

Date: July 17, 2013

Title: Decreasing Compassion Fatigue* among Pediatric Intensive Care Nurses Using Self-Care Skills* and Compassion Fatigue Training*

Clinical Question:

- | | | |
|---|----------------------|---|
| P | (Population/Problem) | Among pediatric intensive care nurses |
| I | (Intervention) | does functional knowledge of compassion fatigue and the practice of self-care skills, |
| C | (Comparison) | compared to not, |
| O | (Outcome) | demonstrate less compassion fatigue? |

[Definitions for terms marked with * may be found in the Supporting Information section.](#)

Target Population for the Recommendation:

Nurses working in pediatric intensive care settings who provide direct patient care

Recommendation:

It is recommended that nurses working in pediatric intensive care settings receive training that includes compassion fatigue awareness, coping strategies, stress management, relaxation techniques and self-care interventions to decrease the level of compassion fatigue experienced in the work environment (Marine, Ruotsalainen, Serra, & Verbeek (2009) [1a]; Gunusen, & Ustun (2010) [2a]; Kravits, McAllister-Black, Grant, & Kirk (2010) [4a]; Meadors & Lamson (2008) [4a]).

Discussion/Synthesis of Evidence related to the recommendation:

The evidence referred to a variety of concepts related to the manifestation of compassion fatigue, including burnout, emotional exhaustion, and workplace stress. The concepts were all similar in referring to nurses' limitations in providing a high standard of patient care due to the events, experiences and challenges associated with their job responsibilities. Meadors & Lamson (2008) [4a] discussed evidence specifically focused on compassion fatigue. The researchers reported significantly more negative behaviors and feelings ($p = 0.001-0.003$) demonstrated by the high stress level participant group versus the low stress level group on a compassion fatigue tool developed by the researchers for use in their study. After attending a compassion fatigue seminar, participants demonstrated significant increases ($p = 0.001$) in compassion fatigue knowledge, and awareness of stress management resources (Meadors & Lamson, 2008 [4a]).

Interventions to address compassion fatigue, stress and burnout varied from study to study. A randomized control trial showed coping intervention training lowered emotional exhaustion levels ($p = 0.00$), however, the levels increased again after 6 months (Gunusen & Usten, 2010 [2a]). One meta-analysis looked at both work-directed and person-directed interventions to decrease healthcare workplace stress (Marine et al., 2009 [1a]). Results indicated person-directed interventions that included coping skills training, and work-directed interventions (changes to the work environment) that included improved communication significantly decreased stress when compared to no intervention. Although well-synthesized, most articles in this meta-analysis were small and graded as low quality, so the review provided limited evidence to support the PICO question.

Two studies emphasized the inclusion of self-care training as an intervention to decrease burnout. Significant decreases in emotional exhaustion ($p < 0.0005$) and depersonalization ($p < 0.0005$) were found after a course that included the use of self-care discussion, relaxation, guided imagery, art, and wellness planning (Kravits, McAllister-Black, Grant, & Kirk, 10 [4a]). Meadors & Lamson (2008) [4a] showed that the low stress level participant group in their study had a significantly higher incorporation of self-care practices ($p = 0.001-0.003$) as compared to the high stress level group.

Reference List:

- Gunusen, N. P., & Ustun, B. (2010). An RCT of coping and support groups to reduce burnout among nurses. *International Nursing Review*, 57, 485-492 [2a].
- Kravits, K., McAllister-Black, R., Grant, M., & Kirk, C. (2010). Self-care strategies for nurses: A psycho-educational intervention for stress reduction and the prevention of burnout. *Applied Nursing Research*, 23, 130-138 [4a].
- Lambert, V. A., & Lambert, C. E. (2008). Nurses' workplace stressors and coping strategies. *Indian Journal of Palliative Care*, 14(1), 38-44 [5a].
- Marine, A., Ruotsalainen, J. H., Serra, C., & Verbeek, J. H. (2009). Preventing occupational stress in healthcare workers (Review). *The Cochrane Collaboration*, 1, 1-44 [1a].
- Maslach, C. (1982). *Burnout: The cost of caring*. New York: Prentice-Hall [5a].
- Meadors, P., & Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self-care on intensive care units for children. *Journal of Pediatric Health Care*, 22(1), 24-34 [4a].

IMPLEMENTATION**Applicability Issues:**

Implementation of a compassion fatigue training program would require trained instructors educated in the components needed to meet the desired objectives, including compassion fatigue awareness, self-care and coping skills. Resources required would include a comfortable learning environment, materials and supplies needed for training, such as paper or electronic copies of materials for participants, and presentation equipment. Participants would require time away from the patient care area for training which could be incorporated into approved educational time. Small numbers of participants could attend multiple sessions, due to the limitations of removing a large number of staff from the unit at one time.

Relevant CCHMC Tools for Implementation:

No CCHMC tools for implementation found.

Outcome or Process Measures:

Compassion fatigue levels can be measured prior to, and after, the training program, using tools selected for their validity and reliability, as well as using narrative written or verbal statements from participants. The Maslach Burnout Inventory (Maslach, 1982 [5a]) is a valid and reliable tool for measuring nursing burnout. Researchers have noted a lack of valid and reliable compassion fatigue awareness tools, so the process could include development of an applicable tool.

SUPPORTING INFORMATION**Background/Purpose of BEST Development:**

The pediatric intensive care setting is a highly stressful and emotionally exhausting work environment. Nurses provide care to critically ill patients of various ages, as well as providing support and education to families. In addition to providing safe, high quality family-centered care, these nurses must manage complex and often-changing equipment, critical lines, constant monitoring, and electronic documentation, which results in difficult and potentially overwhelming responsibilities. Many intensive care nurses are unaware or undereducated regarding the existence of compassion fatigue and its impact on job performance, as well as the benefits of self-care and stress reduction strategies. Lambert & Lambert (2008) [5a] provided expert opinion on the subject of workplace stress, prevalence among nurses, and methods for stress management. Their operational definition of workplace stress supported the connection between this concept and compassion fatigue. The authors recommended researching various strategies and interventions to determine which methods would be effective for specific populations (Lambert & Lambert, 2008 [5a]).

Definitions:

Compassion Fatigue: A state in which nurses experience an inability to maintain a desired level of compassionate energy, due to frequent and regular exposure to prolonged, emotionally and psychologically challenging patient circumstances in the workplace.

Self-Care Skills: Positive skills practiced by an individual that provide a sense of calm, emotional and physical relief, and often improved health and mood. Skills can be unique to the individual's preferences and interests.

Compassion Fatigue Training: A training session that could include all or a combination of the following: Education on the concept of compassion fatigue; holistic health practices such as guided imagery and relaxation techniques; stress and grief management training; cognitive reappraisal training and simulation; self-care skills; resilience training; and personal and professional resources.

Search Strategy:

Databases: CINAHL, Medline

Search Terms: Compassion Fatigue, Self-Care, Burnout, Workplace Stress, Coping, Intensive Care Nursing, Pediatric Nursing

Limits, Filters, Search Dates: Limited to English literature; all search dates included.

Date Search Done: 4/9/13

Relevant CCHMC Evidence-Based Documents:

Best Evidence Statement entitled Building Resiliency in Nurses:

<http://www.cincinnatichildrens.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=101413&libID=101108>

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Conflicts of Interest were declared for each team member:

- No financial or intellectual conflicts of interest were found.
- No external funding was received for development of this BEST.
- The following conflicts of interest were disclosed:

Note: Full tables of the [LEGEND evidence evaluation system](#) are available in separate documents:

- [Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality](#) (abbreviated table below)
- [Grading a Body of Evidence to Answer a Clinical Question](#)
- [Judging the Strength of a Recommendation](#) (dimensions table below)

Table of Evidence Levels (see note above):

Quality level	Definition
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

Table of Language and Definitions for Recommendation Strength (see note above):

Language for Strength	Definition
It is strongly recommended that... It is strongly recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. (or <i>visa-versa</i> for negative recommendations)
It is recommended that... It is recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation...	
<i>Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group. (Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)</i>	
Rationale for judgment and selection of each dimension:	
1. Grade of the Body of Evidence	<input type="checkbox"/> High <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Low
<i>Rationale:</i> The body of evidence included a 1a meta-analysis that provided a review of 14 studies of interventions to reduce workplace stress in healthcare workers. Although well-synthesized, the authors concluded that limited evidence exists supporting the effectiveness of interventions, and larger, higher quality studies are needed. The meta-analysis did not specifically address compassion fatigue, but instead referred to the concepts of workplace stress and burnout, which are closely related to compassion fatigue.	
2. Safety/Harm (Side Effects and Risks)	<input checked="" type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Serious
<i>Rationale:</i> No identified risks to nurses who participate in the recommended intervention program.	
3. Health benefit to participant	<input checked="" type="checkbox"/> Significant <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal
<i>Rationale:</i> The potential for significant health benefit to nurse participants includes emotional, psychological and physical health.	
4. Burden on participant to adhere to recommendation	<input type="checkbox"/> Low <input type="checkbox"/> Unable to determine <input checked="" type="checkbox"/> High
<i>Rationale:</i> If attendance increases nurse participants' weekly work hours, the burden is high, due to the commitment and motivation required for program attendance, participation and adherence to be successful.	
5. Cost-effectiveness to healthcare system	<input type="checkbox"/> Cost-effective <input checked="" type="checkbox"/> Inconclusive <input type="checkbox"/> Not cost-effective
<i>Rationale:</i> Potential cost benefits include improved job performance, lower turnover and absence, lower incidence of errors, and improved patient and family satisfaction (Marine, et al. (2009) [1a]; Gunusen & Ustun, (2010) [2a]; Meadors & Lamson, (2008) [4a]). Costs could include unit staffing to cover participant attendance, trainers, and supplies and equipment needed for training.	
6. Directness of the evidence for this target population	<input checked="" type="checkbox"/> Directly relates <input type="checkbox"/> Some concern of directness <input type="checkbox"/> Indirectly relates
<i>Rationale:</i> Populations included in the evidence include complex care nurses, adult and pediatric intensive care nurses, general care nurses, and other direct patient care providers.	
7. Impact on morbidity/mortality or quality of life	<input type="checkbox"/> High <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Low
<i>Rationale:</i> Nurse participants will potentially experience improved quality of life by improving their job satisfaction and performance, improving their self-care skills, and increasing awareness of coping and stress management support (Kravits, et al (2010) [4a]).	

Copies of this Best Evidence Statement (BEST) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.

Website address: <http://www.cincinnatichildrens.org/service/i/anderson-center/evidence-based-care/bests/>

Examples of approved uses of the BEST include the following:

- Copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- Hyperlinks to the CCHMC website may be placed on the organization's website;
- The BEST may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- Copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at EBDMinfo@cchmc.org for any BEST adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

Please cite as: Andreotta, J., Cincinnati Children's Hospital Medical Center: Best Evidence Statement Decreasing Compassion Fatigue among Pediatric Intensive Care Nurses Using Self-Care Skills and Compassion Fatigue Training, <http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm>, BEST 173, pages 1-5, 7/17/13.

This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BEST has been in place for five years, the development team reconvenes to explore the continued validity of the recommendation. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff performs a quarterly search for new evidence in a horizon scanning process. If new evidence arises related to this BEST, authors are contacted to evaluate and revise, if necessary.

For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at EBDMinfo@cchmc.org.

Note:

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.