptoms such as hopelessness, frustration, despair, incompetency, impotence, isolation, and “opting out” as the only way to cope with their situation are also symptoms of CF (Nolte, Downing, Temane, & Hasting-Tolsma, 2017). CF is impacts many healthcare clinicians. There is a need for resilience in nursing as it relates to CF to support the healthcare clinician’s decision making (Potter, et al., 2013).

Critical care nurses has been identified as a population that is more susceptible to burnout due to high acuity, high volumes, families in crisis, increased responsibility, and a strong dependency on technology (Epp, 2012). Hooper, Craig, Janvrin, Wetsel, & Reimels (2010) also found a tendency for nurses who were isolated in their specialty to focus on the specific stressors in their own environment and lose sight of challenges that nurses in other specialties face in maintaining empathetic and caring attitudes with patients they care for on a daily basis.

Shoji, et al., (2015) identified that age, experience, and the profession played a role in CF. The strongest associations between burnout and self-efficacy identified older individuals or those with more experience, where previous studies showed that the same attributes of age and experience may be related to lower levels of CF (Shoji, et al., 2015).
The degree of CF can vary depending on the patient population as well as the nurse’s personal circumstance (Sacco, et al., 2015; Shoji, et al., 2015).

**Strategies and Interventions**

There are many interventions and strategies in the literature regarding CF. Out of 21 studies, nine articles addressed strategies and interventions. It is imperative that organizations recognize CF as a pressing issue in healthcare. It is further recommended that they impact this issue by providing resources and support to their staff. Identifying how organizations can impact CF and burnout by providing resources to support their staff members is imperative in the workforce (Epp, 2012; Klein, et al., 2018). Having a keen awareness of one’s self and participating in self-care practices can decrease the incidence of CF (Henry, 2014; Klein, et al., 2018). McKeekin et al. (2017) identified the importance of the availability of organizational support to help mitigate the severity of psychological distress and CF.

Lee, et al. (2016) identified cognitive-behavior training or emotional coping programs as interventions that can provide long-term emotional relaxation and change. Positive reappraisal is also included in the cognitive restructuring and reinterpretation of individuals' situations to improve the individuals' self-esteem and promote successful coping skills (Lee, Kuo, Chien, & Wang 2016; Potter, et al., 2013). Practicing self-care and self-awareness has been shown to decrease CF (Henry, 2014; Klien, et al, 2018). Multiple behaviors are used together that may be maladaptive or ineffective, blunting the effects of the positive behaviors that are encouraged (McMeekin, et al., 2017). This means that looking at CF from one demention will not have a significant impact on the
problem, the impact will come when there is a multidimensional approach from both a

cognitive and behavioral standpoint.

**Conceptual Framework**

The Iowa Model of Evidence-Based Practice is used to promote a systematic
method of practice change within organizations that are in need (Schmidt & Brown,
2014). The model addresses the different triggers that make the practice change important
to an organization, the purpose of the change, and team members who will be involved in
the change. The Iowa Model of EBP was used as the conceptual framework for this
scholarly project.

The Iowa Model of EBP is widely used in the U.S. and around the world, as a
framework to guide the evidence-based practice process (Iowa Model Collaborative
[IMC], 2017). Permission was obtained from the University of Iowa, to utilize the model
for this scholarly project (see Appendix N). The steps in the Iowa Model of EBP include:
identifying triggers for the project; stating the question or purpose; identifying if the topic
is a priority; forming a team; assembling and synthesizing the evidence; assessing if the
evidence is sufficient; designing and piloting the practice change; assessing the change to
see if it is appropriate for adoption in practice; integrating and sustaining the practice
change and disseminating the results (IMC, 2017).

**Triggers**

CF has been a catalyst in generating new research in nursing resilience. New
research is listed in the IOWA Model as a knowledge focused trigger. Currently, the
setting for the scholarly project does not measure CF in the critical care environment.
This project established baseline data for CF in the CCU setting.
Organizational standards are listed as a knowledge focused trigger. The knowledge focused triggers for this project were the lack of knowledge regarding CF among clinicians in the CCU setting. Increasing the knowledge of CF among clinicians is paramount to support improved retention rates in the profession.

**Purpose**

The purpose of this scholarly project was to raise awareness of CF among healthcare clinicians in the CCU setting of a community-based hospital and to provide them with strategies and interventions that can be utilized to combat this pressing phenomena of interest. There was no baseline data at the time of the study on the nursing unit for CF.

The clinical question asked: does an educational intervention regarding CF and its proven strategies and interventions for healthcare clinician’s impact the healthcare clinician’s awareness of CF in the CCU setting? This is important to the organization because of the physical and emotional symptoms that CF can cause (Nolte Downing, Tenmane, & Hasting-Tolsma, 2017). Identifying how organizations, can impact CF and burnout by providing resources to support their staff members is imperative in the workforce (Epp, 2012; Klein, et al., 2018).

**Team**

Following the recommendations of the Iowa Model of EBP, a team was formed. The team consisted of the project chair, the project leader, the nurse educator, and the Director of Nursing on the CCU. The team worked together to design and implement the project. The project chair provided approval for the project. Permission to perform the project was granted from the Institutional Review Board (IRB) at the University and also...
at the institution where the CF project took place (IMC, 2017). Support from the Nursing Director of the CCU was also obtained for the project (see Appendix K). The results have been evaluated to see if the change is appropriate to be adopted in to practice per the steps of the Iowa Model of EBP (IMC, 2017).

**SECTION THREE: METHODOLOGY**

This scholarly project was an evidence-based practice (EBP) project. A quasi-experimental approach was used to collect and analyze data. The framework for the project was the Iowa Model of EBP. The project implemented an educational intervention for RNs and PCTs about CF in the critical care setting of a community-based hospital within the CCU. A pre-test, pre-survey, post-test and post-survey were administered to assess knowledge of CF and the reduction strategies and interventions to combat CF among RNs and PCTs in the CCU.

**Variables**

The independent variable for the project was an educational intervention for CF on the CCU for RNs and PCTs. The dependent variables included awareness of CF, and the strategies and interventions to combat it within the RNs and PCTs in the CCU setting.

**Design**

The design for this scholarly project was a quasi-experimental design. Quasi-experimental designs serve to provide a way to identify causality (Schmidt & Brown, 2014). The relationships between the variables were reviewed to determine the effectiveness of the CF educational intervention among healthcare clinicians in the CCU setting.
The pre- and post-tests regarding CF were each a variable. The pre-test identified what the participants already knew about CF and the strategies and interventions of CF prior to the educational intervention. The post-test was used after the intervention to identify if there was any change in the healthcare clinician’s knowledge of CF. The ProQol 5, a validated survey was also given at the time of the pre-test to determine a baseline level for CF. After two weeks, another ProQol 5 survey was administered among the clinicians on the CCU to determine if any of the interventions that were discussed in the educational intervention were utilized. Changes in the dependent variable from the initial test regarding the clinician’s knowledge of CF were compared to the post-test.

**Measureable Outcomes**

A comparison of the pre- and post-test on knowledge about CF, after specific education that explained the definition, signs/symptoms, and how to combat CF was used to measure the outcomes. The targeted outcomes of the scholarly project included:

1) After a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an improved awareness of CF.

2) After a CF educational intervention, clinicians in the CCU setting will demonstrate an improved awareness of strategies and intervention to reduce CF.

3) After a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an increased utilization of strategies and interventions to reduce CF.

4) Two weeks after a CF educational intervention the ProQol 5 scores will decrease.
The first two outcomes were assessed before and after the clinicians completed the CF educational intervention using a pre- and post-test. The two tests assessed for participants awareness of CF, as well as interventions and strategies to cope with CF (see Appendix E for the pre-test and Appendix F for the post-test). The ProQol 5 post-survey was used two weeks after the educational intervention to attain a measure of the level of CF among RNs and PCTs (Appendix F for post-survey and Appendix I for educational intervention). The post-test also assessed additional qualitative feedback from clinicians to see if they found the CF educational intervention helpful and if they noticed any changes in patient outcomes.

**Setting**

The community-based hospital is a non-profit, magnet designated facility. The CCU has 10 beds with 26 RNs and six PCTs. This hospital is located on the outskirts of the state capital of Virginia, serving populations from urban, suburban, and rural outlying areas. CF is the progressive and cumulative outcome of prolonged, continuous, and intense contact with patients, self-utilization, and exposure to multidimensional stress leading to a compassion discomfort that exceeds nurse’s endurance levels (Zhang, Zhang, Han, Li, & Wang, 2018). The RNs in the CCU setting are responsible for responding to all rapid responses called in the hospital. A rapid response is an alert that is called for a patient who is deteriorating and immediate intervention is needed. Many times these rapid responses deteriorate into a resuscitation effort. This puts the nurse who responds in repeated stressful situations, which can lead to CF. On average the CCU RNs respond to 80 rapid responses throughout the hospital per month.
This scholarly project aligned with the mission of the organization, which states, “to bring compassion to healthcare and to be good help to those in need, especially those who are poor and dying. As a system of caregivers, we commit ourselves to help bring people and communities to health and wholeness as a part of the healing ministry of Jesus Christ and the Catholic Church” (Bon Secours, 2018). The project further supported the code of ethics, which is based on Jean Watson’s Theory of Human Caring. The code states, “Jean Watson’s Theory of Human Caring, our foundational nursing theory, and Relationship-Based Care, our nursing care delivery model, focuses on the value of all human beings and integrates care for self, colleagues and patients/families into the model” (Bon Secours, 2018). This scholarly project focused on providing RNs and PCTs with education regarding CF, and clearly supported of the organization’s code of ethics. The project further supported improving the quality of care provided by RNs and PCTs. Support for the project was provided by the unit director of the (see Appendix K).

Sample

A convenience sample was used for the scholarly project. Mateo & Foreman (2014) identify convenience sampling, as sampling of the individuals who were close at hand. The project sample consisted of healthcare clinicians (RNs and PCTs) working in the CCU who volunteered to participate in the project. To be included in the sample, the subject had to be a RN or PCT working on the CCU. The subjects also had to commit to participation in all aspects of the project including the pre-test, ProQol 5 pre-survey, educational intervention, and the post-test and ProQol 5 post-survey that was administered two weeks later. Clinicians not identified as a RN or PCT on the CCU were excluded from project participation.
Subjects

There were 32 clinicians invited to participate in the scholarly project. The participants who were invited included: 26 registered nurses and 6 PCTs on the CCU.

Informed Consent

After approval from the university and the hospital’s IRB permission was obtained the project leader sent an email to the RNs and PCTs on the CCU describing the purpose of the scholarly project (see Appendix K). A consent form was included in the initial email along with the dates and times of the educational intervention (see Appendix M). The ProQol 5 pre-survey was given prior to the educational intervention and the pre-test. The clinicians were assured that confidentiality would be maintained. The decision to participate or to not participate did not affect their job security.

Ethical and Cultural Considerations

The project leader completed the Collaborative Institutional Training Initiative (CITI) to make sure human subjects were protected and ethical considerations were made (see Appendix L). The scholarly project was presented and then defended to the project leader’s Chair for approval. After the Chair’s approval, permission from the university’s IRB and the hospital’s IRB was obtained.

Protection of Human Rights

The scholarly project involved minimal risk to participants. The only intervention that was performed was educational. Clear information about the project and obtaining an informed consent before participation in the scholarly project ensured the participant’s rights were adequately protected (Mateo & Foreman, 2014). The results were collected and entered into a password-protected Excel spreadsheet and saved on a password-
protected computer only accessible by the project leader. The data will be kept for three years after completion of the project, and no copies will be made. After three years, the information will be deleted from the computer using commercial software to permanently delete data. No identifying information of the participants will be included in any presentation of this scholarly project.

**Instruments/Tools**

Several tools and instruments were used to support the scholarly project. A PowerPoint, devised by the United States Department of Justice (DOJ) was the basis for the educational intervention of the RN’s and PCTs. The PowerPoint on CF was developed by the DOJ for healthcare providers who consistently provide care to victims who have been through a traumatic experience (see Appendix I) (Department of Justice, 2018). This places the DOJ healthcare workers in a situation that presents prolonged stress, making these healthcare workers candidates for CF. There was a pre-test (see Appendix E) and a ProQol 5 pre-survey (see Appendix G) prior to the educational intervention (see Appendix I). After two weeks a post-test (see Appendix F) and ProQol post-survey (see Appendix G) was administered to the RNs and PCTs in the CCU to evaluate their knowledge and coping skills regarding CF before and after the intervention.

The ProQol 5 (Professional Quality of Life Scale), a validated survey, was administered prior to the pre-test; and two weeks after the implementation of the educational intervention the same ProQol 5 survey was administered. The ProQol 5 is a validated survey from the CF Awareness Project, used to measure the affects of helping others who have been through a traumatic event or who are suffering (Compassion
Fatigue, 2018). The survey was used to assess if the level of CF changed with the intervention.

**Intervention**

In this scholarly project, the project leader implemented a pre-test to assess the clinician’s knowledge about CF and a pre-survey, the ProQol 5, to determine if the clinician was experiencing CF. An educational intervention was presented to clinicians on the CCU. Castillo-Montoya (2016) identified that learning in contexts other than the classroom provides a strong learning base for the subject matter. The intention of presenting an educational module on CF after the RNs and PCTs may have already experienced CF, will increase the understanding of CF. The educational intervention was presented during a lunch and learn on the unit. The project leader offered this at shift-change to try to impact the most staff members. This was done a total of five times. Two weeks after the CF educational intervention, a post-test and ProQol 5 were administered to assess the use of coping interventions presented in the CF education and to see if the ProQol 5 scores decreased.

**Implementation**

The implementation of the project consisted of a pre-test to determine the clinician’s awareness of CF (see Appendix E), and the ProQol 5, as a pre-survey tool. A PowerPoint educational intervention was administered at lunch and learns to raise awareness of CF among the clinicians on the CCU (see Appendix I). After two weeks, the post-test and ProQol 5 was administered again to determine the use of coping interventions that were taught in the educational intervention and to see if the ProQol 5 scores decreased (see Appendix G).
Data Collection

A number was assigned to the participants of the study for each of the pre-tests, ProQol 5 pre-surveys, post-tests, and ProQol 5 post-surveys. Basic demographics were collected on the pre-test, including the number of years experience in healthcare, job title, and gender. This information was used to look at CF awareness and use of strategies and interventions among participants. The differences in the pre-test and the post-test, as well as the ProQol 5 pre-survey and ProQol 5 post-survey for each participant was tracked by a randomly assigned number that each participant entered into each test and survey. This number was included in the second email that participants received and allowed the project leader to suggest correlation between the pre-test and ProQol 5 pre-survey to the post-test and ProQol 5 post-survey. This data is being kept in a password-protected Excel spreadsheet and was further analyzed by a statistician.

Feasibility

The following information was taken into consideration to determine the feasibility of the scholarly project: technology, personnel, budget, and a cost/benefit analysis.

Technology. The technology that was needed to support the scholarly project included:

- Computer
- Email
- PowerPoint
- SPSS Software
**Personnel.** The personnel who aided in the execution of the scholarly project included:

- Project leader
- Project Chair
- Practicum preceptor
- Director of CCU
- Editor
- Statistician
- Registered Nurses and Patient Care Technicians on the CCU

**Budget/ Cost-Benefit Analysis.** The scholarly project was budget neutral, as there were no direct costs of the facility. The project leader provided lunch during the educational intervention for the participants. The time it took for the nurses to go over the education and the time it took for the clinicians to complete the pre-test, post-test, and ProQol 5 pre- and post-survey were completed while the RNs and PCTs were on a break. The ProQol 5 survey and test took no more than 15 minutes each and the educational module took 30 minutes. A total of 1.5 hours was required by each RN and PCT participant in support of the project.

**Statistical Analysis and Evaluation**

Data collected from the pre-test, post-test, ProQol 5 pre-survey, and ProQol 5 post-survey was analyzed using Excel and SPSS software. Descriptive statistics were collected and analyzed to determine if there was a significant difference in CF on the CCU. The pre-test was multiple choice and was examined to gain an understanding of the clinicians’ awareness of CF prior to the educational intervention. The post-test was also
multiple choice and added a qualitative measurement to evaluate and analyze the knowledge of CF gained by the clinicians and their ability to implement what they learned. The statistical analysis was completed with the support of a statistician.

SECTION FOUR: RESULTS

Demographics

A total of 32 healthcare clinicians were invited to participate in the project. There were 16 who met the inclusion criteria to participate. A total of 12 completed all the project tools supporting the intervention. The results are discussed below.

Sample size. Pre- and post-test data was collected from 15 participants \((n = 15)\). The ProQol 5 pre-survey had 16 responses \((n= 16)\) and the ProQol 5 post-survey included 12 responses \((n = 12)\). Those participants who did not complete the ProQol 5 post-test were still included in the data analysis due to the small sample size.

Gender. The pre-test, ProQol 5 pre-survey, educational intervention, the post-test, and the ProQol 5 post-survey was completed by 15 females. One male attended the educational intervention and completed the pre-test, ProQol 5 pre-survey, the post-test, and the ProQol 5 post-survey.

Type of healthcare clinician. RNs and PCTs were both invited to participate in the scholarly project. Fourteen of the participants identified themselves as RNs, one participant identified themself as a PCT (see Figure 1).
Figure 1. Job Title

**Years of practice.** The majority of the healthcare clinicians that participated in the scholarly project were relatively new. The years of experience ranged from one year to 32 years, this is the shaded number on the chart. The frequency describes how many individuals have been a nurse for that length of time. Forty percent of the participants had two years of experience or less in their current role as a RN or PCT (see Table 1).

**Table 1. Clinicians’ Years of Experience**

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>26.3</td>
<td>33.3</td>
<td>40.0</td>
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<td>8</td>
<td>2</td>
<td>10.5</td>
<td>13.3</td>
<td>60.0</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>66.7</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>73.3</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>80.0</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>86.7</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>93.3</td>
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<tr>
<td>32</td>
<td>1</td>
<td>5.3</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>78.9</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Missing Data

Of the participants, 16 completed the informed consent, engaged in the pre-test, and pre-survey. There were 15 participants who participated in the post-test, and 12 who participated in the post-survey. There was no missing data for the pre-test or post-test in regards to questions. There was no other missing data.

Assumptions

There were some assumptions made for the statistical analysis. The participants completed both the pre-test and ProQol 5 pre-survey before the educational intervention. Another assumption was that the participants did not discuss the test or survey questions with their colleagues. The last assumption made was that if the ProQol 5 post-survey was completed, the participant also completed the pre-test, post-test, and the ProQol 5 pre-survey.

Key Findings

The key findings of the CF pre- and post-test were used to evaluate the healthcare clinicians’ awareness of CF and recommended strategies and interventions to cope with it. The pre- and post-test consisted of 10 multiple choice or true/false questions with an additional three demographic questions on the pre-test and two on the post-test. The qualitative question on the post-test was grouped into four categories (see Figure 3). The categories included time off, self-care, change schedule, or no plan at this time. The ProQol 5 pre- and post-survey consisted of 30 questions on a Likert scale. The questions were compared from the ProQol 5 pre-survey to the ProQol 5 post-survey after the educational intervention.
Descriptive statistics. The descriptive statistics for the pre-test showed a mean of 6.7500, standard deviation of 1.28806, and standard error mean of 0.37183. The post-test descriptive statistics showed a mean of 7.500, standard deviation of 0.90453, and standard error mean of 0.26112.

Table 2. Paired Samples Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test total</td>
<td>6.7500</td>
<td>12</td>
<td>1.28806</td>
<td>0.37183</td>
</tr>
<tr>
<td>Post-test total</td>
<td>7.5000</td>
<td>12</td>
<td>0.90453</td>
<td>0.26112</td>
</tr>
</tbody>
</table>

Paired t-test. A paired-samples t-test was performed to determine the pre- and post-intervention means of CF awareness. The results suggest that the mean before the intervention ($m = 6.750$, $sd = 1.288$) is not statistically different at alpha = 0.05, from the post-intervention mean ($m = 7.500$, $sd = 0.904$) with the $p$ value of 0.009 (See Tables 2 and 3).

Table 3. Paired Samples Correlations

<table>
<thead>
<tr>
<th>Total Correct</th>
<th>N</th>
<th>Correlation</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-test and Post-test</td>
<td>12</td>
<td>0.195</td>
<td>0.543</td>
</tr>
</tbody>
</table>

Confidence interval. The 95% confidence interval indicates that plausible values of the mean differences of the pre- and post-intervention range from -1.65364 to -0.15364 (See Table 4). There was no statistical difference between the pre- and post-test.

Table 4. Paired Differences

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference Lower</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td>Pre_total - Post_total</td>
<td>-.75000</td>
<td>1.42223</td>
<td>.41056</td>
</tr>
</tbody>
</table>
Clinical significance. The intervention had a small impact on the mean differences between the time points. The absolute mean difference of 0.750 suggests small differences on the current scale. This mean is not significant enough to conclude that the educational intervention had an impact on the understanding of CF.

ProQol 5 pre- and post-survey. Sixteen participants completed the ProQol 5 pre-survey \((n = 16)\). Twelve participants completed the ProQol 5 post-survey \((n=12)\). Both the ProQol 5 pre- and post-test did not identify CF in the staff in the CCU. Similar to the pre- and post-test, the ProQol 5 pre- and post-survey did not identify any significant differences after the educational intervention.

![Did you find the compassion fatigue intervention helpful?](image)

Figure 2. Clinicians’ Responses to Finding the Intervention Helpful

Short Answer Question

In response to question three of the post-test, “Did you find the compassion fatigue intervention helpful”, 14 of the 15 clinicians found the educational intervention helpful (See Figure 2). A list of the types of strategies and interventions that clinicians have planned to use to combat CF since the intervention included: changing their schedule, self care (such as increased time with hobbies and doing things they enjoy),
time off, and two participants have not yet planned to utilize the strategies presented (see Figure 3).

![Table showing responses to combating CF strategies]

*Figure 3. Clinicians’ Responses to What Was Done to Combat CF in the Post-Test*

**Summary of Findings**

The measurable outcomes for this project included: (1) after a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an improved awareness of CF; (2) after a CF educational intervention, clinicians in the CCU setting will demonstrate an improved awareness of strategies and intervention to reduce CF; (3) after a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an increased utilization of strategies and interventions to reduce CF; and (4) two weeks after a CF educational intervention the ProQol 5 scores will decrease. Each outcome is discussed below.

**Outcome 1: After a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an improved awareness of CF.** While there was no significant difference between the pre-test and post-test, most of the participants reported that they found the CF educational intervention helpful (see Figure 2).
Outcome 2: After a CF educational intervention, clinicians in the CCU setting will demonstrate an improved awareness of strategies and intervention to reduce CF. The findings suggest an increase in awareness strategies and interventions among healthcare clinicians to combat CF; as two weeks after the intervention, 11 of 13 people had clear plans to utilize the recommended strategies taught in the intervention (see Figure 3). While the statistical analysis did not demonstrate clinical significance the results suggest that the healthcare clinicians found the educational intervention useful and they were aware or became aware of recommended strategies and interventions to combat CF.

Outcome 3: After a CF educational intervention, healthcare clinicians in the CCU setting will demonstrate an increased utilization of strategies and interventions to reduce CF. The post-survey results suggest that over half of the healthcare clinicians, 13 out of 15, healthcare clinicians had a plan to utilize the CF strategies and interventions two weeks after the educational intervention (see Figure 3). It is notable that most of the healthcare clinicians found the intervention helpful (see Figure 2); however, because of a small sample size and the loss of four clinicians who did not follow up, it is not clear if the educational intervention caused this plan.

Outcome 4: Two weeks after a CF educational intervention the ProQol 5 scores will decrease. Twelve of the 16 healthcare clinicians who completed the ProQol 5 pre-survey, the pre-test, the educational intervention, and the post-test, also completed the ProQol 5 post-survey. With the ProQol 5 pre-survey, there were no signs of CF among the healthcare clinicians and they reported being happy in their role. Because of this positive nature, the educational intervention did not impact the ProQol 5 post-survey.
SECTION FIVE: DISCUSSION

Limitations

The scholarly project successfully increased the awareness of this issue of CF in the CCU. A strong dialog surrounding this topic with RNs and PCTs who are actively engaged in patient care and are at an increased risk from CF was achieved. The dialogue supported insight about the signs and symptoms of CF as well as ways to combat these symptoms. CF is multifactorial and involves different areas of experience, which can be triggered by prolonged professional burdens and lack of support (Nolte, Downing, Temane, & Hastiing-Tolsma, 2017). It is important to understand the nature of compassion and its prevalence and contribution in nursing. Compassion must be represented by measureable data, so that a clear understanding of CF and how to prevent it can be determined (Ledoux, 2015).

Limitations were noted in the project. The sample for this project was a small convenience sample taken from a specific population of healthcare clinicians in one CCU at a local hospital. Only 16 of the 36 participants invited took part in the project. This limited the generalizability of the results.

The project also had a short time frame (two weeks) for implementation and evaluation, which may have impacted the results of the project. For example, if anyone was on vacation, they would not have received the educational intervention. Also this left a short time frame for any implementation of the project, such as scheduled time off or vacation.
Significance and Implications for Practice

CF can have a significant impact on healthcare clinicians. Research has shown that professionals exposed to trauma indirectly, through their work, may suffer from consequences that can be both emotional and physical (Cieslak, et al., 2014; Nolte, et al., 2017). There is a tendency for healthcare clinicians to focus on the stressors and lose sight of empathy, which may make them feel isolated, overloaded, or underappreciated (Hooper, et al., 2010; Aycock & Boyle, 2008). Nurses may decrease or prevent CF by being able to identify it. Practicing self-care and self-awareness has been shown to decrease CF (Henry, 2014; Klien, et al., 2018). It is important for organizations to provide necessary resources to support healthcare providers to identify stressors, become self-aware, and to participate in self-care practices (Klein, et al., 2018). Implementing a standard to educate and to monitor CF in the RNs and PCTs on the CCU has the potential to decrease CF and decrease turnover as a result of CF. The American Nurses Association Code of Ethics for Nurses identified the importance for nurses to ensure work-life balance to decrease the impact of CF (Al-Majid, et al., 2018). It is essential that CF be raised to a measurable status to make sure that healthcare clinicians have the awareness and opportunities to prevent and cope with CF. The evidence-based scholarly project raised the awareness of the challenges of CF among nurses and patient care technicians (PCTs) in a CCU, and provided them with strategies and interventions that can be used in their daily practice.

Implications for Research

After reviewing the data, opportunities for further research include: conducting the CF project with a larger group of clinicians across other units including but not
limited to the emergency department, critical care units, women’s services, and other units. CF extends itself across all nursing fields in one way or another. Implementing this project among a larger audience will allow for greater generalizability of the results and better understanding of CF in nursing.

**Dissemination Plan**

The project took place at St. Mary’s Hospital, one of the four hospitals within the Bon Secours hospital system. The project will be shared with leadership members within the organization and plans to publish in scholarly journals are being considered. The project will also be shared via scholarly venues to include conventions and conferences.

Objectives related to the dissemination of the project include:

1) To expand healthcare clinician awareness and understanding of CF.
2) To support action by the healthcare system to implement a yearly educational intervention about CF.
3) To promote the use of CF strategies and interventions by healthcare clinicians in their practice.

**Conclusion**

Learning to recognize and combat CF has far reaching implications for nurses across the world due to the nursing shortage. With an estimated attrition rate of 30-50% of new nurses changing positions or leaving nursing completely within the first three years of their career, providing education on CF has the potential to be beneficial (Salmond, 2017). When nurses are being overwhelmed and stressed by tasks, the caring element that nurses are known for can be lost and cause nurses to feel as if they are unable to fulfill their moral responsibilities to the patient (Ledoux, 2015). Healthcare
professionals exposed to trauma indirectly, through work, suffer from symptoms unique to their occupation (Cieslak, et al., 2014). CF is noted as a determinant of nursing retention in health care systems today; yet, there is a documented decreased awareness of CF (Houck, 2014; Sorenson, et al., 2016). There is a lack of training and documented incidence of CF in hospitals. It is imperative that nurses be given education to recognize symptoms and be given education to combat CF (Nolte Downing, Tenmane, & Hasting-Tolsma, 2017). Providing nurses with evidence-based knowledge of what CF is and how to combat it is pivotal for the nursing profession- increasing quality of care of patients and quality of life for practicing professionals.
References


Li, H., Cheng, B., & Zhu, X. P. (2018). Quantification of burnout in emergency nurses: A


Yaklaşımlar, 10(1), 59-70. doi:10.18863/pgy.336495


### Appendix A

CF Literature Review

<table>
<thead>
<tr>
<th>Article</th>
<th>Study Purpose</th>
<th>Sample</th>
<th>Methods</th>
<th>Study Results</th>
<th>Level of Evidence</th>
<th>Study Limitations</th>
<th>Use as evidence to support a change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-Majid, S., Carlson, N., Kiyohara, M., Faith, M., &amp; Rakovski, C. (2018). Assessing the degree of compassion satisfaction and compassion fatigue among critical care, oncology, and charge nurses.</td>
<td>The purpose of this study is to assess the degree of compassion fatigue among critical care, oncology, and charge nurses.</td>
<td>The sample consists of 8 direct care nurses and 10 charge nurses in the critical care and oncology field.</td>
<td>A cross-sectional survey design was used to collect data from nurses working on the oncology and critical care units. A survey was given to 65 Critical Care nurses and 43 oncology nurses. The participants were given 6 weeks to complete and return the survey. Two follow up emails were sent as a reminder.</td>
<td>• The only demographic variable associated with Compassion Sensitivity (CS) was number of years of experience in nursing. Nurses who had less than 10 years of experience in nursing had a significantly lower CS score.</td>
<td>Level 4: Cross-sectional study, correlational design</td>
<td>There was a small sample size and a 44% return rate of the surveys.</td>
<td>• Prevention strategies that were talked about in the literature included: providing opportunities for professional development, training nurses to recognize signs and symptoms of Compassion Fatigue (CF) in themselves as well as coworkers, promoting team debriefing activities after traumatic or stressful events, and engaging</td>
</tr>
</tbody>
</table>
and charge nurses. *The Journal of Nursing Administration, 48*(6), 310-315. doi:10.1097/NNA.0000000000000620

Aycock, N. & Boyle D. (2008). *Interventions to manage compassion fatigue* to replace the nurses in stress reduction techniques, which also encourage positive coworker relationships.

- The American Nurses Association Code of Ethics for Nurses identified the nurses’ responsibility to ensure work-life balance to decrease the impact of CF.

<table>
<thead>
<tr>
<th>Purpose of the article</th>
<th>A group of 231 chapter presidents of Oncology Nursing Society</th>
<th>A survey was given to the Oncology Nursing Society it was requested to be completed and returned within three weeks. The survey asked questions</th>
<th>Only 22% of survey participants reported access to on-site professional support, 45% had not had the opportunity for training for coping</th>
<th>Level 6: Descriptive Study</th>
<th>A small sample size of 103 Not all Oncology Nursing Society’s met</th>
</tr>
</thead>
</table>

- Stress from close relationships with patient and families can increase the strain of dealing with death.

- Oncology nurses who feel isolated, over-

- Only 22% of survey participants reported access to on-site professional support, 45% had not had the opportunity for training for coping.

- A small sample size of 103 Not all Oncology Nursing Society’s met

- Concept of burnout in oncology nurses, made up the sample. About on site professional support for nurses, education regarding coping skills, and off site retreat to promote renewal. Skills, and only 10% had an opportunity for a yearly retreat. Over the summer when the survey was distributed. Overloaded, unappreciated, and who are in denial about the impact of work on their emotions have higher incidence of compassion fatigue.

- Responses such as “hang in there” or “everyone else seems to be handling it okay” without the availability of professional resources to aide nurses in distress will continue to fail in providing necessary training and support to a cadre of nurses experiencing compassion fatigue.
The meta-analysis investigated the relationship among job burnout and psychosocial consequences of a secondary exposure to trauma (i.e., compassion fatigue, secondary PTSD, or vicarious trauma; collectively, secondary traumatic stress [STS]) in professionals working with traumatized clients. After the data was collected, it was categorized into two main areas of negative consequences: PTSD-like symptoms and vicarious trauma. A two-model burnout diagram looked at disengagement and exhaustion.

- The results of the meta-analysis provided the first quantitative synthesis of research on the relationships between job burnout and STS among professionals working with traumatized clients.
- The meta-analysis investigated the relationship between STS and job burnout among employees indirectly exposed to trauma. The indirect exposure could be due to contact with clients or patients who have experienced traumatic events or due to an exposure to other traumatic materials. High levels of burnout and other consequences of indirect exposure to trauma are likely to

### Limitations of the meta-analysis

- Language interpretation variations from English to other languages when the survey is given.
- The level of secondary exposure to trauma was not accounted for in the analysis, because several original studies did not assess the exposure. Other confounding variables, such as personal

### There is a strong relationship between job burnout and STS

Recent research on mental health providers has extended the focus beyond job burnout to investigate the consequences of exposure to specific stressors, such as contact with people who have experienced traumatic events, exposure to graphic trauma content (reported by the survivor), or exposure to people’s cruelty to one another

- Professionals exposed to trauma indirectly, through their work, may suffer from consequences or symptoms unique to this occupational
| Henry, B. J. (2014). Nursing Burnout Interventions. Clinical Journal of Oncology Nursing, 18(2). 211-214. https://doi.org/ezproxy.liberty.edu/10.1188.14.CJON.211-214 | The purpose of this article is to compare different interventions for compassion fatigue. N/A | A literature search of CINHAL and PubMed were conducted. 10 articles from 2005-2013 were identified. A cumulative table of interventions was compiled. Six areas of burnout were identified as: workload, control, reward, community, fairness, and values. Possible interventions to help combat these areas of burnout were also listed. | Level 6: Literature Review | Lack of objective measurement tools and experimental design to evaluate efficacy. |

### Summary

- Burnout and job stress have increased, in part, because of technology, insurance changes and demands, and the vast amount of new education needed to understand current and expanding oncology treatment and disease knowledge.
- Nurses may decrease or prevent burnout by practicing self-care and encouraging treatment centers to support burnout intervention programs.
Organizations that implement burnout interventions may experience increased retention, reduced turnover and performance problems, and increase patient satisfaction.

<table>
<thead>
<tr>
<th>Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., &amp; Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue</th>
<th>The purpose of the study was to determine the prevalence of compassion satisfaction, burnout, and compassion fatigue among emergency nurses. The study was conducted at a level 2 trauma center with 461 beds. Eligible RNs included those who worked in the ED, This study looked at a specific point in time. The nurses were given a survey that they could respond to and return anonymously. 138 surveys were distributed, 114 were returned.</th>
<th>The findings of this study included 49 emergency nurses failed to support the hypothesis at a statistically significant level that emergency nurses are at greater risk for compassion fatigue and burnout compared with the 60 nurses who participated from 3 Level 4: Correlational design, cross-sectional study</th>
<th>The sample size was small and created a limitation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• There is a tendency for nurses who are isolated in their specialty services to focus on the stressors in their own environment and to lose sight that RNs in each area experience their own personal challenges in maintaining</td>
</tr>
</tbody>
</table>

Klein, C. J., Riggenbach-Hays, J. J., Sollenberger, L. M., This study introduced education about compassion fatigue to prevent or address 27 neonatal advanced practice providers at a large Midwester An exploratory, pre–post, interventional pilot study method was used to examine the efficacy of a copyrighted resiliency program aimed at improving • Higher mean scores of burnout and lower scores of compassion satisfaction were reported. This information differed from other studies.

Level 4: Cohort Study There was not consistency in those who chose to enroll in the resiliency program versus those who did not enroll may • Self-awareness acts as a buffer for palliative care professionals, whereas caring for end-of-life patients potentially has empathetic and caring attitudes with patients they care for daily.
| Harney, D. M., & McGarvey, J. S. (2018). Quality of life and compassion satisfaction in clinicians: A pilot intervention study for reducing compassion fatigue. *The American Journal of Hospice & Palliative Care*, 35(6), 882. | negative effects of compassion fatigue. n academic medical center participated in the study. | quality of life as measured by the Professional Quality of Life Scale (ProQOL, Version 5). The survey was given before and 6 months after the completion of the program. | • The pre-intervention findings within this study mirror those reported in other specialty populations of pediatric intensive care unit (ICU) nurses and emergency department nurses be affected by compassion fatigue. Also there was a small sample size. | adverse effects on them as providers. • In order to support their workforce, organizations need to provide necessary resources to support healthcare providers to identify stressors, become self-aware, and to participate in self-care practices. |

The purpose of this study is to examine how compassion fatigue is viewed in nursing.

The literature from 1992-2014 was reviewed regarding compassion fatigue.

The methods were not very detailed. The method stated that CINAHL, Proquest, Nursing and Allied Health Source, PubMed and PsychInfo were searched for primary sources using the keywords compassion and compassion fatigue.

- There is not a match between definitions of compassion and nurse compassion fatigue.
- No theory on nurse compassion and almost no research on the construct of nurse compassion was found. The tools most often used to measure nurse compassion fatigue do not appear to measure the construct of compassion.

Level 5: Systematic review of the literature. No limitations were mentioned in the article.

- Compassion must be raised from an iconic status to a real and measurable attribute.
- Once compassion’s nature, prevalence and contribution in nursing are known then it might be understood what effect there is when compassion is not present or is thwarted.
| Lee, H., Kuo, C., Chien, T., & Wang, Y. (2016). A meta-analysis of the effects of coping strategies on reducing nurse burnout. Applied Nursing Research, 31, 100-110. doi:10.1016/j.apnr.2016.01.001 | This meta-analysis aimed to evaluate the literature on the effects of coping strategies in reducing nurse burnout. 1,521 articles were reviewed in the meta-analysis for each burnout subgroup. Participants were measured immediately after the intervention and 6 months. Systematic reviews of English and Chinese articles were conducted for relevant articles published between 1979 and 2014 in six electronic databases. Coping strategies were hypothesized to decrease burnout. The maintained period for coping strategies was 1 year for emotional exhaustion and depersonalization and 6 months for personal accomplishment. | • Coping strategies can reduce nurse burnout and maintain effectiveness between 6 months and 1 year. • Active coping was used to solve the problem and passive coping was used to regulate emotion. Because the emotion-focused coping strategies emphasize the emotional regulation and help individuals to feel, understand, and express their feelings it could help individuals to know their true feelings. The emotion-focused coping was a more passive approach and helped individuals to regulate their emotions. Level 1: Meta synthesis, a review of qualitative studies. The number of studies analyzed was limited (only 7 articles). The research design focused on RCTs or clinical interventions, most researchers did not describe the method of randomization or the method used to assess adverse effects. If the individuals would like to get long-term emotional relaxation and change, the positive thinking training, such as mindfulness-based programs or cognitive–behavior training was needed. Conversely, the emotion-focused coping also provided positive reappraisal and acceptance. Positive reappraisal also included cognitive restructuring and reinterpretation of individuals' situations to improve the individuals' self-esteem and promote successful coping. |
McMeekin, D., Hickman, J., Ronald L, Douglas, S., & Kelley, C. (2017). Stress and coping of critical care nurses after unsuccessful cardiopulmonary resuscitation. *American Journal of Critical Care: An Official Publication, American Association of Critical Care Nurses*. 490 Critical Care Nurses were recruited online to participate in this study. The 490 nurses were recruited from e-newsletters or social media. The nurses had to have at least 2 years of experience and had to have an unsuccessful resuscitation attempt within a year. The participants took a Post Code Stress Survey, a brief inventory to address coping skills, and PTSD symptoms were measured. Demographics were also collected here.

- A weak correlation between postcode stress score and PTSD was present.
- There was a significant correlation between effective coping behaviors of acceptance, the ineffective coping behaviors or self-distraction and PTSD.

**Level 5: Systematic review of descriptive and qualitative studies**

- The use of nonprobability sampling, which yielded a relatively low response, which may have been biased.
- The availability of institutional support to critical care nurses would mitigate the severity of psychological distress.
- Critical care nurses may use multiple behaviors simultaneously and that maladaptive or ineffective coping behaviors blunt the effects of the positive behaviors.
- Critical care nurses who had institutional debriefing support available had significantly lower postcode stress than critical care nurses who lacked institutional debriefing support.
The purpose of this study was to interpret existing qualitative work on compassion fatigue. The hope was to find a clearer understanding that could be applied to nursing. A meta-ethnographic approach was implemented to identify articles. The meta-ethnographic method includes seven steps: determining the study, determining relevance to initial issue, identifying common themes and concepts, identify how studies are related to each other, search for concepts across data, synthesize findings, and lastly express.

- This meta-synthesis identified four major themes.

The four major themes consisted of physical symptoms, emotional symptoms, factors triggering compassion fatigue, and measures to overcome or prevent compassion fatigue.

Level 1: Meta synthesis, a review of qualitative studies.

Limitations include that all pertinent research may have not been identified in the search. Because the qualitative studies that were examined in this meta-synthesis were completed by different authors, the authors interpretations may differ.

- Compassion fatigue involves many different areas of the human experience and is triggered by prolonged professional burdens and a lack of support.

- Physical symptoms include feeling worn out, fatigue, and aches and pains. Emotional symptoms are hopelessness, frustration and despair, incompetency, impotence, isolation, and “opting out” as the only option.
The purpose of this article is to evaluate a resiliency program designed to educate nurses on compassion fatigue. The sample included 13 oncology nurses who worked in an outpatient infusion center. The nurses were given a Maslach-Burnout Inventory (MBI)- Human Services Survey, ProQol IV, Impact of Event scale, and the Nursing Job Satisfaction scale prior to a 5 week program that required five, 90 minute sessions on CF and resiliency. The participants were given the surveys again after the 5 weeks of training. Long-term benefits from the program were found. Secondary traumatization scores on the ProQOL IV declined immediately after the program, remained down at three months, and then dropped again at six months, with a statistically significant mean difference compared with baseline. A small sample size was identified as a limitation. Also the fact that participants could select to be part of the study indicating they may have been more ready to receive and apply the information.

Understanding complex demands which creates an environment that fosters the inability to care and nurture are the fundamental in understanding compassion fatigue.

- Compassion fatigue is a prevalent among healthcare providers. Resiliency with regards to compassion fatigue may improve decision making, clarity of communication, and patient and nurse satisfaction
- Self-regulation offers an approach to reduce stress during a perceived threat. Working by intention reduces reactivity in the workplace and makes communication
**Forum, 40(2), 180-187.** https://doi-org.ezproxy.liberty.edu/10.188/13.ONF.180-187

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. The purpose of this study is to establish the prevalence of compassion satisfaction and compassion fatigue in adult nurses and to describe 221 nurses in the adult, pediatric, and neonatal critical care fields were assessed for compassion fatigue. A survey was presented to all critical nurses at a 739-bed tertiary care facility. An email was sent out with information on the survey and a link to the survey itself. A reminder was sent out two weeks later. Once nurses completed the survey they were able to enter a code to receive a voucher for $2.50.

- Of the individual demographic factors, few affected the degree of compassion satisfaction, burnout, or secondary traumatic stress.
- Nurses 50 years or older scored higher on the compassion satisfaction scale and lower on the burnout and secondary traumatic stress scales than did their younger.

**Level 4: Cross-sectional study, correlational design**

Limitations include a small sample size and because it was cross-sectional, one bad day could influence the results.

- Nurse leaders can use ProQOL assessment and staff satisfaction scores to measure the effect of work environment interventions.
- Critical care nurses most likely have fluctuating levels of compassion satisfaction and compassion fatigue, depending on the population of

more intentional and, therefore, effective.
The purpose of this meta-synthesis was to conduct an investigation to see if burnout or self-efficacy would be moderated by: (a) the type of measurement of job burnout and self-efficacy, (b) the relationship between self-efficacy and burnout was assessed, or authors provided appropriate statistics upon request; (c) articles reported statistics.

A database search of independent studies examining self-efficacy and job burnout that were available before 2013 was conducted. The inclusion criteria were: (a) self-efficacy and job burnout were measured; (b) the relationship between self-efficacy and burnout was assessed, or authors provided appropriate statistics upon request; (c) articles reported statistics.

The meta-analysis of 57 studies suggested that the association between these constructs was moderate. The findings might indicate that self-efficacy plays a protective factor role against the components of burnout or that low levels of burnout may contribute to higher self-efficacy.

Level 1: Meta-synthesis, a review of qualitative studies.

Limitations included no causal conclusions for self-efficacy and burnout could be made.

- Significant self-efficacy/burnout relationships were observed internationally. Age, experience, and profession played a role in the individual factors as well.

- The meta-regression results indicate that the strongest associations between burnout and self-efficacy occurred among older individuals or those with more work experience. Previous systematic reviews showed that older age or more years of work experience.
Stress, & Coping, 29(4), 367-386. doi:10.1080/10615806.2015.1058369

(b) the type of occupation, (c) the number of years of work experience and age, and (d) employees’ culture or country.

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondeje wski, J., & Smith-MacDonald, L. (2017). The purpose of this article is to critically examine the construct of compassion fatigue and to determine if it is an observable phenomenon. The methods included searching the PubMed, Medline, CINAHL and PsycINFO databases from 1980–2016 using the term ‘compassion fatigue,’ and ISI Web of Science Citation Index was used to identify all articles cited 5 times. All study authors in this review agree that nurses and all healthcare providers reported to be suffering from compassion fatigue are unlikely to be able to deliver quality patient care. Compassion is multifaceted, involving virtues, a proactive response, seeking to...

<table>
<thead>
<tr>
<th>Sorenson, C., Bolick, B., Wright, K., &amp; Hamilton, R. (2016).</th>
<th>The purpose of the article is to identify, review, synthesize, and</th>
<th>The sample consisted of 43 articles that were reviewed.</th>
<th>The literature review examined articles from 2005 to 2015. Search terms included compassion fatigue, compassion satisfaction, secondary traumatic stress, relational communicating, confronting and action.</th>
<th>The current review identified the concept of compassion fatigue as a euphemism for a broad family of occupational stresses uniquely attributed to healthcare providers that lacks construct validity and therefore cannot be empirically validated or measured.</th>
<th>Few studies reviewed discussed the validity of their results.</th>
<th>The lack of a well-constructed concept analysis for CF has created limitations to understanding its effects and identifying strategies to prevent or treat it.</th>
</tr>
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<tr>
<td>accurate descriptor of work-related stress in healthcare providers or more.</td>
<td>understand, relational communicating, confronting and action.</td>
<td>Nurses working in intermediate and critical care vascular units experienced average to high levels of compassion satisfaction, and low to average scores of Level 5: Systematic review of descriptive and qualitative studies.</td>
<td>One study of registered psychiatric nurses in Athens found that women had a significantly higher risk (1.2–8 times) for developing compassion fatigue than men.</td>
<td>Sorensen, C., Bolick, B., Wright, K., &amp; Hamilton, R. (2016). The purpose of the article is to identify, review, synthesize, and</td>
<td>The sample consisted of 43 articles that were reviewed.</td>
<td>The literature review examined articles from 2005 to 2015. Search terms included compassion fatigue, compassion satisfaction, secondary traumatic stress, relational communicating, confronting and action.</td>
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| Underst
| anling | compassion fati
| gue in | healthcare | providers | : A review of current
| analyze the existing literature addressing compassion fatigue in healthcare providers. | stress, burnout, healthcare providers, and bad news. | STS and burnout. | • Clarifying the definition of CF and addressing gaps in research will help clinicians and administrators identify, intervene, and prevent CF in healthcare providers. |

| Wentzel, D. & Brysiewicz, P. (2017). | The purpose of this literature review is to look at different interventions. | N/A | An electronic search of literature from 1992-2015 using CINHAL, PubMed, Web of Science, Google Scholar, and PsycINFO. After a synthesis of 161 Most of the studies were conducted in Western cultures. The article discusses the need for further research in countries around the world. | Level 6: Descriptive Literature Review | Only 31 articles were evaluated. Limited conclusions could be drawn from small studies. | Because of the global increase of patients, compassion fatigue will need to be evaluated more closely to be prevented cross-culturally. |

ns to determine the effectiveness and feasibility regarding interventions to manage compassion fatigue. articles, only 31 articles were included.

| The purpose of this article is to provide an intervention to oncology nurses who are suffering from CF and provide bereavement support to those nurses. | A mixed method study was used. The ProQol scale was used to evaluate CF before the intervention of debriefings after each patient death. There were individuals on staff 24 hours a day and 7 day a week during the second quarter. A post ProQol scale was used after the intervention as well. | There was a 91% return of the second ProQol scale. Using an SPSS program it showed there was no significant difference. To maintain anonymity, the surveys were not matched and an addition question was added to the second ProQol scale, which asked if the initial ProQol scale had been completed. | Level 4: Cohort Study | Limitations include that it was only done on one unit and the intervention lasted 4 months. Participants were also not matched on their data points. |

- There was a notable outcome for participation, which may reflect that the staff wanted the debriefings. The study also showed no difference between the RN’s and the assistive personnel in their CF scores.
<table>
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<tbody>
<tr>
<td>To review literature on nurses’ coping strategies with patient death.<em><a href="#">1</a></em></td>
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<tr>
<td>25 articles were included in this meta synthesis. 16 of the 11 studies were qualitative.</td>
</tr>
<tr>
<td>2272 studies were identified in this literature review. Of these 158 were duplicates 2114 were assessed for eligibility</td>
</tr>
<tr>
<td>Level 1: Meta synthesis, a review of qualitative studies.</td>
</tr>
<tr>
<td>Neonatal, pediatric and adolescent populations were excluded from this review. Some of the coping methods and strategies such as education programs and formal debriefing were highlighted in this review but were not available to the</td>
</tr>
<tr>
<td>• The process of dealing with patient dying and death is a personal experience, perceived differently by each nurse. In this systematic review, the mechanisms nurses used to cope with death were explored, and intrinsic and extrinsic resources were identified as two main means of support, representing diverse coping styles, which enabled them to care for dying</td>
</tr>
<tr>
<td>• A wide range of intrinsic and extrinsic coping strategies have been identified; and there were similarity and contrast in the coping styles that the nurses used to deal with patient death.</td>
</tr>
<tr>
<td>• Some nurses were inadequately prepared to cope with patient death, and the issues of formal education and training for coping have received little research and practice attention.</td>
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<td>-----------------------------------------------------------</td>
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The purpose of the article is to analyze the relationship between structural empower and compassion fatigue. The sample for this meta-analysis included 24 articles. The methods used to conduct the meta-analysis included two individual searches through the same databases, with the same key words. Articles that were initially seen with the keywords. After screening, 82 studies with full texts were found suitable. These retrieved publications were reviewed. Level 1: Meta-synthesis, a review of qualitative studies. The limitations include each of the methodologies in the individual studies they examined were insufficient. Nurses who have strong organizational support feel less powerless. It is vital to keep nurses' values, beliefs, and behaviors in congruence with compassion fatigue patients and experience patient death. Setting boundaries, talking and being heard, spiritual practices and support from co-workers and family members were expressed as major elements of coping with patient death, which have already been reported and described elsewhere as being vital and beneficial for nurses to cope with patient death.

Zhang, X., Ye, H., & Li, Y. (2018). Correlates of structural empower. The sample for this meta-analysis included 24 articles. The methods used to conduct the meta-analysis included two individual searches through the same databases, with the same key words. Articles that were initially seen with the keywords. After screening, 82 studies with full texts were found suitable. These retrieved publications were reviewed. Level 1: Meta-synthesis, a review of qualitative studies. The limitations include each of the methodologies in the individual studies they examined were insufficient. Nurses who have strong organizational support feel less powerless. It is vital to keep nurses' values, beliefs, and behaviors in congruence with compassion fatigue patients and experience patient death. Setting boundaries, talking and being heard, spiritual practices and support from co-workers and family members were expressed as major elements of coping with patient death, which have already been reported and described elsewhere as being vital and beneficial for nurses to cope with patient death.

written in either Chinese or English were searched. articles were subsequently evaluated in line with the inclusion criteria.

- It has been reported that Chinese nurses experience more emotional exhaustion than nurses from Western countries because they undertake more tasks and experience more work stress.

- However, the emotion of all clinical nurses is affected by the organization environment in terms of access to information, support, resources and opportunities related to their duties.

- Too many influencing factors, such as region, economic position of local hospital, social welfare, nurses' experience, and level of education.

- Value or belief systems also make nurses to appreciate their professional roles, and improves the level of their psychological empowerment through optimal use of workplace condition and environment.

Zhang, Y., The aim of this study examined

This study was performed in

Overall, there were 4054 respondents in Level 1: Meta

The participants in the study were

- Compassion fatigue is strongly correlated
| Zhang, C., Han, X., Li, W., & Wang, Y. (2018). Determinants of compassion satisfaction, compassion fatigue, and burnout in nursing: A correlational meta-analysis. *Medicine, 97*(26), e11086. doi:10.1097/MD.0000000000011086 | is to evaluate factors affecting compassion satisfaction, compassion fatigue, and burnout in nursing. Eleven studies were examined, with 4,054 participants. | accordance with the Cochrane Collaboration’s guidelines provided in Cochrane Handbook for Systematic Reviews and is reported in line with the PRISMA statement. The study—involves an appraisal of working nurses to gather information about the factors affecting compassion satisfaction, compassion fatigue and burnout along with related demographic and sociocultural data; the study used Professional Quality of Life (ProQoL) scale as instrument of data collection; and reported correlation | the included studies and overall response rate was 64.34% (38.82, 89.86). Age of the participants was 39.81 years (31.36, 48.27). Percentage of female nurses among respondents was 87.11% (79.48, 94.73) and 65.18% (57.37, 73.00) of the respondents were married. These respondents were serving as nurses since the last 13.39 years (10.23, 16.56). Overall, there was a strong positive association between compassion fatigue and burnout synthesis, a review of qualitative studies. from many departments and different areas of nursing. So the sampling was heterogeneous. with burnout whereas compassion satisfaction has a negative correlation to burnout. • Compassion fatigue is the progressive and cumulative outcome of prolonged, continuous, and intense contact with patients, self-utilization, and exposure to multidimensional stress leading to a compassion discomfort that exceeds nurse’s endurance levels. • Constant exposure to stress and traumatic experiences inherent in nursing profession significantly contribute to the development of a reduced job satisfaction, compassion fatigue,
| coefficient between one or more work/life domain/s and compassion satisfaction, compassion fatigue or burnout. | and burnout leading to a considerably high turnover rate in nursing. |
Appendix B

Melnyk Level of Evidence Pyramid

Reference


Appendix C

Liberty University IRB Approval

March 20, 2019

Keri Tifft
IRB Application 3700: Raising Awareness of Compassion Fatigue among Healthcare Providers in the Coronary Care Unit

Dear Keri Tifft,

The Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Your study does not classify as human subjects research because evidence-based practice projects are considered quality improvement activities, which are not considered “research” according to 45 CFR 46.102(d).

Please note that this decision only applies to your current research application, and any changes to your protocol must be reported to the IRB for verification of continued non-human subjects research status. You may report these changes by submitting a new application to the IRB and referencing the above IRB Application number.

If you have any questions about this determination or need assistance in identifying whether possible changes to your protocol would change your application’s status, please email us at irb@liberty.edu.

Sincerely,

[Signature]

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office
Appendix D

Bon Secours IRB Approval

March 18, 2019

Keri Tiffit, RN

Dear Keri,

Thank you for providing all the documents regarding your project “Raising Awareness of Compassion Fatigue Among Healthcare Providers in the Coronary Care Unit.”

Based on your project’s details and overall objectives, the [redacted] has made a formal determination that it does not fall within the “human subjects research” definition as that term is currently defined in the federal regulations. Therefore, it does not fall within the purview of Bon Secours IRB review, approval, and oversight responsibilities. Further, since there is no identifiable patient data being utilized and transmitted [redacted], the project does not need a Regulatory & Compliance Committee review.

Since this is an EBP/QI project, the only approval you will need is from St. Mary’s Hospital Coronary Care Unit leadership and/or administration. Please verify if any further departmental approvals are required. Our office just makes the determination of whether a project is human subjects research or not, and proceeds accordingly through our IRB process if it meets that criteria.

Congratulations on your project and best wishes for its successful implementation!

Thank you,

Sue

Sue Henderson, CCRC
Senior Human Research Subjects Protections Analyst
Appendix E

Pre-Test

We would like to get a sense of the knowledge and understanding you have about compassion fatigue. Please complete this brief quiz that assesses some key facts regarding compassion fatigue.

1. The unique number that was provided to you in the invitation email: ________________
2. Your job title: ________________
3. How many years of experience you have: ________________
4. Your gender:
   A. Male
   B. Female
5. What is compassion fatigue?
   A. Inability to have empathy for patients who are ill
   B. Tired of caring for others for a 12 hour shift
   C. Cumulative exposure to traumatic stories when helping others
   D. Stress due to feeling over worked
6. Compassion Fatigue is associated with:
   A. Shutting down emotionally
   B. Declining invitations to social gatherings
   C. Disruptions in self-care habits
   D. All of the above
7. Who is at high risk for acquiring compassion fatigue?
   A. Those who work with victims of trauma
   B. Physically demanding position
   C. Students
   D. Those who work at low acuity, high volume facilities
8. Can you tell a person has compassion fatigue by looking at them?
   A. Yes
   B. No
9. What are coping mechanisms for compassion fatigue?
   A. Practicing self-compassion
   B. Be aware of how you are functioning
   C. Meet with supervisor
   D. All of the above
10. Can compassion fatigue impact patient care?
    A. Yes
    B. No
11. I feel like I could be suffering from compassion fatigue.
A. Yes
B. No
12. What is the cost of compassion fatigue?
   A. Exhausted, overwhelmed, lack of connection
   B. Not caring, lazy, tired
   C. Wandering thoughts, carelessness, apathy
   D. Inability to sit still, inability to prioritize patient care
13. How can I prevent compassion fatigue?
   A. Change job position at place of employment
   B. Commit to self-care
   C. Try harder to connect with patients
   D. Decrease patient load
Appendix F

Post-Test

We would like to get a sense of the knowledge and understanding you have gained about compassion fatigue from the educational intervention. Please complete this brief quiz.

1. The unique number that was provided to you in the invitation email: 
   ____________________

2. I attest that I have completed the educational PowerPoint presentation at the lunch and learn.
   A. Yes
   B. No

3. What is compassion fatigue?
   A. Inability to have empathy for patients who are ill
   B. Tired of caring for others for a 12 hour shift
   C. Cumulative exposure to traumatic stories when helping others
   D. Stress due to feeling over worked

4. Compassion Fatigue is associated with:
   A. Shutting down emotionally
   B. Declining invitations to social gatherings
   C. Disruptions in self-care habits
   D. All of the above

5. Who is at high risk for acquiring compassion fatigue?
   A. Those who work with victims of trauma
   B. Physically demanding position
   C. Students
   D. Those who work at low acuity, high volume facilities

6. Can you tell a person has compassion fatigue by looking at them?
   A. Yes
   B. No

7. What are coping mechanisms for compassion fatigue?
   A. Practicing self-compassion
   B. Be aware of how you are functioning
   C. Meet with supervisor
   D. All of the above

8. Can compassion fatigue impact patient care?
   A. Yes
   B. No

9. I feel like I could be suffering from compassion fatigue.
   A. Yes
   B. No
10. What is the cost of compassion fatigue?
   A. Exhausted, overwhelmed, lack of connection
   B. Not caring, lazy, tired
   C. Wandering thoughts, carelessness, apathy
   D. Inability to sit still, inability to prioritize patient care

11. How can I prevent compassion fatigue?
   A. Change job position at place of employment
   B. Commit to self-care
   C. Try harder to connect with patients
   D. Decrease patient load
Appendix G

Professional Quality of Life Scale (ProQOL) Pre- and Post-Survey

https://www.proqol.org/uploads/ProQOL_5_English.pdf
Appendix H

Permission for ProQol Survey

© B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). © www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.
Appendix I

Educational Intervention

Module 10
Compassion Fatigue and Self-Care

Learning Objectives
- Describe the symptoms and effects of compassion fatigue.
- Identify actions and behaviors that violate healthy boundaries.
- Develop a personalized self-care plan to prevent compassion fatigue.

Compassion Fatigue
- Advocates get doses of the trauma while helping survivors to heal.
- Work also provides meaning and reward.

Survivors as Advocates
- Often become particularly sensitive to fears and concerns of victims, and the magnitude of their needs.
- May have had a positive or disappointing experience with the system.
- May seek to continue healing.
- May or may not have greater empathy.
- Wounds may reopen.

Vicarious Trauma
Vicarious trauma is a cognitive shift in beliefs about one's self or one's world view about issues such as safety, trust, or control.
For example, hearing about a particularly horrible event might compromise one's trust or faith in humanity.

(Stewart and MacNeil 2016)
Secondary Traumatic Stress

Secondary traumatic stress (STS) results from bearing witness to another person’s trauma via an empathetic relationship, often resulting in anxiety and intrusive thoughts—however, STS is a normal reaction to the stressful and sometimes traumatizing work with survivors. STS may occur independently or co-occur with vicarious trauma.

(Newell and MacNeil 2010; Rosenbloom, Pratt, and Peartman 1995)

**Conditions Affecting Advocates**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Who is Affected</th>
<th>Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Fatigue</td>
<td>Those who work with trauma survivors.</td>
<td>Develops over multiple exposures to traumatic stories.</td>
</tr>
<tr>
<td>Vicarious Trauma</td>
<td>Those who work with trauma survivors.</td>
<td>May develop from exposure to one or more instances.</td>
</tr>
<tr>
<td>Secondary Traumatic Stress</td>
<td>Those who work with trauma survivors.</td>
<td>May develop from exposure to one or more instances.</td>
</tr>
<tr>
<td>Burnout</td>
<td>Anyone in a stressful work environment.</td>
<td>Develops over time.</td>
</tr>
</tbody>
</table>

**Disruptions in Frame of Reference**

- Likely to experience disruptions in your sense of who you are.
- Disrupted worldview.
- Spirituality challenged.
- Intrusion of sexually traumatic images.

**Disruptions in Self-Capacities**

- Shut down emotionally.
- Refuse social engagements or activities.
- Disruptions in self-care habits.

**Disruptions in Ego Resources**

Disruption of your abilities to effectively meet your psychological needs and manage interpersonal relationships.
Costs of Working With Survivors

- Increasingly difficult to attend to survivors with empathy, hope, and compassion.
- Caregivers and supervisors must be aware of this possibility and recognize early symptoms.
- Remain connected to survivors and protect yourself emotionally by remaining conscious of the broader context.

Costs of Compassion Fatigue

Caregivers often work in a culture where it is largely unacceptable to talk about feeling exhausted, overwhelmed, or not connecting with victims. Pay attention to how you are affected by your work, and prioritize your own self-care.

Activity

**Boundaries Checklist**

*Worksheet 10.1*

Meet With a Supervisor

- Difficult, new, or unusual cases.
- Cases involving vicarious trauma.
- Cases with boundary issues.
- Cases in which you are meeting with the victim frequently.
- Cases similar to your own victimization.

Strategies for Self-Care

- Commit to replenishing yourself.
- Practice self-compassion.
- The alternative is to continue doing advocacy at an impaired level or leave the field.
- Be aware of how well you are functioning.
- Meet with your supervisor.

Activity

**Self-Care Planning**

*Worksheet 10.2*
Review of Learning Objectives

- Describe the symptoms and effects of compassion fatigue.
- Identify actions and behaviors that violate healthy boundaries.
- Develop a personalized self-care plan to prevent compassion fatigue.

End of Module 10

Questions? Comments?

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Appendix J

Permission for Educational Intervention
Appendix K

Letter of Support

October 10, 2018

Attention: IRB

IRB Members:

Mrs. Keri Tiffi, a Doctor of Nursing Practice Student, has proposed to conduct her Scholarly Project related to compassion fatigue in the Coronary Care Unit at Bon

Mrs. Tiffi’s Doctor of Nursing Practice Scholarly Project aligns with commitment to their employees to foster a work environment that supports pressing issues. Operating under the auspice of Jean Watson’s Theory of Human Caring, this project will help our system to invest more in our clinicians at the bedside.

Hospital is pleased to support Mrs. Tiffi’s Doctor of Nursing Practice Scholarly Project on Compassion Fatigue in the Coronary Care Unit.

Please feel free to contact me if I can be of further assistance.

Respectfully,

CCU Nurse Director
Appendix L
CITI Training

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS

*NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- Name: [Redacted]
- Institution Affiliation: [Redacted]
- Institution Email: [Redacted]
- Institution Unit: [Redacted]
- Curriculum Group: Human subject - Basic
- Course Learner Group: Nursing
- Stage: Stage 1 - Basic Course
- Description: This course is appropriate for students doing class projects that qualify as "No More Than Minimal Risk" human subjects research.
- Record ID: [Redacted]
- Completion Date: [Redacted]
- Expiration Date: [Redacted]
- Minimum Passing: [Redacted]
- Reported Score: [Redacted]

REQUIRED AND ELECTIVE MODULES ONLY

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<td>Liberty University (ID: 15111)</td>
<td>04-Feb-2017</td>
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For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprograms.org/verify?h=7aad5659-b24e-d9fa-a862-21f1d3940417-17561174
COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on the Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- Name: [Blank]
- Institution Affiliation: [Blank]
- Institution Email: [Blank]
- Institution Unit: [Blank]
- Curriculum Group: Human subject - Basic
- Course Learner Group: Nursing
- Stage: Stage 1 - Basic Course
- Description: This course is appropriate for students doing class projects that qualify as "No More Than Minimal Risk" human subjects research.
- Record ID: [Blank]
- Report Date: [Blank]
- Current Score**: [Blank]

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES

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<th>Module Description</th>
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<th>SCORE</th>
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Appendix M

Consent Form

Raising Awareness of Compassion Fatigue Among Healthcare Providers in the Coronary Care Unit
Keri Tifft
Liberty University
Doctor of Nursing Practice Program, School of Nursing

You are invited to take part in an evidence-based practice project to increase your awareness of the challenges of compassion fatigue and the recommended strategies and interventions that you can utilize to cope with or prevent compassion fatigue. You were selected as a possible participant because you are at a high risk of experiencing compassion fatigue as the nature of your current position. Please read this form carefully and ask any questions you may have before agreeing to participate in the project.

What the Project is About: The purpose of this project is to raise the awareness of compassion fatigue among healthcare clinicians on the CCU; and to provide them with strategies and interventions that they can utilize in their practice. The goal is to provide the healthcare clinicians with the knowledge base to identify what compassion fatigue is and measure to help prevent or cope with compassion fatigue.

What You Will be Asked to Do: If you agree to be in this project, I would ask you to do the following things:

1. You will be sent an email with a link to a pre-test through Survey Monkey, which will ask you questions related to health literacy and recommended strategies and interventions. This is to see what you already know regarding compassion fatigue and if you are using any strategies and interventions in your practice. This will take two to five minutes to complete. All responses will remain confidential.
2. You will be asked to sit in on a lunch and learn about compassion fatigue. This will take fifteen minutes.
3. You will take a post-test through Survey Monkey, which will ask you questions related to compassion fatigue and the recommended strategies and interventions. This is to see what you learned about compassion fatigue from the PowerPoint presentation and learning module. This will take two to five minutes. All responses will remain confidential.
4. Two-weeks after completing the post-test you will receive a post-survey via email through Survey Monkey. This will ask if you are using any compassion fatigue strategies or interventions in your practice, your thoughts on the education you received, and if you have noticed any changes in your practice. This will take two to five minutes. All responses will remain confidential.

Risks and Benefits: I do not anticipate any risks to you for participating in this project other than those encountered in everyday life.
The direct benefits that you should expect to receive from taking part in this project include improving your knowledge of compassion fatigue and the challenges that healthcare providers can face; increased awareness and understanding of the recommended strategies and interventions that you can use in your practice; and the ability to utilize strategies and interventions in your practice, which will help to build on the excellent care that you already provide.

Benefits to participants include decreased incidence of compassion fatigue and an increased knowledge of strategies and interventions to cope with compassion fatigue.

Compensation: You will not receive any financial compensation for being part of this project.

Confidentiality: The records of this project will be kept private. Any type of report that I might publish, will not include any information that will make it possible to identify a participant. Records will be stored securely with special encrypting software, and only the project leader will have access to the records. I may share the data that I collect from you for use in future research studies or with other researchers; if I share any of the data that I collect about you, I will remove any information that would identify you, if applicable, before I share the data.

Survey Monkey will be used to collect the information in the pre-test, post-test, and post-survey.

Voluntary Nature of the Project: Participation in this project is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University, or Bon Secours Health System. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Project: If you choose to withdraw from the project, please contact the project leader at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in the project.

Contacts and Questions: The project leader conducting this project is Keri Tifft, MSN, RN. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at: ktifft2@liberty.edu.

If you have any questions or concerns regarding this project and would like to talk to someone other than the project leader, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., or email at irb@liberty.edu.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. By completing the pre-test through Survey Monkey, I consent to participate in the project.
Appendix N

Permission to Use Iowa Model

Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care

You have permission, as requested today, to review and/or reproduce The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care. Click the link below to open.

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