

UC Irvine

UC Irvine Electronic Theses and Dissertations

Title

Decreasing Compassion Fatigue in Emergency Nurses through Resilience Training

Permalink

<https://escholarship.org/uc/item/9m90w1hv>

Author

HERNANDEZ-RAMIREZ, NORMA

Publication Date

2022

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA,
IRVINE

Decreasing Compassion Fatigue in Emergency Nurses through Resilience Training

DNP Scholarly Project Paper

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF NURSING PRACTICE

in Nursing Science

by

Norma D. Hernandez-Ramirez

DNP Project Team:
Associate Professor Amir M. Rahmani, Co-Chair
Associate Clinical Professor Director Nicole Martinez, Co-Chair

2022

DEDICATION

To

My Lord and Savior Jesus Christ who I owe my profession and life to. To my parents who sacrificed their life so that I can be the first in our family to pursue higher education. To my brother for believing in my academic achievements no matter what. To the Lobito Family for supporting me. To the Delgado Family for being in my spiritual and education walk since day one and seeing God's promises come true. To Sarah Wells for being a great friend and guiding me through this DNP project. To Chiara Cardoza, for being my wonderful friend and partner-in-crime from beginning to end of this DNP program.

TABLE OF CONTENTS

	Page
LIST OF TABLES	v
ACKNOWLEDGEMENTS	vi
VITA	vii
ABSTRACT OF DNP PROJECT SCHOLARLY PAPER	viii
CHAPTER 1: INTRODUCTION	1
Background Knowledge/Significance	
Problem Statement	
CHAPTER 2: BODY OF EVIDENCE	5
Search Process/Results	
Appraisal of Evidence	
Comprehensive Synthesis of Evidence	
Clinical Practice Guideline Appraisal (If necessary)	
Evidence-Based Recommendation for the Project	
CHAPTER 3: PROJECT FRAMEWORK	11
Logic Model	
EBP Model/ or Conceptual Framework	
CHAPTER 4: METHODS	12
Project Goals	
Project Description	
✓ Project Type/Design	
✓ Project Setting/Population	
✓ Participants/recruitment	
✓ Stakeholders/Barriers	
✓ Description of Intervention	
✓ Measures/Instruments	
✓ Data Collection Procedure	
Data Analysis	
Ethical Considerations	
Stakeholders/Barriers	
CHAPTER 5: RESULTS AND CONCLUSIONS	17
Results	
Discussion	
Conclusion	
REFERENCES	25

APPENDIX A: Site approval/authorization	29
APPENDIX B: Kualu Approval	31
APPENDIX C: PRISMA CHART	32
APPENDIX D: Table of Evidence	33
APPENDIX E: Conceptual Framework	39
APPENDIX F: Logic Model	40
APPENDIX G: Recruitment Material	41
APPENDIX H: Data Collection Instruments	45
APPENDIX I: Demographic Survey	49
APPENDIX J: Pre and Post Survey Questionnaires	50
APPENDIX K: Intervention Material	51
APPENDIX L: Project Budget	61

LIST OF TABLES

Table 1. Demographic Data	62
Table 2. Burnout Scores	63
Table 3. Secondary Traumatic Stress Scores	64
Table 4. Connor-Davidson Resilience Scale Score	65

ACKNOWLEDGEMENTS

I would like to express the deepest appreciation to my committee chair, Dr. Amir Rahmani, who had dedicated endless hours in helping me and guiding me in completing this project. Without your guidance, knowledge, and experience this would not have been possible.

I would like to thank my committee members, Dr. Nicole Martinez and Dr. Susan Tiso for providing wise council and insight in my project. Dr. Angela Jun for guiding me step-by-step throughout this DNP program.

I want to express gratitude towards the Cohort 1 students of this program. We started and have completed this together. I wish you all the best in your future endeavors.

VITA

Norma Hernandez-Ramirez

2012	BA in Spanish, BS in Physiology, San Francisco State University
2017	MSN in Clinical Nurse Leadership, University of San Francisco
2022	DNP Candidate, Family Nurse Practitioner, University of California, Irvine

FIELD OF STUDY

Doctor of Nursing Practice, Family Nurse Practitioner in Nursing Science

ABSTRACT OF THE DNP PROJECT FINAL PAPER

Decreasing Compassion Fatigue in Emergency Nurses through Resiliency Training

by

Norma Hernandez-Ramirez

Doctor of Nursing Practice, Family Nurse Practitioner in Nursing Science

University of California, Irvine, 2022

Associate Professor Amir M. Rahmani, Co-Chair

Associate Clinical Professor Director Nicole Martinez, Co-Chair

Background: Emergency Nurses are constantly exposed to traumatic experiences due to the nature of the Emergency Department. This exposure over time can lead to Compassion Fatigue and its subcategories: Burnout and Secondary Traumatic Stress. Literature shows evidence of higher levels of resiliency being related to lower levels of Compassion Fatigue, which in turn can lead to greater persistence in the nursing workforce. Resiliency can be learned through awareness and skills to help cope with stressful times and reduce suffering, like the Covid-19 pandemic.

Aim: The goal of this Doctorate in Nursing Practice (DNP) project was to decrease Compassion Fatigue in Emergency Nurses using the Community Resiliency Model (CRM) for resiliency training. **Design:** Emergency Nurse participants completed a survey that included the Professional Quality of Life Version 5 (ProQOL V) scale and the Connor-Davidson Resilience 10-item scale (CD-RISC 10) at pre-intervention and eight weeks post-intervention. A one-time 1-hour intervention was delivered via Zoom using the CRM skills to build resiliency during a nursing shift. The nurse participants were provided the iChill app to use during the span of eight weeks for reference. Pre and Post-intervention surveys were compared to determine the effectiveness of the CRM skills to reduce CF. **Results:** There was a total of 19 Emergency Nurse participants who completed both pre and post intervention surveys. There was a statistical significance in STS ($p < 0.0016$), and a improvement in the resiliency domain of flexibility. Although there were no significant changes in overall CF or Resiliency, results suggest that the one time 1-hour CRM intervention helped with STS during a Covid-19 surge. Results also suggest that a one-time intervention may not be enough to reduce overall CF and increase resiliency in emergency nurses. Organizations need to support nurses by having a more long-term approach to CF and resiliency.

Keywords: compassion fatigue, resiliency, emergency nurse, burnout,

CHAPTER 1: INTRODUCTION

Decreasing Compassion Fatigue in Emergency Nursing through Resiliency Training

Compassion is one of the most essential core elements in the nursing profession (Pérez-García, et al., 2020). According to Aagard et al. (2018), compassion in nursing has five different characteristics: listening, developing a relationship, alleviating suffering, touching, and going beyond the role of the nurse. With compassion, nurses help patients heal, provide hope, preserve dignity, and overall change patient outcomes (Peters, 2018). Nurses are the backbone of healthcare (Mintz-Binder et al., 2021). Due to the stressful nature of the nursing role, nurses can lose the ability to provide compassionate care over time, which is called Compassion Fatigue (CF). The negative psychological impact of CF can cause a domino effect influencing nursing judgment, collaboration with providers, and advocating for patients. With the recent Covid-19 pandemic, organizations are witnessing the mental and physical strain nurses are carrying and how that affects patient care, safety, and nurse retention. Of all specialties in healthcare, critical care nurses, like emergency nurses, have been the front-line workers of a two-year-long pandemic and facing an increase in constant trauma. As the world is transitioning to a post-pandemic era, organizations have the opportunity to explore how to solve and prevent CF within their front-line nursing staff (Zhang et al., 2020). The literature demonstrates that resilience-building interventions have been found to decrease compassion fatigue (Çam, 2017). In providing resiliency education, compassion fatigue decreases, ultimately affecting nursing job satisfaction, patient care outcomes, and nursing retention.

Background/Significance

Compassion Fatigue is defined as feelings of hopelessness and the declining empathic ability from repeated exposure to others' suffering (Peters, 2018; Blackburn et al., 2020). CF is a multi-faceted concept that impacts the nurse, the patient, and their family members and can have a significant financial burden on facilities. There are four types of themes that construct CF: physical, emotional, triggering, and measures to overcome CF (Nolte et al., 2017).

Literature has sometimes used the term CF interchangeably. For example, CF in both literature and the nursing profession has been confused with burnout, secondary traumatic stress, vicarious trauma, and victimization (Nolte et al., 2017). Recognizing the differences is vital so that the targeted population affected by CF can have successful outcomes. CF alone has its own set of symptoms and its subcategories: Burn out (BO) and Secondary Traumatic Stress (STS) (Stamm, 2010). BO is defined as the physical and emotional exhaustion leading to psychological and physiological distress (Scarlet et al., 2017), while STS comes from witnessing a traumatic event and experiencing stress due to that event (Peters, 2018). Compared to BO alone, CF is more acute; if identified and managed early on, recovery time is faster (Transitional Support, 2016). Some symptoms of CF stated in the literature include the following: irritability, lack of joy in personal life, overindulgence, aggravation of physical ailments, and overall fatigue (Blackburn et al., 2020). CF in emergency nurses has been witnessed over the past two years due to the Covid-19 pandemic. Perez-Garcia et al. (2020) reveal that if high levels of exhaustion continue over time, it will be a threat to the mental health of all healthcare professionals, amplifying the impact on our overall healthcare system.

A wealth of data on the causes of CF in nursing illustrate that this concept is multi-layered. Many factors that contribute to CF are not in the nurse's control at all. For example, Perez-Garcia et al. (2020) state that CF causes include frustrations over being able to alleviate the suffering of patients, daily contact with seriously ill patients, and disconnect in communication between professions, causing negative patient impact. This further causes difficulties in job performance, feeling unfit for nursing, avoiding attending to the patient, and lack of emotional strength and motivation.

The nature of the Emergency Department also contributes to being a victim of CF. Nurses have been experiencing worsening stress since the pandemic; according to (Mintz-Binder et al. (2021), a nursing survey done by the American Nurses Association showed that 79% of those nurses ranked stress as the

top workplace hazard. Their self-giving nature places them at high risk of compassion fatigue because of the constant exposure to trauma and focuses on helping others heal (Peters, 2018).

Lastly, one factor contributing to CF is the personal approach to the nursing profession and self-care strategies. Peters (2018) mentions that the antecedents of CF include lack of professional boundaries, sacrificing self-care at work, lack of inner resiliency and professional support, or inability to cope with environmental stressors. CF causes erosion of nurses' bodies, minds, and spirit; without recovery, nurses see leaving the profession as their only way to have relief (Peters, 2018). According to the recent report from Nursing Solutions Inc. in their RN staffing report, the national average for hospital turnover is 19.5% (2021). The nursing shortage also impacts patient outcomes, quality care, patient satisfaction, safety, and reimbursement rates and puts a financial strain on healthcare organizations. Literature reveals the dire need for immediate interventions to help front-line workers like emergency nurses, to help with compassion fatigue (Amberson, 2021).

According to the literature, CF is measurable and preventable by learning healthy coping skills. Research shows that high resiliency is one of the contributing factors in nurses with lower levels of compassion fatigue and more remarkable persistence in the nursing workforce (Slatyer 2017). Resiliency can be defined as the "ability to adapt and thrive in face of a challenging working environment" (Mintz-Binder et al. (2021). Risk factors that affect nurse resilience include lack of organizational support, insufficient professional skills, ability to cope with stress and utilize emotions, and lack of positive expectations (Çam, 2017). Resilience, however, can be maintained through multiple factors: environmental and personal (Mintz-Binder et al. (2021). Personal factors like internal and external factors mentioned in Çam, (2017) are under the control of the individual. Internal factors include positive emotions, self-respect, cognitive flexibility, and emotional intelligence. In contrast, external factors include family relationships, support from peers, job satisfaction, and establishing a balance between work and life (Çam, 2017). Peters (2018) adds that resilience obtained with age, experience, and professional empowerment could protect someone from CF.

Before Covid-19, literature focused on implementing resiliency interventions in targeted specialties like oncology and critical care nursing (Blackburn et al., 2020; Sullivan et al., 2019). At this time, there is limited evidence of resiliency training translated into practice for emergency nurses. However, as society is starting to recover after two years of a pandemic disaster, evidence of the need for immediate intervention is spreading throughout all specialties, including emergency nurses.

Problem Statement

The impact of Covid-19 has caused a mass exodus in the nursing profession (McMahon, 2021). An abundance of evidence exists expressing unique interventions that address CF through resiliency training. However, few have been translated into practice. Additionally, those translated into practice focus more on burnout alone and not compassion fatigue and its subcategories. Literature shows that higher resiliency levels attribute to lower levels of compassion fatigue (Çam, 2017). Training nurses with application to “mindfulness courses, work-life balance, increasing positive thinking, or enhancing emotional intelligence” has been proven to improve resiliency levels (Mintz-Binder et al. (2021).

This Doctorate in Nursing Practice (DNP) project is an Evidence-Based Practice (EBP) that aimed at decreasing CF in emergency nurses using a one-time 1-hour resiliency training. The intervention was measured using the Professional Quality of Life Version 5 scale (ProQOL V) and the CD-RISC 10 Item scale (CD-RISC 10) administered eight weeks after the training.

PICO(T) statement

P (Population/Problem) Emergency nurses

I (Intervention) resilience training

C (Comparison) compared to not,

O (Outcome) decrease compassion fatigue?

For emergency nurses, does resilience training decrease compassion fatigue compared to those who do not receive resilience training, in a period of eight weeks?

CHAPTER 2: Body of Evidence

Review of the Literature

Search Process

Relevant electronic database studies such as CINAHL, PubMed, and Google Scholar were used as the search strategy. Search terms included the following: *compassion fatigue, compassion satisfaction, job satisfaction, burnout, secondary traumatic stress, resilience, resiliency training, resiliency education, nursing, nurses, emergency nurses, emergency nursing and healthcare workers.*

Literature around compassion fatigue, such as systematic reviews, meta-analyses, surveys, options, or concept analysis, is excluded in the synthesis of evidence due to the lack of specific details needed to describe the measurement tool and interventions to decrease compassion fatigue. However, such data is valuable in understanding the concept and severity of CF and in learning strategies to combat compassion fatigue and improve resilience. Literature that involved non-clinicians was excluded. Nursing students were excluded due to their lack of bedside experience. Demographic data such as gender were excluded because many articles have conflicting data on its correlation to CF. Lastly, studies not involving acute or in-patient hospital settings were excluded.

Articles that focused on resolving burnout, compassion fatigue, and job satisfaction levels were included in the study since many of them connected it back to resiliency. Literature that implemented tactics to improve resiliency were also included. The research focused on other nursing specialties, and MDs were part of the inclusion criteria. The PRISMA 2009 Flow Diagram in Appendix C shows the research process and elimination of data.

Appraisal of Evidence

As stated above, with using PRISMA, many articles were yielded. Articles that were identified needed to be relevant to the PICOT question. With the inclusion and exclusion criteria, and full-text access, only 15 articles were chosen to contribute to this project. Refer to the Table of Evidence (TOE) in Appendix D for details regarding each individual article.

Comprehensive Synthesis of Evidence

The cause of CF is multi-factorial. Some articles focus on CF's contributing factors and focus more on interventions for one of its subcategories. Literature around CF also shows diverse interventions for decreasing CF. For example, some articles focus on resiliency training. Other articles support reducing CF with mindfulness meditation, yoga, art therapy, aromatherapy, and self-care educational activities. Some interventions are more app-based and have a more individualistic approach, while others are in group settings. Literature also mentions the different lengths of time used for intervention, whether it's a one-time workshop or throughout 20 weeks. Overall, evidence shows an abundance of ways CF is targeted in the nursing profession.

Well-being

Much of the literature includes that a nurse's well-being is vital to have the compassion to care for others. Aggarwal et al. (2017) focus on the concept and science behind well-being with 188 residents, implementing a single 60-min didactic course, a 15-min weekly booster session, and wellness competitions using free phone apps to promote physical activity. This article validates that engagement in having staff work on well-being and physical activity is an essential aspect of increasing resiliency.

Slatyer et al. (2017) report focus on mindfulness strategies and self-care helps with resiliency. This intervention was a randomized controlled trial. The participants chosen for the intervention were given mindfulness concepts, basic practices like exercise, and home-based practices to create resiliency around compassion fatigue.

Self-Compassion

Many articles appraised for this project focused on exploring and evaluating self-compassion. Delaney (2018) conducted a qualitative and quantitative study that implemented an 8-week Mindful Self-Compassion intervention with a small number of nurses. This included a 2.5hr session per week, and a half-day retreat, watching CDs to help with formal and informal practices that include Love and Kindness Meditation (LKM), Mindfulness Meditation (MM) and Compassionate Meditation (CM). This article is helpful for this project because its results yield positive in decreasing Compassion fatigue and its

subcategories by using the ProQOL tool and improved resiliency using the Connor-Davidson Resilience Scale 25 item.

Chesak et al. piloted a randomized controlled trial in nurse leaders at a single facility to measure resilience using Authentic Connections Groups (2020). This intervention included group sessions of one hour per week for 12 weeks, with a facilitator, where participants discussed depression, self-compassion, and stress. This article included only nurse leaders that were mothers. Results do you mean “immediately after” after and 3-months post-intervention showed that this intervention improved resilience at work through an increase of self-compassion, perceived stress, and depression. Although this study showed positive outcomes, it is limited in that its population included only nurse leaders that were mothers. However, this study clarifies that there are different components of compassion and that self-compassion is a factor in improving compassion and resilience. It gives insight that implementing a 3rd-party or facilitator in guiding group interventions helps strengthen resilience in the workplace.

Resiliency Training

One of the ways research shows to improve compassion fatigue is through resiliency training. Sullivan et al. (2019) state, “personal resilience is a trait thought to promote compassion satisfaction and protect against compassion fatigue.” Çam (2017) says that nurses who have resilience experience a lower level of compassion fatigue. More specifically, these nurses demonstrate less burnout in their profession. Zhang et al. is a systemic review that explores burnout and resilience, stating that interventions for these are individual-focused, structural, or organizational, and combine interventions (2020).

Grabbe et al. state that trauma-informed education, called the Community Resilience Model (CRM), can help with improving resiliency over time (2020). This randomized controlled trial used an intervention group where the participants were delivered a 3-hour CRM program while the control group attended a nutrition workshop. CRM participants reported using sensory awareness skills taught in this course in difficult situations of high stress like a patient coding, dying, or crisis. Trained certified facilitators taught this course by California’s Trauma Resource Institute (TRI). This article is valid because emergency nurses face many different levels of trauma in a single shift. Teaching nurses skills to

handle tough situations and manage their emotions is part of improving resilience and potentially improving compassion fatigue since this article focuses on secondary trauma and burnout subcategories.

Foster (2018) implemented facilitator-led focus groups through a Promoting Adult Resilience (PAR) program that was seven weeks long to improve resilience in mental health nurses. This qualitative study was effective in that, through active participation, nurses identified their own strengths, learned resilience strategies through other nurses in the focus groups, and handled emotional distress and self-efficacy during stressful shifts.

Technology-based

Mistretta et al. (2018) conducted a randomized controlled- trial that implemented both in-person and app-based interventions to improve resilience training targeting self-compassion, anxiety, stress, sleep habits, and other strategies in both mindfulness and well-being. This article is unique and valid because it included the utilization of technology, which means that the implementation of strategies can be off the clock and at home. Rushton et al (2021) also implemented mindfulness using both in-person and technology-based methods of intervention to improve resilience.

Multi-layered interventions

Literature shows some interventions around improving resiliency are multi-faceted. Rees et al. (2020) is a mixed-method design using both face-to-face and video-conference learning. Magtibay et al. (2017) also implement multiple interventions, including didactics, self-help books, and in-person and phone conversations. These articles provided insight into how multi-layered interventions can also improve nurses' resilience, not just one individual intervention.

Mintz-Binder et al., 2021, mentioned that many articles around resilience interventions aim at mindfulness, life balance and self-improvement exercises. Such activities can be time-consuming, especially if done outside of work hours. This quasi-experiment uses a toolkit of interventions to improve resilience throughout the nursing shift. Results showed that the most impactful interventions were the breathing exercises and lavender inhaler sticks as an immediate intervention to decrease stress from high acuity patients during a shift. This article has valuable information that focuses on multiple interventions

with immediate relief rather than lengthy training that can take weeks or months-long to impact compassion fatigue.

Length of Interventions

Some interventions were weeks-long, focusing on a couple of hours per week for application. Literature showed that the average length for resiliency or compassion fatigue education was 6-12 weeks. Some articles mentioned having six-month-long interventions. In an emergency department, is this feasible? Slatyer et al. state that “it has been argued that the duration and intensity of conventional 8-week mindfulness-based interventions can be a challenge in recruiting and retaining busy workers such as nurses” (2017). This author suggests that with its positive outcomes in this study, an intervention of only 11.5hr duration can produce significant reductions in burnout that persist even 6 months later. Delaney (2018) is another example of effective intervention. However, it is 8-weeks long.

Magtibay (2017) explores compassion fatigue and burnout through focus groups, mindfulness, and being present in 24 weeks. Results were measured by Scale Connor-Davidson Resilience Scale, and Copenhagen Burnout Inventory. Although the article shows positive results, the length of the study is less likely feasible to carry out in an emergency department setting at this time.

Organizational approach

Zhang et al. (2020) states that BO is a collaboration of failed self-care and organizational support (Zhang et al., 2020). Çam, (2017) supports this concept by explaining that higher levels of resiliency are associated with professional protective factors like job satisfaction, positive attitude towards the job, intimate relationships with colleagues, and team support. Foster (2018) states that personal and organizational barriers need to be addressed through a resilience program. Ultimately, there are organizational factors that contribute to CF that are not in the nurse's control. Such factors should be prevented by advocating for hospital leadership to create policies that further support the well-being of emergency nurses in the long run(Amberson, 2021).

Approaches to Virtual vs In-person education

During Covid-19, the teaching pedagogy switched from in-person to online. Articles throughout the past two years show the mixed opinions, preferences and effectiveness of virtual learning. Online learning is defined as “the use of a platform to provide education over the internet” has increased dramatically because of the pandemic (Chatziralli et al., 2020). Because changes have been recent, many challenges have risen with virtual learning including internet connection, environmental disturbances, lack of practical training, increased distractions, decreased personal interactions, and lack of motivation (Bowers et al., 2022; Chatziralli et al., 2020; Siah et al., 2022). The sudden need to change to online learning had also placed challenges in educators and professors. There has been a challenge in usage of learning platforms, lack of training, (Achmad et al., 2021). “Teaching approaches also differ between face-to-face and online-tutorials, thus the choice of platforms meant for communication should be tailored accordingly” (Siah et al., 2022).

Summary of Evidence

Whatever the approach is to target CF and/or Resiliency, literature shows that both can be measurable and preventable. Ultimately, the CRM model by Grabbe et al. (2020) is the most feasible for this DNP project given that it is a short term intervention, teachable, and shows positive results in a short period of time.

Evidence-Based Recommendation for the Project

There is sufficient evidence that has various interventions for improving compassion fatigue by increasing resiliency in nurses. Limited research exists in implementing such strategies specifically to emergency nurses. Literature has demonstrated the effectiveness in unique strategies from implementing books, to third-party facilitators, modules, apps, video conferencing, focus groups, meditation and mindfulness as interventions to promote resiliency. Mindfulness training was one of the most popular interventions found in the literature that demonstrated effectiveness, however, such interventions take weeks to months of application.

In addition, the literature showed the importance of self-care strategies since this is something that nurses have control over and teachable by emergency nurse educators.

Recommendations include implementing a feasible approach for the emergency department and showing long-term effects in improving resiliency. Grabbe's CRM is an ideal approach in increasing resiliency as a one time intervention that focuses on psycho-somatic reaction to trauma, mindfulness, emotions and resiliency. It also comes with a phone application that contains educational resources of the workshop.

CHAPTER 3: PROJECT FRAMEWORK

Conceptual Framework

It is noted that compassionate care is the cornerstone of nursing practice (Peters, 2018). Chesak et al. (2020) mentions the Jean Watson's Theory of Human Caring, stating "compassion is a prerequisite for providing authentic care to oneself and others and creating a healing environment". Dr. Watson created the Theory of Human Caring in nursing practice in 1975 (Watson Caring Science Institute, 2021). This theory is the chosen framework as it illustrates the importance of nurses taking care of themselves in order to take care of others authentically and holistically.

The theory also mentions that caring consists of specific factors called the '10 Caritas Processes'. Three caritas are applicable to the CRM model. Caritas two focuses on being authentically present, caritas three on being sensitive to one's self and others, and caritas five on allowing for expression of positive and negative feelings (Watson Caring Science Institute, 2021). These caritive factors align with the CRM model where the CRM teaches nurses sensory-based skills that support awareness of one-self and others' reactions to triggers or traumatic events and help stay in the present moment.

In CRM, the key theoretical concept is the Resilient Zone (Grabbe, 2020). This zone is an individual's emotionally stable zone and place where one is capable of adapting to challenges in a given shift or day. The resilient zone becomes narrowed by constant triggers and little skills used to bring oneself back to stability (Grabbe, 2020). Those triggers can be from anything personal to environmental. Being outside of the zone includes symptoms such as depression, isolation, and avoidance or mania,

hypervigilance and anxiety (Grabbe, 2020). To bring someone back into the resiliency zone, CRM teaches sensory awareness skills to identify triggers and to control emotional response to stress and trauma to bring body back and mind back into the resilient zone (Grabbe, 2020).

Logic Model

The logic model further explains the strategies, short and long-term goals for implementation of the CRM skills (Appendix F).

CHAPTER 4: METHODS

Project Goals

Project goals are displayed in the Logic Model (Appendix F). Short term plans include nurses understanding the concept of CRM, having access to the iChill App, and application of the skills learned during the 1-hour workshop. Long term goals include evaluation of compassion fatigue and resiliency levels eight weeks post-intervention using ProQOL and CD-RISC scales to measure effectiveness of intervention. The long-term goals that benefit organizations would include increase in nurse resiliency, better patient outcomes, jobs satisfaction and nursing retention.

Project Description

Project Type/Design

This project is an Evidence-Based Project to analyze the effectiveness decreasing compassion fatigue using a 3-hour resiliency training workshop called CRM. The trauma-informed educational workshop teaches sensory-based skills that help with sensory awareness during a stressful situation.

Project Setting/Population

This project took place in various settings due to the anticipation of low participation rate due to the Covid-19 surge during Winter 2022. One of the settings was the University of California Irvine Medical Center (UCIMC) Emergency Department. Promotion was done in person, via email and online to all available emergency registered nurses. The second targeted setting was the California Emergency Nurses Association East Bay Chapter (EBENA) Chapter. Promotion for EBENA was delivered on the

chapter's private FB page that only registered nurses and nursing students that belong to EBENA have access to. Due to the Covid-19 pandemic, this project was promoted to be delivered via Zoom.

Participants and Recruitment

The targeted participants were emergency nurses who were currently working at UCIMC and emergency nurses who were members of EBENA. The participants were recruited in person during dayshift and nightshift huddle, where the DNP project facilitator would describe the nature of the project and the compensation amount. The DNP project facilitator was given 5-10 mins to talk about the project and gather emails from the nurses who showed interest. Due to a surge in Covid-19, recruitment continued via email. The invitation was sent to all 395 emergency nurses at EBENA, and all 200 emergency nursing staff of UCIMC Emergency Department. A total of 595 registered emergency nurses. Recruitment continued for a total of three weeks. Due to meeting academic timelines, recruitment stopped after 3 weeks, and only 29 nurses signed up to participate and completed the pre-implementation survey.

Description of Intervention

Due to the Covid-19 pandemic surge during time of intervention and low participation rate, an agreement between stakeholders and the DNP project facilitator was established to reduce the resiliency training from a 3-hour to a 1-hour educational workshop. The CRM skills have been previously delivered for a 1-hour workshop previously by the TRI facilitators, in which is also showed positive results. The CRM model was initially intended to be delivered in person, however, it was delivered through online learning in the Zoom platform. CRM is a trauma-informed educational workshop that focuses on defining resiliency and then teaches six sensory-based skills. The skills are called "Tracking, Resourcing, Grounding, Gesturing, Shift N Stay, and Help Now" (Grabbe et al., 2020). Each skill has examples for participants to better understand how to use the skill. Participants are then asked to perform each skill as they are being taught throughout the training. Evidence on the effectiveness of CRM in non-nursing professions are presented. The iChill application is provided to participants and are taught how to use is for sustainability of the project.

Measures/Instruments

The measurement tools being used are the Professional Quality Of Life Version 5 scale (ProQOL) and the Connor-Davidson Resilience 10-item scale (CD-RISC). The ProQOL measures Compassion Fatigue and its subscales of BO and STS. Permission to use the ProQOL Version 5 scale was approved, and scale was free of charge. Although the ProQOL scale also measures Compassion Satisfaction, it is not needed for this project, for the focus is on Compassion Fatigue. CD-RISC measures resiliency and its domains. Permission to use CD-RISC was obtained with an additional charge of \$33. (Appendix L)

All scales were used in both pre and post-intervention. The BO and STS scales were presented using the Likert scale, ranging from 1 meaning ‘never’ and 5 ‘very often’. The scales had 10 questions per category, with points ranging from 10 to 50. Scores less than 22 were classified as low, 23-41 as moderate, and greater than 42 as high (Stamm, 2010). In the BO scale, questions #1, 4, 15, 17, and 29 were reverted in scoring with the following: 0=0, 1=5, 2=4, 3=3, 4=2, 5=1 (Appendix H).

The CD-RISC tool also had 10 questions. Each question belongs to a domain. There are five domains: flexibility (question 1 and 5) , self-efficacy (question 2,4 and 9), ability to regulate emotion (10), optimism (3,6 and 8), and maintaining attention under stress (7). This tool was also delivered in Likert style, score ranging 0 to 4, Zero meaning ‘not true at all’ to 4 meaning ‘true nearly all the time. The score ranges from 0-to 40 for total scoring and is divided into four quartiles. Scores between 0-29 are in the lowest quartile, 30-32 in the second quartile, 33-36 in the third quartile, and 37-40. Scores 0-32 “suggest problems in coping with stress or bouncing back from adversity (Davidson, 2022). Overall, the scores per tool are interpreted as follows: In CD-RISC, the lower scores indicate less resilience and the higher scores indicate greater level of resilience. The opposite is for ProQOL: the higher the scores the worse the CF. (Appendix H)

Data Collection Procedure

The purpose of this project was to measure compassion fatigue in emergency nurses after the implementation of resiliency training. Emails and announcements during nurse huddle were delivered to emergency nurses during the first few weeks of January, 2022. Those who replied with interest in the

project were given a link to a pre-intervention survey created via Qualtrics. Once completed, the participants were emailed with a Zoom link to attend a one-time one hour virtual workshop. All pre-intervention surveys were completed in 3rd week of January 2022 and the resiliency workshop was implemented between January 28th, 2022 and February 10th, 2022. Initially, 29 emergency nurses completed the pre-implementation survey. However, of those 29, only 22 attended the virtual resiliency workshop. A total of six workshops were delivered. Those who completed both the survey and workshop were compensated with a \$10 Starbucks or Visa eGiftcard from Giftcardgranny.com. The 22 nurse participants were reminded to use the iChill app to download as a resources tool that can be used during their nurse shift for the span of eight weeks. At midpoint, around 4 weeks, an email was sent out to remind participants to continue using the resiliency skills learned and to use the iChill app. Post-intervention data were collected via Qualtrics eight weeks after the intervention, by the end of the second week of April 2022. A total of 19 participants completed the post-intervention survey.

Data Analysis

All data was collected online using Qualtrics. Data collected during the pre-intervention phase included demographics, free-text questions, and two measurement tools ProQOL and CD-RISC. Data collected during the post-intervention phase included free-text questions and the two measurement tools. All responses were screened, reviewed, and scored via Qualtrics. The results were downloaded from Qualtrics into a Microsoft Excel spreadsheet. Microsoft Excel's Data Analysis toolbox was used to perform the statistical analysis. All pre and post-survey data collected was analyzed using descriptive analysis and reported as means, standard deviation, and range. The scales CD-RISC and ProQOL were analyzed to compare the mean difference between pre and post-intervention outcomes and to calculate statistical significance (ie: p-value) using the Data Analysis t-Test: paired two-sample to compare the effect of change per category. The p-value score of 0.05 or less was to be considered statistically significant. For the CD-RISC scale, an average was calculated per individual score and a t-test was performed for each domain.

Ethical Considerations

Although this project was considered a non-Human Subjects Research, an IRB process was still completed as advised by the project chair and DNP project coordinator and was switch to Except Self-determination. The IRB was re-processed and approved by mid-January 2022 by UCI Quali Research Department, indicating multiple sites needed to obtain enough emergency nurse participants for data collection and obtaining personal email addresses from participants for the sake of compensation (Appendix B).

Approval for project implementation was obtained by the emergency nursing educator and managers of the UCIMC (Appendix A). Additional approval was obtained at EBENA. Each participant was consented prior to participation. By continuing the survey mean they agreed to the consent. The end of the survey provided an option for compensation, in which an email needed to be obtained to compensate. The consent clearly stated that emails addresses would not be used in the project and anonymity would be maintained throughout their participation. It also stated that participation is voluntary and they may withdraw at any moment. Participants had the option to show or hide their screen during the virtual resiliency training for to respect privacy - a rule obtained by CRM facilitators. The demographic portion, and measurement tools used had no identification questions. The University of California, Irvine Sue and Bill Gross School of Nursing did not fund this Doctorate in Nursing Practice project.

Stakeholders/Barriers

The facilitators and stakeholders of UCIMC's Emergency Nursing Department play a vital role in this project to gain access to their nursing staff to implement this project. Barriers to this project included having a site mentor and access to the emergency department during the Covid-19 pandemic. Continuous access to the department was needed for participant recruitment via posting flyers, making announcements during nurse huddle and finding a site mentor. One of the biggest challenges was gaining access to the department as a non-employee, however, was overcome by reaching out to UCIMC nurse employees and other UCI affiliated NPs that were willing to provide resources that would essentially help in gaining access to the ED nurse email addresses to continue recruitment. Another barrier was the Covid-

19 Omicron Variant surge during January 2022, which was the initial timeframe for intervention. Due to the overwhelming amount of patients in the ED and lack of nursing staff, the ED nurse educators and managers were overwhelmed and were nearly impossible to contact. The project was needed to be delivered virtually instead of in-person as planned. Changing the style of delivery to virtual was also a benefit for my second site- East Bay ENA chapter, since most of their meetings are held virtually and members are already used to virtual learning.

Formative Process Evaluation

Three opened-ended questions were included during pre-intervention. Of the 19 participants, 14 were able to describe 3 ways to stay resilient during a nursing shift. The participants described CF in the following terms: “less compassion, more stressed, emotional and physical exhaustion”. Resiliency was described as “ability to recover, bounce back, and overcoming difficulty”. Common themes in staying resilient during a nursing shift included: “staying positive, taking breaks, having a grateful attitude, and humility”. Of the 29 participants who completed the pre-intervention formative questionnaire, five were unable to identify ways to stay resilient (Appendix J).

These questions allowed for the delivery of the CRM workshop by implementing definitions, and signs and symptoms of CF, BO, STS and resiliency prior teaching the CRM skills. It allowed for a more interactive workshop by having participants verbalize back or type in the chat how each CRM skill can be utilized during a nursing shift. The formative questions were helpful because it tells readers and researchers that nurses maybe be knowledgeable of CF and Resiliency but may struggle with the issue itself.

CHAPTER 5: RESULTS AND CONCLUSIONS

Results

The purpose of this quality improvement project was to decrease Compassion Fatigue in Emergency Nurses through resiliency training using the CRM model.

Analysis of Demographic Outcomes

Of the 595 emergency nurses, only 19 completed all required data for this DNP project, yielding a participation rate of 3.91%. The number of nurse participants throughout this project ranged from 29 pre-implementation, 22 who attended the virtual workshop, to 19 who completed the post-implementation survey. Of the 19 participants who participated in the entire project, most of them were ages 30-39 (n =12, 63.2%), who have a BSN degree (n = 9, 47.4%) and 6-10 years of RN experience (n=8, 42.1%), with 1-5years of experience in the Emergency Department (n=9, 47.4%). About 36.8% (n= 7) of the participants were in an assistant manager or supervisor position, and 31.6% (n= 6) were bedside nurses. Of the 19 participants, 13 of them worked full time (68.4%) in the emergency department during the DNP implementation (Table 1). Overall, there was no correlations between demographic data such as years of experience an emergency nurse, bedside nurse and age with the levels of compassion fatigue or resiliency.

Analysis and Pre and Post Intervention Outcomes

The goal was to see a decrease in BO and STS scores and see an increase in CD-RISC scores eight weeks post-intervention. For CF, during in pre-intervention survey, the BO scores ranged from 29 to 45, with an average of 38.32 (SD= 5.14). The post-intervention scores ranged from 29 to 48, with an average score of 36.42 (SD= 5.62) (Table 2).

The STS pre-intervention scores ranged from 19 to 41, with an average of 32 (SD= 7.41), while the post-intervention scores ranged from 17 to 41, with an average of 29.05 (SD= 6.35) (Table 3). There was a 9% decrease in STS ($p < 0.016$). Of the 19 participants, 13 reported a lower score post-intervention, the rest either stayed the same or slightly increased.

For Resiliency, the pre-intervention CD-RISC scores ranged from 23 to 40, with an average of 31.11 (SD=5.62). The post-intervention scores ranged from 22 to 40, with an average of 31.63 (SD=4.77) (Table 4). In pre-intervention, of all five domains, flexibility was the lowest domain with an average score of 2.77, while self-efficacy was the highest at 3.02. At post-intervention, the flexibility domain became the highest average score of 3.32, while maintaining attention under stress was the lowest at an average of 3.0. Within the domains of the CD-RISC score, there was an increase in the flexibility domain after CRM

was implemented. Overall, 42.10% showed an increase in resiliency score by a few points despite no statistical significance (Table 4).

The results for the p-values of the difference between pre and post-intervention survey scores are the following: BO was 0.201 and STS was 0.016. For CD-RISC, the p-value was 0.628. With the exception of STS, the p-values were not statistically significant. Given the small sample size, Cohen's d was used to evaluate the effect size of the pre and post-intervention surveys. Cohen's d for BO was 0.35 showing a small effect, for STS was 0.43, demonstrating the medium effect, and lastly for CD-RISC was 0.10 resulting in a small effect.

Summative Results

At post-intervention, 18 of the 19 participants were able to download the iChill app and describe at least three CRM skills to help stay resilient during a nursing shift. All 19 participants stated that they were able to use the CRM skills in the span of two months, however, specifics on utilization of the app nor frequency on the usage of the CRM skills were not questioned. Therefore, the DNP project cannot determine if the frequency of use affected the level of CF and resilience scores.

Two open-ended questions were completed by all participants in the post-intervention survey. Thirteen of the 19 participants expressed being able to jump back into the 'Resilient Zone' by using one of their chosen CRM skills. Tracking and Gesturing were the top 2 skills that most participants used during the implementation period. The other skills were effective as well: "Grounding is CRM skill that helped me alot more [...]I use this skill especially when I just had a rough day or maybe things are no going so well. I use the skill to clear my mind". One of the participants expressed that resources: " was the most helpful during stressful times. I might still want to leave ed to find more balance but I think these skills will help to remain connected". Another participant stated that the skill of Shift N Stay: "will SHIFT to a more comfortable zone". Overall, participants expressed the need and usefulness of the CRM skills.

Discussion

Limitations

Some limitations regarding this project include the preference for doing in-person learning. During the promotion phase of the project, it was verbalized to the DNP project facilitator by the nursing staff themselves during the nurse huddle that virtual learning may not be effective since its less personable, and therefore many declined to participate. Doing virtual learning and having a low participation rate for this project could have impacted the results and effectiveness of the CRM skills. Despite increasing the compensation rate from \$5 per survey to \$10 per survey, participation rate continued to be low during the promotion phase of the project, ultimately leading to small sample size.

The lack of leadership support to actively deliver this project was evidenced by nurse managers leaving their leadership positions to work as bedside nurses given the low staffing rate due to the Covid-19 surge with Omicron Variant. It became very challenging to communicate with leadership due to the overwhelming nature of the unit during this time. Delivery of this project would be best delivered in person and not during a pandemic where the healthcare system is in a survival mode. Doing this DNP project during a pandemic that no one has faced before maybe also have been the reason for low participation. The participation time frame was between January 2022- April 2022 for a span of eight weeks. Many nurses at this time had already faced numerous challenges with Covid-19 surges and low staffing issues for two years. These factors validate Siah et al., (2022) article on low motivation for online learning.

Lastly, the time available for delivery of the intervention was limited due to the academic timeframe. The CRM skills, although a one-time delivery, are evaluated after 3 months, however, this was cut down to eight weeks. Suggestions for future use include using the time for intervention and evaluation as indicated in previous research studies on CRM intervention.

Implications

The impact of Covid-19 upon the participating nursing staff suggests that there is a need for longer-term intervention and management of Compassion Fatigue and Resiliency in emergency nurses. The CRM intervention was originally a 3-hour intervention. Although there is evidence that both a 3-hour and a 1-hour workshop are effective, the UCIMC ED and ENA-East Bay Chapter nursing team preferred a shorter intervention due to a lack of motivation for nurse participation and due to Covid-19. Reducing the CRM workshop to an hour intervention instead of the full 3-hours could have impacted the results of this project.

The delivery of CRM was via Zoom rather than in person due to the Covid-19 surge. Evidence shows that virtual learning alters the effectiveness of interventions (Siah et al., 2022). Turning the CRM model into a virtual workshop in a short span of time was also challenging, given that the same topic can be taught in different ways depending on the method of delivery. The request for delivering a 1-hour model versus 3-hours also reflects the level of motivation and severity of CF, since leadership mentioned that 3-hours seemed too long to teach self-care skills. It is important for future stakeholders to have a buy-in on the proper timeframe needed for the implementation of a self-care tool that can be very useful to the nursing staff.

Further suggestions for future CRM educators include distributing a mid-point survey to assess utilization of the iChill app and frequency of CRM. By implementing an additional mid-point survey one can further analyze if participants have been actively using the CRM skills evenly during the eight weeks. Results also reflect the fact that nurses have been facing a pandemic for two years. A one-time one-hour workshop to address CF (and its subcategories of Burnout and Secondary Traumatic Stress) is not enough. There is a need to better address CF and resiliency with longer-term interventions. Literature does show longer-term outcomes with interventions that are more lengthy (Appendix D). This DNP project further confirms the existing evidence and severity of CF in Emergency Nurses. Given that the healthcare system is transitioning from a pandemic, there is a lack of understanding of the potential psychological effects that Covid-19 it will have on ER nurses in the long run. It is recommended for

organizations to address CF and its subcategories now that evidence continues to show the present severity of CF.

Additionally, the project findings may suggest that CF can be multi-factorial. CF was addressed in this workshop and resiliency skills were provided. However, CF in the concept of BO can be caused by not only from lack of personal resiliency but organizational reasons, poor scheduling, poor staffing, toxic nursing environment or an unsafe working environment (Pehlivan, 2017). This project also suggests that there is a need for more evidence in finding the root cause of CF within the ED and ED nursing staff and what organizations can do to help nurses decrease CF.

Budgeting Plan

The CRM is provided by the Trauma Resource Institute, which provides either third party facilitators or a teaching workshop to learn how to deliver the CRM. The cost of the 5-day Teacher Course is \$1850.00. To be able to deliver the project, the DNP project facilitator had take the teaching course, however TRI was able to waiver the cost. There was a non-refundable \$50.00 registration fee paid by the DNP student. Each participant who completed a survey was compensated \$10. Additionally, the Zoom platform was \$15 to be able to deliver the CRM model, given that the Zoom app is only free if used for less than 40 minutes. In the future, using the CRM and hiring facilitators from TRI may come at a cost, however, existing nurses or other non-healthcare CRM teachers have also delivered the CRM model at no cost, after being CRM certified; they are eligible to be thirist party facilitators to deliver CRM anywhere. Overall, CRM is worth financing since the cost for a resiliency training is less costly than hiring and training new nurses. Appendix L provides more details on the project budget.

Sustainability

The utilization of the iChill app which contains all six CRM skills and more resources can be continued to be used among the nurse participants to ensure long-term effects and sustainability of the resiliency skills. The CRM skills may be continued and promoted to other nurses within the unit, as the

department now has access to educators and nurses who are can teach the CRM skills in person or virtually. Posters on the Resilient Zone can be posted in the break room to remind nurses to use the skills to stay in their Resilient Zone during a nursing shift. Organizations can create a required educational workshop for nurses to attend and learn these skills. Payment and/or CEU is also suggested for requirement to attend and renewal workshop of such skills.

Conclusion

Emergency nurses have been in constant traumatic stress since the start of Covid-19. Prior to the pandemic, nurses were already struggling with CF, and resiliency. The pandemic has only exacerbated this issue in nursing causing a huge impact in the mental health of nurses. Literature shows that implementation of resiliency education helps with CF. In this project, the expected outcomes to improve resiliency and decrease CF based on the CRM intervention were not met. However, the breakdown of the post-intervention quantitative data showed that CRM helped in the domain of flexibility and in Secondary Traumatic Stress. The post-intervention qualitative questions also suggest that CRM was helpful with stress management and staying in the Resilient Zone (Appendix J) Prior to the resiliency training, knowledge-based questions showed that the nurse participants were well informed on the definitions of CF and Resiliency and were able to describe personal skills used to stay resilient. This is important information because it shows that although having this knowledge, their pre-intervention surveys showed high rates of CF. Prior to intervention, none of the participants were knowledgeable about CRM skills. Participants were taught six new skills that help them stay in the ‘Resilient Zone’ and were advised to use them during a span of eight weeks. Overall, results show an improvement in STS, an emotion that front-line workers have been facing during the Covid-19 pandemic. STS is known as “a traumatic stress reaction from a secondary source (Pehlivan, 2017)”, and the results of this project suggest that CRM can be a useful tool in helping to cope with STS during a nursing shift.

In conclusion, facilities do not have a resiliency training course, nor do they teach about CF or BO in the on-boarding process or in clinical practice. Organizations need to find a more long-term approach to

support nurses with CF. Nurses continue to face CF ultimately impacting patient care outcomes, placing financial strain on organizations, and leading nurses to leave their unit or overall profession. The finding from this project can be used by organizations to better understand the concepts and severity of CF, domains of resiliency, and the pedagogical approach to delivering resiliency skills for effective learning.

Completion of this DNP project met all the DNP Essentials. Research on the chosen topic was conducted in various data basis to aid in understanding. Results were then translated into a table of evidence and assess need for intervention. Through literature search, the topic was then validated as a need to translate into practice. The project was then design to deliver by following the logic model. A meeting with stakeholders was held to promote the need for intervention. The concept of improving compassion fatigue by building resiliency through skillsets was approved by the stakeholders which then allowed for the DNP student to deliver the evidence-based resiliency training. Evidence of technological use was evident. The DNP project survey was provided using via Qualtrics and the workshop was delivered via Zoom due to a pandemic. Although no overall statistical changes, the project allowed for lessons learned on the need for long-term intervention that will help support resiliency in emergency nurses through the support of hospital leadership.

REFERENCES:

- Aagard, M., Papadopoulos, I., & Biles, J. (2018). Exploring Compassion in U.S. Nurses: Results from an International Research Study. *OJIN: The Online Journal of Issues in Nursing*, 23(1). <https://doi.org/10.3912/ojin.vol23no01ppt44>
- Aggarwal, R., Deutsch, J. K., Medina, J., & Kothari, N. (2017). Resident Wellness: An Intervention to Decrease Burnout and Increase Resiliency and Happiness. *MedEdPORTAL : the journal of teaching and learning resources*, 13, 10651. https://doi.org/10.15766/mep_2374-8265.10651
- Amberson, T. (2021). Postpandemic Psychological Recovery and Emergency Nursing: Creating a Narrative for Change. *Journal of Emergency Nursing*, 47(3), 362–365. <https://doi.org/10.1016/j.jen.2021.03.002>
- Blackburn, L. M., Thompson, K., Frankenfield, R., Harding, A., & Lindsey, A. (2020). The THRIVE© Program: Building Oncology Nurse Resilience Through Self-Care Strategies. *Oncology nursing forum*, 47(1), E25–E34. <https://doi.org/10.1188/20.ONF.E25-E34>
- Çam, O. (2017). Nurses' Resilience and Effective Factors. *Journal of Psychiatric Nursing*. <https://doi.org/10.14744/phd.2017.75436>
- Chesak, S. S., Bhagra, A., Cutshall, S., Ingram, A., Benoit, R., Medina-Inojosa, J. R., Hayes, S. N., Carolan, B. J., & Luthar, S. (2020). Authentic Connections Groups: A Pilot Test of an Intervention Aimed at Enhancing Resilience Among Nurse Leader Mothers. *Worldviews on evidence-based nursing*, 17(1), 39–48. <https://doi.org/10.1111/wvn.12420>
- Cocker, F., & Joss, N. (2016). Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review. *International Journal of Environmental Research and Public Health*, 13(6), 618. <https://doi.org/10.3390/ijerph13060618>
- Davidson, J. R. T. (2022, January 01). *Connor-Davidson Resilience Scale (CD-RISC) Manual*. Unpublished. <https://www.cd-risc.com>

- Delaney M. C. (2018). Caring for the caregivers: Evaluation of the effect of an eight-week pilot mindful self-compassion (MSC) training program on nurses' compassion fatigue and resilience. *PloS one*, 13(11), e0207261. <https://doi.org/10.1371/journal.pone.0207261>
- Foster, K., Cuzzillo, C., & Furness, T. (2018). Strengthening mental health nurses' resilience through a workplace resilience programme: A qualitative inquiry. *Journal of psychiatric and mental health nursing*, 25(5-6), 338–348. <https://doi.org/10.1111/jpm.12467>
- Grabbe, L., Higgins, M. K., Baird, M., Craven, P. A., & San Fratello, S. (2020). The Community Resiliency Model® to promote nurse well-being. *Nursing outlook*, 68(3), 324–336. <https://doi.org/10.1016/j.outlook.2019.11.002>
- Magtibay, D. L., Chesak, S. S., Coughlin, K., & Sood, A. (2017). Decreasing Stress and Burnout in Nurses: Efficacy of Blended Learning With Stress Management and Resilience Training Program. *The Journal of nursing administration*, 47(7-8), 391–395. <https://doi.org/10.1097/NNA.0000000000000501>
- McMahon, E. (2021, March 13). *Nurse Staffing: How COVID-19 Highlighted an Issue that Always Existed*. ANA Illinois. <https://www.ana-illinois.org/news/nurse-staffing-covid-19/>
- Mintz-Binder, R., Andersen, S., Sweatt, L., & Song, H. (2021). Exploring Strategies to Build Resilience in Nurses During Work Hours. *JONA: The Journal of Nursing Administration*, 51(4), 185–191. <https://doi.org/10.1097/nna.0000000000000996>
- Mistretta, E. G., Davis, M. C., Temkit, M., Lorenz, C., Darby, B., & Stonnington, C. M. (2018). Resilience Training for Work-Related Stress Among Health Care Workers: Results of a Randomized Clinical Trial Comparing In-Person and Smartphone-Delivered Interventions. *Journal of occupational and environmental medicine*, 60(6), 559–568. <https://doi.org/10.1097/JOM.0000000000001285>

- Nolte, A. G., Downing, C., Temane, A., & Hastings-Tolsma, M. (2017). Compassion fatigue in nurses: A metasynthesis. *Journal of Clinical Nursing*, 26(23–24), 4364–4378.
<https://doi.org/10.1111/jocn.13766>
- Pérez-García, E., Ortega-Galán, N. M., Ibáñez-Masero, O., Ramos-Pichardo, J. D., Fernández-Leyva, A., & Ruiz-Fernández, M. D. (2020). Qualitative study on the causes and consequences of compassion fatigue from the perspective of nurses. *International Journal of Mental Health Nursing*, 30(2), 469–478. <https://doi.org/10.1111/inm.12807>
- Peters, E. (2018, July 2). *Compassion fatigue in nursing: A concept analysis*. Wiley Online Library.
<https://onlinelibrary.wiley.com/doi/abs/10.1111/nuf.12274>
- Rees, C. S., Craigie, M. A., Slatyer, S., Crawford, C., Bishop, M., McPhee, E., & Hegney, D. G. (2020). Pilot study of the effectiveness of a Mindful Self-Care and Resiliency program for rural doctors in Australia. *Australian Journal of Rural Health*, 28(1), 22–31. <https://doi.org/10.1111/ajr.12570>
- Rushton, C. H., Swoboda, S. M., Reller, N., Skarupski, K. A., Prizzi, M., Young, P. D., & Hanson, G. C. (2021). Mindful Ethical Practice and Resilience Academy: Equipping Nurses to Address Ethical Challenges. *American journal of critical care : an official publication, American Association of Critical-Care Nurses*, 30(1), e1–e11. <https://doi.org/10.4037/ajcc2021359>
- Scarlet, J., Altmeyer, N., Knier, S., & Harpin, R. E. (2017). The effects of Compassion Cultivation Training (CCT) on health-care workers. *Clinical Psychologist*, 21(2), 116–124.
<https://doi.org/10.1111/cp.12130>
- Slatyer, S., Craigie, M., Heritage, B., Davis, S., & Rees, C. (2017). Evaluating the Effectiveness of a Brief Mindful Self-Care and Resiliency (MSCR) Intervention for Nurses: a Controlled Trial. *Mindfulness*, 9(2), 534–546. <https://doi.org/10.1007/s12671-017-0795-x>
- Stamm, B.H. (2010). *The Concise ProQOL Manual* (2nd ed.). Pocatello, ID: ProQOL.org

- Sullivan, C. E., King, A. R., Holdiness, J., Durrell, J., Roberts, K. K., Spencer, C., Roberts, J., Ogg, S. W., Moreland, M. W., Browne, E. K., Cartwright, C., Crabtree, V. M., Baker, J. N., Brown, M., Sykes, A., & Mandrell, B. N. (2019). Reducing Compassion Fatigue in Inpatient Pediatric Oncology Nurses. *Oncology nursing forum*, 46(3), 338–347.
<https://doi.org/10.1188/19.ONF.338-347>
- Transitional Support. (2016, October 19). *Burnout Vs Compassion Fatigue*.
<http://transitionalsupport.com.au/transitional-phase/compassion-fatigue-trauma/>
- Watson Caring Science Institute. (2021, August 15). *Caring Science & Theory*.
<https://www.watsoncaringscience.org/jean-bio/caring-science-theory/#theory>
- Zhang, X. J., Song, Y., Jiang, T., Ding, N., & Shi, T. Y. (2020). Interventions to reduce burnout of physicians and nurses: An overview of systematic reviews and meta-analyses. *Medicine*, 99(26), e20992. <https://doi.org/10.1097/MD.0000000000020992>
- Zhang, Y.-ying, Zhang, C., Han, X.-R., Li, W., & Wang, Y.-lei. (2018). Determinants of compassion satisfaction, compassion fatigue and burn out in nursing. *Medicine*, 97(26).
<https://doi.org/10.1097/md.0000000000011086>

APPENDIX A: Site approval/authorization letter

Letter of Cooperation with Outside Organization for UCI DNP Project

Date: 11/09/21

Dear: (name of DNP Student): NORMA HERNANDEZ RAMIREZ

This letter confirms that I, as an authorized representative of
allow the above-named Doctor of Nursing Practice student access to conduct a leadership, policy, quality improvement, or evidence-based practice project activities at the listed site(s) as discussed with the DNP student and outlined below. These activities may commence after the DNP student has consulted with UCI IRB about the proposed project.

- **Project site(s):** (list specific site name and address for all sites within which the organization is providing student access to conduct the project)

Emergency Room at UCI Medical Center
101 The City Dr S, Orange, CA 92868

- **Project purpose:** (briefly summarize the project purpose, plan and expected outcomes)

This project is an Evidence-Based Project to analyse the effectiveness decreasing compassion fatigue in emergency nurses using a one time 1-hour resiliency training workshop. Expected outcomes includes decreased compassion fatigue and increased resiliency immediately after and two-months post intervention.

- **Project activities:** (briefly summarize the activities that will commence at the site, including any baseline data collected, educational interventions, PDSA cycle proposed...)

Baseline data will be collected from nurse participants via email or QR code before and after the workshop to measure compassion fatigue and resiliency. The one-hour workshop will be in person (or virtual due to Covid-19). Post intervention surveys will be taken 2 months afterwards. Posters of the CRM model can be posted in the breakroom for reminder to use the resiliency tool and iChill App will be provided for reminder of the skills learned during workshop.

- **Target population:** (identify the population upon whom the project will focus)

Emergency Nurses (Per Diem and Travel nurses included).

- **Site(s) support:** (briefly describe the support the project site(s) agree to provide to support the project, such as space to conduct project activities, data retrieval from electronic records, facilitation of educational activities....)

-Access to space to conduct intervention and make announcements to ED nursing staff will be provided by UCIMC ED site mentor or ED nursing staff. -Permission to post announcement of workshop dates, survey link, and CRM model in nursing breakroom.

- There will be no data retrieval since nurse participants will be individually providing their personal demographics while doing survey.

- **Data management plan:** (briefly describe the plan for management of data such as what data will be collected, whether it will be identified/de-identified, what protections will be in place for data protection...)

Data of participants, such as demographics and survey answers are de-identified and collected via UCI Qualtrics or REDCap. Survey is sent via email, or can be found using the QR code posted in break room.

- **Other agreements:** (briefly describe any additional agreements that have been made to support the project, if applicable)

Due to Covid-19, workshop may be done via virtual.

- **Anticipated end date:** (indicate the anticipated date that the project will be concluded at the site)

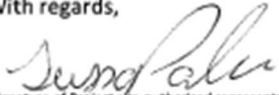
Anticipated dates are throughout January 2022 for the one-time 1 hour Workshop.

It is understood that all DNP Scholarly Project related activities must cease if directed by UCI IRB. It is also understood that any activities that involve Personal Private Information or Protected Health Information must comply with HIPAA Laws and institutional policy.

Our organization agrees to the terms and conditions stated above. If there are any concerns related to this project, we will contact the DNP student named above and their DNP Scholarly Project Chair. For concerns regarding IRB policy or human subject welfare, we may also contact our own institutional IRB.

UCI IRB: <https://www.research.uci.edu/compliance/human-research-protections/researchers/irb-faqs.html>

With regards,


(Signature of Project site-authorized representative)

MANAGER, EMERGENCY DEPARTMENT
(Job title of authorized representative)

(Date signed)

11/24/21

UCI Health

Teresa Polinski, MSN, RN,
CEN,TCRN
Nurse Manager

polinski@hs.uci.edu
714-509-2448 tel
714-456-3508 fax
949-244-5731 mobile

Emergency Department
101 The City Drive S
Route 24
Orange, CA 92868-3298
ucihealth.org

APPENDIX B: Kuali Approval

1/24/22, 10:30 AM

Protocols

PROTOCOLS

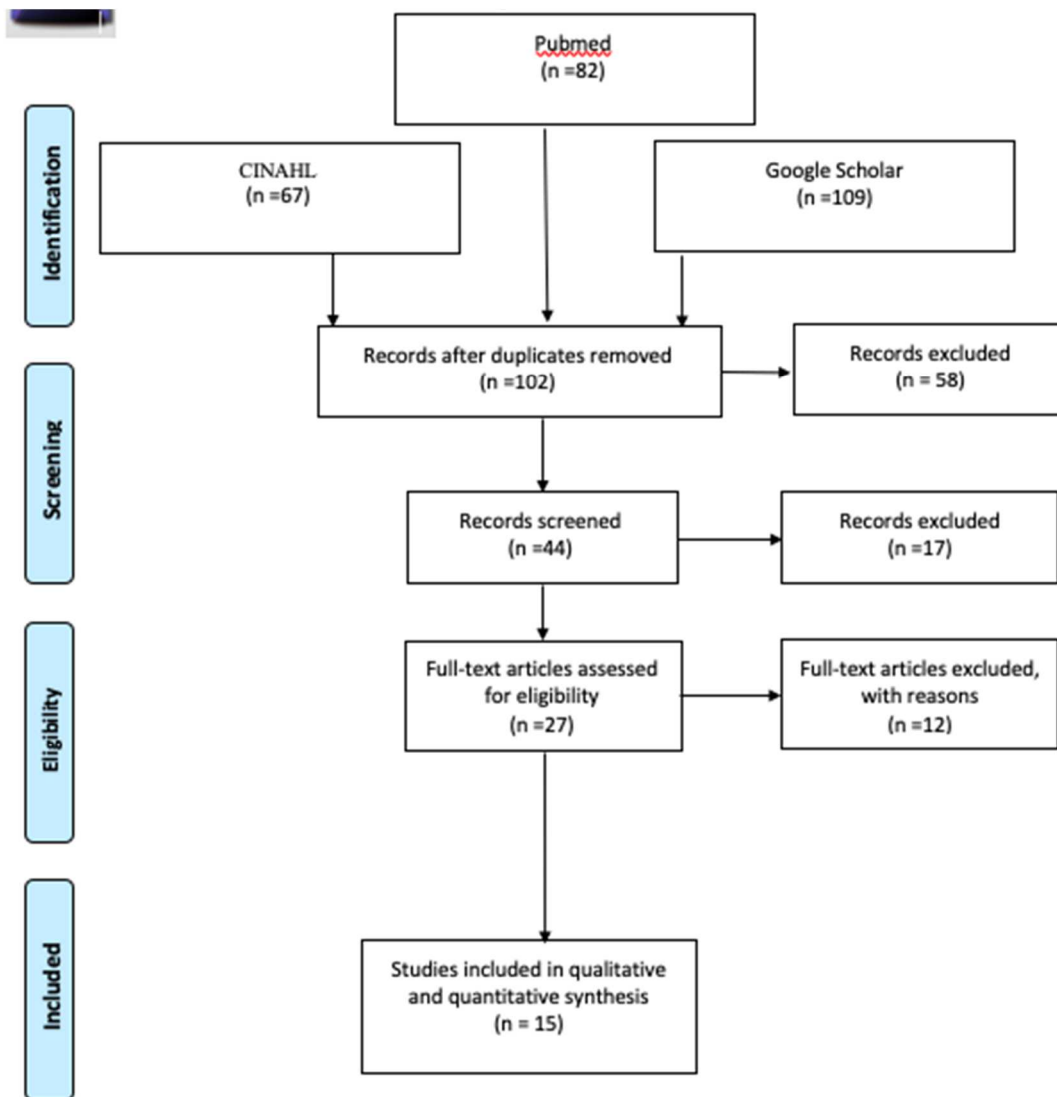


#841 - Decreasing Compassion Fatigue in Emergency Nursing through Resilience Training

Protocol Information

Review Type	Status	Approval Date	Continuing Review Date
Exempt	Exempt	Jan 24, 2022	--
Expiration Date	Initial Approval Date	Initial Review Type	
--	Jan 24, 2022	Exempt	

APPENDIX C: PRISMA Chart



APPENDIX D: Table of Evidence

First author (Year) Title of the article	Conceptual Framework (name it)	Design/Method	Sample/Setting	Major valuables (outcomes) studied (their definitions)	Measurement (Instrument s or tools to measure outcomes)	Data Analysis Method	Findings	Appraisal: Put the level and quality of the article, Worth to use?
Delaney MC (2018), Caring for the caregivers: Evaluation of the effect of an eight-week pilot mindful self-compassion (MSC) training program on nurses' compassion fatigue and resilience	Self-compassion, mindfulness, compassion, loving kindness meditation	Observational study; the effect of an eight-week Mindful Self-Compassion (MSC) training intervention on nurses' compassion fatigue and resilience	N=13, hospital setting, nurses	The independent variables self-compassion and mindfulness and the dependent variables secondary traumatic stress, burnout, compassion satisfaction, and resilience	The Neff 26-item Self-compassion scale, The Freiburg Mindfulness inventory, ProQOL Version 5 Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Version, Connor-Davidson Resilience Scale 25 item (CD-RISC 25)	interpretative phenomenological analysis (IPA), Cohen Pearson's correlation	The Pre- to Post- scores of secondary trauma and burnout declined significantly and were negatively associated with self-compassion and mindfulness, respectively. Resilience and compassion satisfaction scores increased.	YES
Zhang (2020) Interventions to reduce burnout of physicians and nurses	Burnout Resilience	Meta-analysis And systemic reviews	N=9 physicians, n=6 nurses N= 7 healthcare providers	Burn out ; emotional regulation	Systemic reviews	qualitative synthesis	There were three types of interventions: individual-focused, structural or organizational, and combine intervention	NO
Magtibay (2017), Decreasing Stress and Burnout in Nurses: Efficacy of Blended Learning With Stress Management and Resilience Training Program	This retraining is conducted through intentionally paying attention to life experiences and reframing those experiences through the principles of gratitude, compassion, acceptance, higher meaning,	Quasi-experimental, 1-group baseline to postintervention Stress Management and Resiliency Training (SMART) was redesigned from a classroom setting to a Web-based format	N= 50 nurses	The end points for the study, happiness, stress, anxiety, mindful attention, resilience, and burnout were continuous variables and were assessed at baseline and at weeks 8, 12, and 24 after the baseline	Subjective Happiness Scale, ²⁴ Perceived Stress Scale, ²⁵ Generalized Anxiety Scale, ²⁶ Mindful Attention Awareness Scale, ²⁷ Connor-Davidson Resilience Scale, and Copenhagen Burnout Inventory. ²⁸	For the primary analysis, the value of each end point at week 24 was compared with baseline using the paired t test (or Wilcoxon signed rank test). Change from baseline was	Significant decreases in anxiety ($P < .001$), personal burnout ($P < .001$), and work-related burnout ($P < .001$). Of note, the interval between weeks 8 and 12 showed greater improvement than the other time intervals.	YES

	and forgiveness	consisting of 12 modules. To attend 4 discussions facilitated by the book's author (A.S.) and by the principal investigator (D.L.M.) at weeks 8, 12, 16, and 20. Week 8 and 12 sessions were conducted in-person; week 16 and 20 through telephone conversation.				summarized using a point estimate and 95% confidence interval		
Aggarwal (2017)- Resident Wellness: An Intervention to Decrease Burnout and Increase Resiliency and Happiness	Well-being	60-minute didactic featuring both the concepts and science behind well-being. Residents then attended 15-minute booster sessions during protected didactic time each week for a 12-week curriculum. Monthly competitions using free phone apps to promote physical fitness through steps and flights challenges.	N= 188 Residents Five subspecialties of internal medicine, general surgery, anesthesiology, psychiatry, and physical medicine and rehabilitation	Happiness, resiliency, quality of life, and burnout	Subjective feedback	Qualitative, subjective feedback	Positive impact	YES
Rees (2020), Pilot study of the effectiveness of a Mindful Self-Care and	Mindfulness and self-care	A mixed-method study design; Mindful Self-Care and Resiliency	N=7 doctors	Burnout, negative affect, well-being and psychological strain	Connor-Davidson Resilience Scale; State-Trait Assessment of Resilience,		The majority (six out of seven) of the doctors showed reductions in burnout, psychological	YES

Resiliency program for rural doctors in Australia		(MSCR) programme-consisted of a 4-hour face-to-face session and three 1-hour video-conference follow up sessions			Professional Quality of Life Scale, Self-Compassion Scale, The Abridged Job in General Scale, The WHO Health and Work Performance Questionnaire, WHO Five Well-being Index		al strain and negative affect	
Mistretta (2018), Resilience Training for Work-Related Stress Among Health Care Workers: Results of a Randomized Clinical Trial Comparing In-Person and Smartphone-Delivered Interventions	Resiliency Self-compassion, Sleep, stress	Randomized to either the Mindfulness-Based Resilience Training (MBRT) intervention ($n = 22$), the smartphone resilience intervention app ($n = 23$), or the control group ($n = 15$) for 6 weeks.	N=60 healthcare employees	To compare the effectiveness of an in-person mindfulness-based resilience training program to a smartphone-delivered resiliency-based intervention for improving stress and well-being and decreasing burnout	Depression, Anxiety, and Stress Scales, WHO (Five) Well-Being Index, MBI-Human Services Survey, Self-Compassion Scale (SCS), Compassion for Others Scale Daily Affect, Relationship Quality, Valued Action, and Sleep Monitoring	ANOVA and Chi-square analyses	Both the MBRT and the smartphone groups showed improvements in well-being, whereas only the MBRT group showed improvements in stress and emotional burnout over time. The control group did not demonstrate sustained improvement on any outcome.	YES
Blackburn (2020), The THRIVE® Program: Building Oncology Nurse Resilience Through Self-Care Strategies.	Relationship-based care (RBC)	THRIVE® program, which consists of an eight-hour retreat designed to teach self-care strategies, a six-week private group study interaction on a social media platform, and a two-hour wrap-up session	N=164, 160 of them were oncology nurses	Decrease compassion fatigue, increase resilience, and decrease burnout	Compassion Fatigue Short Scale (CFSS) and the Connor-Davidson Resilience Scale (CD-RISC)	In evaluating the outcomes of the THRIVE program with the CD-RISC, all participants rated each of the 25 statements. The total score was tallied by summing scores, then transferred to 0-100 scale.	The greatest improvement in average scores from pre- to post-program assessment was in increased resilience and decreased burnout. Increased resilience scores were sustained for a six-month	YES

							period after THRIVE participation.	
Chesak (2020) Authentic Connections Groups: A Pilot Test of an Intervention Aimed at Enhancing Resilience Among Nurse Leader Mothers.	Jean Watson's Theory of Human Caring as Theoretical Framework; Concepts include self-care, self-compassion, emotional support, stress, depression.	RCT: AC participants attended group sessions for an hour per week for 12 weeks. Control group members were provided 1 hr per week of free time over 12 weeks. Multiple self-report psychological measures were completed at baseline, post-intervention, and 3-month follow-up.	N=36 nurse leaders	Analyzing Depression, anxiety, feeling loved, self-compassion, perceived stress, emotional exhaustion, personal accomplishment using emotional and group support	Zung Self-Rating Depression Scale, Zung Self-Rating Anxiety Scale, and the Perceived Stress Scale, Feeling loved was assessed using four questions: 7-point scale, Self-Compassion Scale, Maslach Burnout Inventory.	Repeated measures ANOVA and one-way ANCOVA analyses were run using SPSS software	Positive outcomes: the greater improvements for participants in the AC Groups than control condition for depression, self-compassion, and perceived stress.	NO
Foster (2018) Strengthening mental health nurses' resilience through a workplace resilience programme: A qualitative inquiry	Interpersonal strength, negative self-talk,	Qualitative study; Promoting adult resilience (PAR) is delivered over 7 weeks with one module/week	N= 29	building participants' interpersonal strengths, developing skills for managing stress and mental well-being, and building resourcefulness	Multiple qualitative data were triangulated : open-ended written responses, semi-structured participant interviews, and participant and facilitator focus groups.		Resilience programmes can help improve nurses' self-efficacy and ability to realistically appraise stressful situations and to moderate their emotional responses to others.	YES
Sullivan, 2019, Reducing Compassion Fatigue in Inpatient Pediatric Oncology Nurses	Burnout, secondary traumatic stress, compassion satisfaction, resiliency, ineffective coping, self-care	Unit-based self-care 6 month program intervention . A face-to face encounter with the project nurse.	59 nurses, pediatric oncology unit	maladaptive coping against stressors will increase stress. Mixed interventions including CF, STS and BO education was	ProQOLV Brief COPE Connor-Davidson Resilience Scale-2	The Wilcoxon signed-rank test for ProQOLV scores. The Spearman rank correlation coefficient for the relationship	Secondary traumatic stress scores significantly improved from baseline to four months. Select coping characteristics	YES

				implemented, including nutrition and self-care education, grief education, and respite room.		between quality-of-life scores and resilience and coping style. Statistical analyses were conducted using SAS, version 9.4.	cs were significantly correlated with ProQOLV subscale scores.	
Scarlet, 2017, The effects of Compassion Cultivation Training (CCT) on health-care workers	self-compassion, fears of compassion, mindfulness, burnout, job satisfaction, and interpersonal conflict	A Cultivation training (CCT) course—consists of eight, 2-hr weekly group sessions in which participants are taught mindfulness, Loving-Kindness Meditation, as well as compassion and self-compassion skills through discussion, psychoeducation and experiential practices.	62 Healthcare workers in a single facility	CCT has been used in previous studies as proof that it works to decrease burnout and improve self-compassion and job satisfaction.	Self-Compassion Scale—Short Form, Toronto Mindfulness Scale, Copenhagen Burnout Inventory, Brief Index of Affective Job Satisfaction, Interpersonal Conflict Scale, Fears of Compassion Scale	ANOVA was conducted using SPSS 22.0 and Excel 2010 to examine the effect of time on each of the outcome variables at pre-test, post-test, and 1-month follow up	The results for this study demonstrated significant improvements in participants' self-compassion, mindfulness, and interpersonal conflict scores. In addition, the results indicated marginally significant improvements in self-reported job satisfaction scores. No differences were observed on the burnout measure due to possible floor effects.	YES
Rushton, 2021, Mindful Ethical Practice and Resilience Academy: Equipping Nurses to Address Ethical Challenge	Mindful Ethical Practice and Resilience Academy (MEPRA) was developed to nurture a culture of mindfulness, ethical competence, and resilience among frontline nurses	• 6 experiential workshops (4 hours) • Daily technology enabled mindfulness and reflective practice • Pre- and post curriculum assessment • Self-report	N=192 MEPRA participants; 223 non-MEPRA participants.	Enhance nurses' skills in mindfulness, resilience to recognize, respond to, and confront ethical challenges in clinical practice. Secondary outcomes included changes in	Perceived Ethical Confidence Scale, Moral Sensitivity Questionnaire, Moral Competence Questionnaire, Brief Resilience Scale, Multi-dimensional Emotional	We evaluated the impact of MEPRA with repeated measures analysis of covariance with a significance level of .05	Improved symptoms of depression and anger, Mindfulness, ethical confidence, ethical competence, work engagement, and resilience increased significantly after the	YES

				empathy, psychiatric symptoms, burnout, moral distress, work engagement , and turnover intention.	Empathy Scale Work, 2-Item burnout questions, Moral Distress Thermometer, Ilfeld Psychiatric Symptom Index, Mindful Attention Awareness Scale		intervention .	
Slatyer, 2017, Evaluating the Effectiveness of a Brief Mindful Self-Care and Resiliency (MSCR) Intervention for Nurses: a Controlled Trial	Autopilot, being present, letting be, body scan, mindful movement, burnout	The intervention involved a 1-day workshop followed by three weekly mindfulness practice sessions.	N= 91, but 65 nurses- intervention group and 26 nurses- control group data	Measuring outcomes of self-regulation, intentionality, maturation, connection and social support and selfcare.	ProQol5 DASS21 CD-RISC10 GSES SCS-SF WHO -5	Via generalized linear mixed modelling (GLMM) using the software SPSS Version 22	Intervention group had reductions in burnout and depressed mood upon completion and persisted at 6-month post-MSCR for the intervention group	YES
Mintz-Binder, 2021 Exploring Strategies to Build Resiliency in Nurses During Work Hours	concept of resilience-correlation between stress and resiliency	quasi-experimental pretest and posttest intervention pilot study used a within-subjects design. The nurses met 5 times with 2 nurse researchers from an academic health sciences center to create the study protocol	N=90 medical-surgical nurses	Measure the feasibility of stress reduction and resiliency enhancement intervention s applied during work ours	Outcomes of resilience were integration, development of personal control, psychological adjustment, and personal growth	Connor-Davidson Resilience Scale-10 scores	Self-reported stress levels decreased over the 10 shifts with continued use of the intervention s.	YES
Grabbe, et al. (2019)- The Community Resiliency Model to promote	'The Resilient Zone', looking at Well being and resiliency.	Randomized - Control Trial measuring the effectiveness of a 3-hour Community	N=77 nurses form different specialties, two different teach hospitals	CRM taught 6 skills: Tracking, Resourcing, Grounding, Gesturing, Shift and	WHO-5 Well-being Index, Connor-Davidson Resilience Scale-10, Secondary	PASS 2019, REDcap system for data collection and management,	80% of nurses in the CRM group showed statistically significant improved	YES

nurse well-being		Resiliency Model training pas an intervention - a novel set of sensory awareness techniques to improve emotional balance, especially in stressful events.		Stay, and Help now!	Traumatic Stress Scale, Copenhagen Burnout Inventory, Somatic Symptom Scale-8	Cronbach's alpha, multilevel linear models and Sidak pairwise error rate adjustment, IBM SPSS statistics for Windows Version 24.0	well-being from baseline at 1 year. Increased outcomes changed includes Secondary traumatic stress, somatic symptoms and resilience.	
------------------	--	---	--	---------------------	---	---	--	--

APPENDIX E: Conceptual Framework

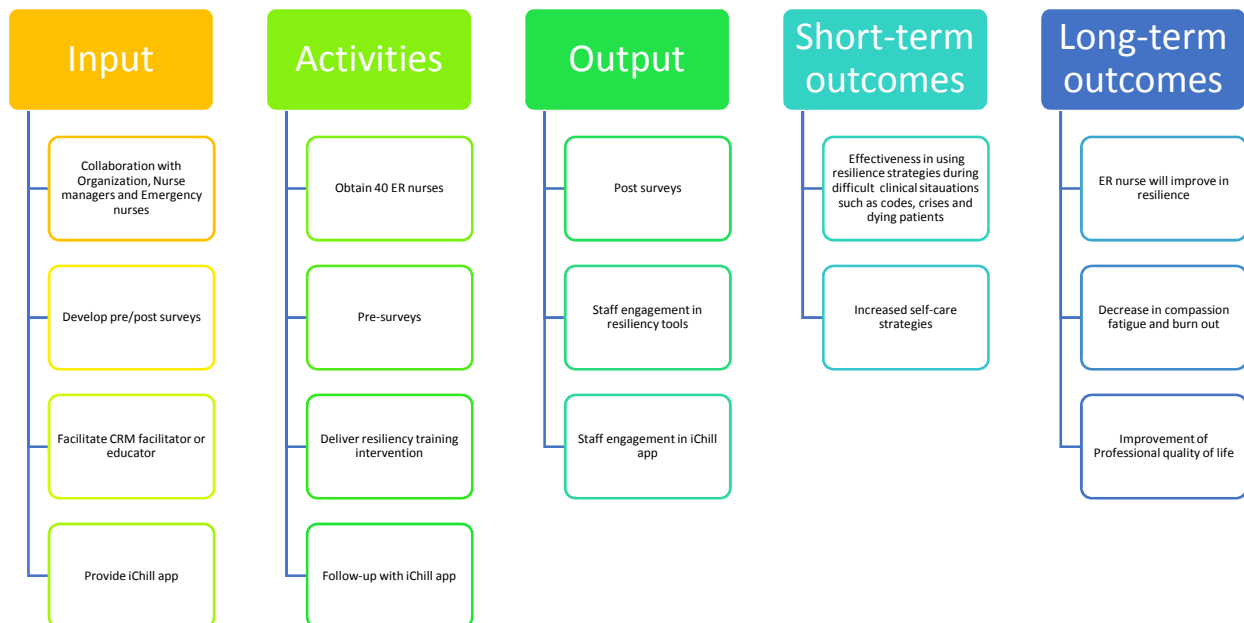
The Resilient Zone

When we are in our "Resilient Zone," we have the best capacity for flexibility and adaptability in mind, body and spirit.



TRM skills help deepen the Resilient Zone

APPENDIX F: Logic Model



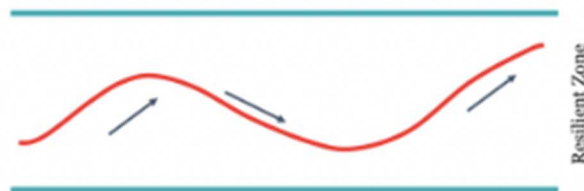
ATTENTION NURSES!

**FEELING COMPASSION FATIGUE?
LEARN NEW SKILLS TO IMPROVE YOUR RESILIENCY!**

THE COMMUNITY RESILIENCY MODEL!



The Resilient Zone- "OK" Zone



GOAL: TO WIDEN YOUR RESILIENCY ZONE

© Trauma Resource Institute

COMING SOON!

FEBRUARY 2022

**CONTACT DNP STUDENT NORMA HERNANDEZ FOR MORE INFORMATION:
NORMADH@UCI.EDU**

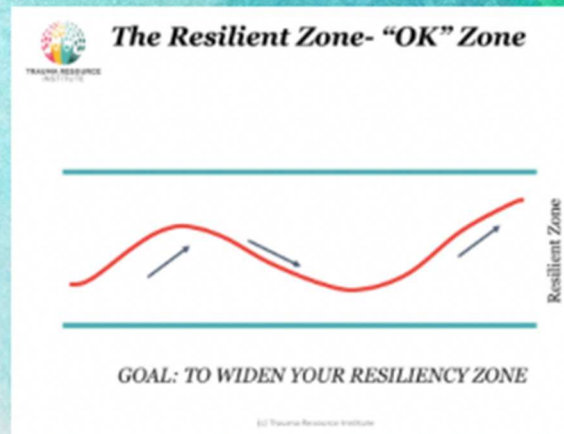
Attention ER Nurses!

FEELING COMPASSION FATIGUE?

learn new ways to
improve your
resiliency!

Coming Soon: February 3rd 2022 @10am

**Join me for a 1-hour, one-time resiliency
workshop using the Community Resiliency Model!**



Nurse participants will be compensated
\$10 Starbucks/Visa gift card for pre-survey and
workshop attendance!

Email Norma Hernandez
normadh@uci.edu

for zoom link and pre-survey!

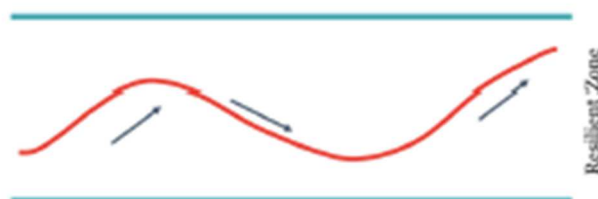
ATTENTION NURSES!

FEELING COMPASSION FATIGUE?
LEARN NEW SKILLS TO IMPROVE YOUR RESILIENCY!

THE COMMUNITY RESILIENCY MODEL!



The Resilient Zone- "OK" Zone



GOAL: TO WIDEN YOUR RESILIENCY ZONE

© Trauma Resource Institute

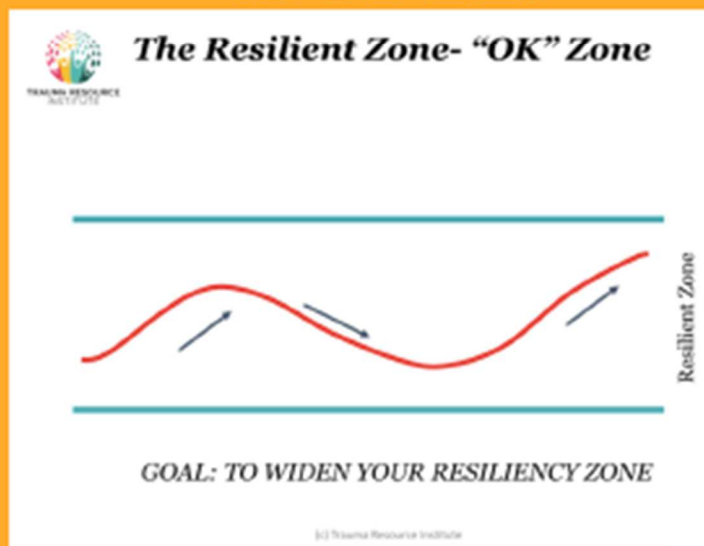
COMING SOON!

JANUARY 2022

CONTACT DNP STUDENT NORMA HERNANDEZ FOR MORE INFORMATION:
NORMADH@UCI.EDU

**LEARN NEW
RESILIENCY
SKILLS
USING...**

**THE
COMMUNITY RESILIENCY
MODEL!**



**COMING
SOON!**

JANUARY 2022

**CONTACT DNP STUDENT NORMA HERNANDEZ FOR MORE INFORMATION:
NORMADH@UCI.EDU**

APPENDIX H: Data Collection Instruments

Connor-Davidson Resilience Scale 10 (CD-RISC-10) ©

initials ID# date / / visit age

Please indicate how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

	not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1. I am able to adapt when changes occur.	☐	☐	☐	☐	☐
2. I can deal with whatever comes my way.	☐	☐	☐	☐	☐
3. I try to see the humorous side of things when I am faced with problems.	☐	☐	☐	☐	☐
4. Having to cope with stress can make me stronger.	☐	☐	☐	☐	☐
5. I tend to bounce back after illness, injury, or other hardships.	☐	☐	☐	☐	☐
6. I believe I can achieve my goals, even if there are obstacles.	☐	☐	☐	☐	☐
7. Under pressure, I stay focused and think clearly.	☐	☐	☐	☐	☐
8. I am not easily discouraged by failure.	☐	☐	☐	☐	☐
9. I think of myself as a strong person when dealing with life's challenges and difficulties.	☐	☐	☐	☐	☐
10. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	☐	☐	☐	☐	☐

Add up your score for each column 0 + ____ + ____ + ____ + ____

Add each of the column totals to obtain CD-RISC score = _____

All rights reserved. No part of this document may be reproduced or transmitted in any form, or by any means, electronic or mechanical, including photocopying, or by any information storage or retrieval system, without permission in writing from Dr. Davidson at mail@cd-risc.com. Further information about the scale and terms of use can be found at www.cd-risc.com. Copyright © 2001, 2018 by Kathryn M. Connor, M.D., and Jonathan R.T. Davidson, M.D. This version of the scale was developed as a work made for hire by Laura Campbell-Sills, Ph.D., and Murray B. Stein, M.D.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

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

Compassion Satisfaction _____

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

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout _____

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

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress _____

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

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

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

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1. I am happy.					
_____ 2. I am preoccupied with more than one person I [help].					
_____ 3. I get satisfaction from being able to [help] people.					
_____ 4. I feel connected to others.					
_____ 5. I jump or am startled by unexpected sounds.					
_____ 6. I feel invigorated after working with those I [help].					
_____ 7. I find it difficult to separate my personal life from my life as a [helper].					
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
_____ 9. I think that I might have been affected by the traumatic stress of those I [help].					
_____ 10. I feel trapped by my job as a [helper].					
_____ 11. Because of my [helping], I have felt "on edge" about various things.					
_____ 12. I like my work as a [helper].					
_____ 13. I feel depressed because of the traumatic experiences of the people I [help].					
_____ 14. I feel as though I am experiencing the trauma of someone I have [helped].					
_____ 15. I have beliefs that sustain me.					
_____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.					
_____ 17. I am the person I always wanted to be.					
_____ 18. My work makes me feel satisfied.					
_____ 19. I feel worn out because of my work as a [helper].					
_____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.					
_____ 21. I feel overwhelmed because my case [work] load seems endless.					
_____ 22. I believe I can make a difference through my work.					
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
_____ 24. I am proud of what I can do to [help].					
_____ 25. As a result of my [helping], I have intrusive, frightening thoughts.					
_____ 26. I feel "bogged down" by the system.					
_____ 27. I have thoughts that I am a "success" as a [helper].					
_____ 28. I can't recall important parts of my work with trauma victims.					
_____ 29. I am a very caring person.					
_____ 30. I am happy that I chose to do this work.					

© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (PROQOL). 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. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

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

Compassion Satisfaction Scale

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

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1, "I am happy" tells us more about

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

the effects of helping when you are not happy so you reverse the score

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

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

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

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

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

APPENDIX I: Demographic Survey

1. Age
 - a. 20-29
 - b. 30-39
 - c. 40-49
 - d. 50-59
 - e. 60-69
 - f. 70+
2. Highest level of education completed
 - a. ADN
 - b. BSN
 - c. MSN
 - d. DNP/PhD
3. Total number of years as an RN
 - a. < 1yr
 - b. 1-5yrs
 - c. 6-10yrs
 - d. 11-15yrs
 - e. 16-20yrs
 - f. 20+
4. Total number of years as an Emergency Nurse
 - a. < 1yr
 - b. 1-5yrs
 - c. 6-10yrs
 - d. 11-15yrs
 - e. 16-20yrs
 - f. 20+
5. Name your position: _____
6. Job status
 - a. Full-time
 - b. Part-time
 - c. Per Diem
 - d. Traveler
 - e. Temporary
 - f. Other
7. How did you find out about this workshop?
 - a. EBENA
 - b. UCI

APPENDIX J: Pre and Post Survey Questionnaires

Pre-intervention open-ended survey questions:

1. What is Compassion Fatigue? If you do not know, please write no answer.
2. What is Resiliency? If you do not know, please write no answer.
3. What are 3 ways you stay resilient throughout a shift? If you do not know, please write no answer.

Post-intervention open-ended survey questions:

1. Were you able to download and use the iChill app?
2. In the past 2 months, were you able to use the CRM in a given nurse shift?
3. Name 3 CRM skills learned in the resiliency workshop.
4. Did you find the CRM skills effective? Please explain why or why not.

APPENDIX K: Intervention Material



Decreasing Compassion Fatigue in Emergency Nurses through resiliency training

By Norma Hernandez Ramirez
The Community Resilience Model developed by The
Trauma Resource Institute

Overview of workshop

Definitions
CRM
Resiliency Zone
6 Skills
Additional info
Attendance





What is Compassion Fatigue?

▀ Negative aspects of working as a helper

▀ Burnout and Secondary Traumatic Stress

▀ Declining empathy

▀ more acute

What is Resiliency?



▀ staying calm and in control when faced with a challenge

▀ adapting well in adversity

What is the Community Resilience Model (CRM)?

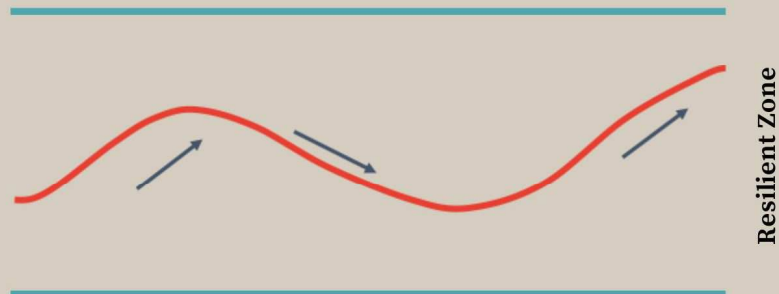


Body awareness can reduce impulsivity and promote emotion regulation and clearer thinking

focuses on the biology of the human nervous system

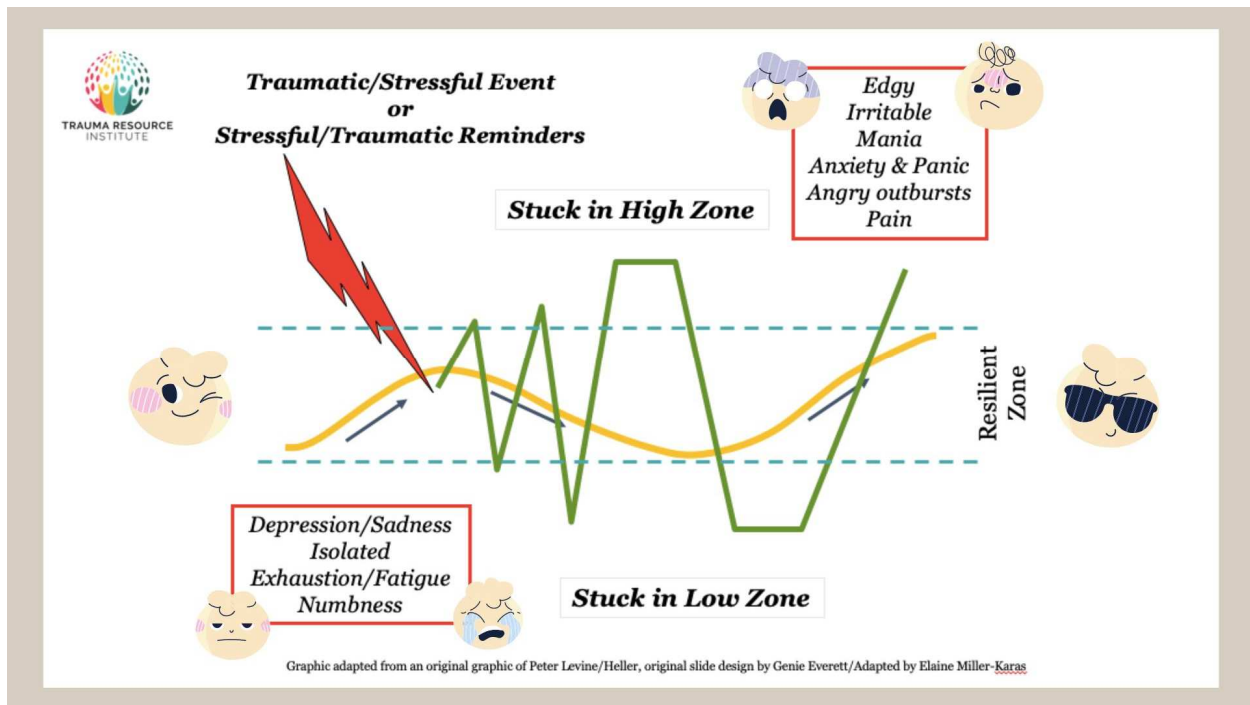
helps individuals learn to read their nervous system to return to the zone of well-being

The Resilient Zone - “OK” Zone



GOAL: TO WIDEN YOUR RESILIENT ZONE

“When in the Resilient Zone, we feel like our best self. We can handle life stresses better.”



The Six Skills



- ▶ Tracking
- ▶ Resourcing
- ▶ Grounding
- ▶ Gesturing
- ▶ Help Now!
- ▶ Shift and Stay



#1 Tracking

Pay attention to sensations
within your body!

The foundation of helping stabilize the nervous system!
What we pay attention to, grows!

Thoughts and feelings have a corresponding
sensation within the body



#2 Resources

Anything that provides
comfort, joy, peace, and
happiness.

A memory, person, place,
animal or spiritual belief.



#3 Grounding

Direct contact of the body with the ground or something that provides support to the body.

Sit in a chair, or stand against the wall.



#4 Gesturing

a movement of the body or limbs or body as means of expression

Self-soothing
Self-calming



#5 Help Now!

Focus on something else!

Reset!

Take a walk!
Push the wall!
Count backwards!



#6 Shift and Stay!

Shift your attention from unpleasant to pleasant

Distress --> Wellbeing

Remember:

When we learn to discern the differences between sensations of distress and well being....

...we begin to have a **CHOICE** of what to pay attention to on the inside



Example of CRM in hospital setting

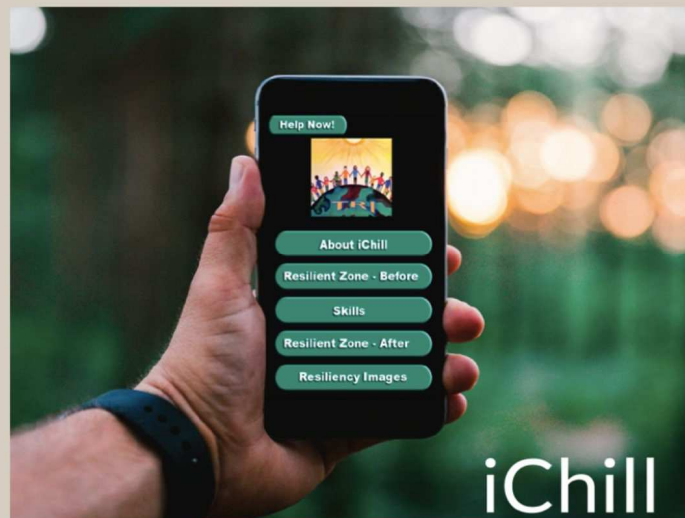
Grabbe et al, 2019, Nursing Outlook
Emory University, RCT

After learning the skills:

tracking sensations
resourcing to calm down
grounding to release my stress
just **pushing up against a wall.**
my ring for grounding
I touch the **fabric of my scrubs** to
ground myself
just **being still** with myself and
noting sensations
touching different surfaces and
noticing the physical sensations.
...used nature and paying attention to
smells and sensations
mindful of my body and
surroundings

When did they use the skills

- walking (out of work); at bedtime
- during '**clinical stressful/scary**'
situations with patients.
-in the **midst of the chaos**
-things become way to **hectic**
-I am dealing with **family dynamics**
-I feel myself **getting upset**if I'm
feeling anxious or unsettled.
-during **codes**, and when dealing with
dying patients
- after a **difficult shift** at work
-after a **traumatic or distressing**
experience
-during a **stressful day**
- ...**feeling overwhelmed**..... **tachycardia,**
heavy breathing, sweating



Thank you!

Time to write your email in the chat
to count your attendance.

Questions?

Email: normadh@uci.edu



Thank you!

Enjoy!

APPENDIX L: Project Budget

DNP Project budget	Cost
The CRM 5-day Teacher course	\$1850.00
The CRM Teacher course application fee	\$50.00
Printing of materials	\$0.00
\$10 VISA eGiftcards x17 for completion for pre-intervention survey & workshop	\$220.15
\$10 Starbucks eGiftcards x4 for completion of pre-intervention survey & workshop	\$40.00
\$10 VISA eGiftcards x16 for completion of post-intervention survey	\$207.20
\$10 Starbucks eGiftcards x3 for completion of post-intervention survey	\$30.00
One month access to Zoom	\$15.00
Total expense for project	\$2,412.35

LIST OF TABLES

Table 1. Demographic Data

Age	n	%
20-29	6	31.58%
30-39	12	63.18%
40-49	1	5.26%
50-59	0	0.00%
Years as bedside RN	n	%
< 1 yr	0	0.00%
1-5 yrs	7	36.84%
6-10yrs	8	42.10%
11-15yrs	4	21.05%
16-20yrs	0	0.00%
Years as Emergency Nurse	n	%
< 1 yr	0	0.00%
1-5 yrs	9	47.37%
6-10yrs	8	42.10%
11-15yrs	2	10.52%
16-20yrs	0	0.00%
20+	0	0.00%
Position	n	%
Bedside	6	31.58%
Educator	5	26.32%
Assistant Manager/Supervisor	7	36.84%
Charge RN	1	5.26%
Employment	n	%
PD	2	10.52%
PT	4	21.05%
FT	13	68.42%
Education	n	%
ADN	1	5.26%
BSN	9	47.37%
MSN	3	15.79%
DNP/PhD	6	31.58%

Table 2. Burnout Scores

Descriptive Statistics				
	<i>PRE</i>		<i>POST</i>	
Mean	26.36842105		Mean	24.2105263
Standard Error	1.573186371		Standard Error	1.38407599
Median	28		Median	23
Mode	28		Mode	28
Standard Deviation	6.857360411		Standard Deviation	6.03304739
Sample Variance	47.02339181		Sample Variance	36.3976608
Range	27		Range	20
Minimum	11		Minimum	14
Maximum	38		Maximum	34
Sum	501		Sum	460
Count	19		Count	19

t-Test: Paired Two Sample for Means		
	<i>Pre</i>	<i>Post</i>
Mean	26.3684211	24.2105263
Variance	47.0233918	36.3976608
Observations	19	19
Hypothesized Mean Difference	0	
df	18	
t Stat	1.13669829	
P(T<=t) two-tail	0.27057147	
t Critical two-tail	2.10092204	
Cohen's d	0.34	

In general, a d of 0.2 or smaller is considered to be a small effect size, a d of around 0.5 is considered to be a medium effect size, and a d of 0.8 or larger is considered to be a large effect size.

BO scoring:	
<23	positive feelings about your ability to be effective in your work
>41	bad day; need time off ; feel ineffective at work
The sum	Level of BO
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Table3. Secondary Traumatic Stress Scores

Descriptive Analysis				
<i>PRE</i>			<i>POST</i>	
Mean	32		Mean	29.0526316
Standard Error	1.699673171		Standard Error	1.45592896
Median	32		Median	28
Mode	41		Mode	25
Standard Deviation	7.40870359		Standard Deviation	6.34624722
Sample Variance	54.88888889		Sample Variance	40.2748538
Range	22		Range	24
Minimum	19		Minimum	17
Maximum	41		Maximum	41
Sum	608		Sum	552
Count	19		Count	19

t-Test: Paired Two Sample for Means		
	<i>PRE</i>	<i>POST</i>
Mean	32	29.0526316
Variance	54.88888889	40.2748538
Observations	19	19
Hypothesized Mean Difference	0	
df	18	
t Stat	2.644112364	
P(T<=t) two-tail	0.016492762	
t Critical two-tail	2.10092204	
Cohen's D		

In general, a d of 0.2 or smaller is considered to be a small effect size, a d of around 0.5 is considered to be a medium effect size, and a d of 0.8 or larger is considered to be a large effect size.

STS scoring	
<i>>41</i>	<i>feel frightened at work</i>
The sum	Level of STS
22 or less	Low
23 - 41	Moderate
42 or more	High

Table 4. Connor Davidson Resilience Scores

Descriptive Analysis				
<i>PRE</i>			<i>POST</i>	
Mean	31.1052632		Mean	31.6315789
Standard Error	1.2884887		Standard Error	1.09813911
Median	30		Median	33
Mode	29		Mode	33
Standard Deviation	5.61639205		Standard Deviation	4.78667742
Sample Variance	31.5438596		Sample Variance	22.9122807
Range	17		Range	18
Minimum	23		Minimum	22
Maximum	40		Maximum	40
Sum	591		Sum	601
Count	19		Count	19

t-Test: Paired Two Sample for Means		
	<i>PRE</i>	<i>POST</i>
Mean	31.1052632	31.6315789
Variance	31.5438596	22.9122807
Observations	19	19
Hypothesized Mean Difference	0	
df	18	
t Stat	-0.4923991	
P(T<=t) two-tail	0.62838926	
t Critical two-tail	2.10092204	
Cohen's D	0.10	

In general, a d of 0.2 or smaller is considered to be a small effect size, a d of around 0.5 is considered to be a medium effect size, and a d of 0.8 or larger is considered to be a large effect size.

Domains Scores	Pre	Post
Flexibility (1 and 5)	2.771929825	3.315789474
Self-efficacy (2, 4, and 9)	3.021929825	3.144736842
Ability to regulate emotion (10)	3	3.210526316
Optimism (3, 6, and 8)	2.983187135	3.208333333
Maintain attention under stress (7)	2.99751462	3