COMPASSION FATIGUE AND BURNOUT: LEADERSHIP STRATEGIES AND RESOURCES TO SUPPORT OUR TEAMS

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SESSION OBJECTIVES

- At the conclusion of the presentation, the learner will be able to identify symptoms and stages of compassion fatigue.
- At the conclusion of the presentation, the learner will be able to list examples of how compassion fatigue can impact patient care and safety.
- At the conclusion of the presentation, the learner will be able to identify methods that can be used to reduce compassion fatigue and burnout.
The issue of compassion fatigue and job burnout is a problem that is increasingly coming to the fore of scholarly attention, both in the health professions and beyond.

Well-documented in hospice, and throughout the allied health professions.

Dynamic extends beyond these fields to other occupations such as teachers, congregational clergy, librarians, engineers, accountants and even cruise ship employees (Skaalvik & Skaalvik, 2009; Beebe, 2007; Maslach, 2003; Kalliath & Morris, 2002; Sweeney & Summers, 2002; Tracy, 2000; Shaw, 1992 and Bachrach, Bamberger & Conley, 1991).
Burnout, Compassion Fatigue, Long Term Affects of Trauma in ED staff

ED nurses are at a moderate to high risk for experiencing compassion fatigue and burnout, which can result in decreased quality of care provided to patients and affect staff retention and turn over, patient safety, and patient satisfaction.

Cumulative effects of secondary traumatization along with environmental factors such as high patient acuity, ED overcrowding, unrealistic patient expectations, workplace violence, and repeated exposure to sudden death can cause emotional withdrawal and lack of empathy as well as physical symptoms, sleep disturbances, and complete collapse in emergency department workers.

Compassion fatigue and burnout in nursing staff thus affect not only the personal and professional well-being of employees but also patient outcomes and can have a significant, negative fiscal impact on healthcare organizations. Staff support programs utilizing chaplaincy interventions to manage stress have been implemented in outpatient care settings as well as in inpatient settings. Evaluations of these initiatives suggest that chaplains are an effective resource for staff care.
WHAT ARE WE TALKING ABOUT?
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.
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.
WHAT ARE WE NOT TALKING ABOUT?

"I'm right there in the room, and no one even acknowledges me."
Compassion Fatigue: First used by Johnson in 1992 to refer to the internalization by nurses of the trauma of those for whom they care. Figley (2002) defines it as a tension and preoccupation with the individual or cumulative trauma of clients that exacts a personal toll on the caregiver.

Burnout: James and Gilliland (2001) define burnout as the slow erosion of a person’s total psychic energy, that becomes visible when a person’s inner struggles erupt into pronounced and recognizable behavior in one or more areas, behavioral, physical, social and emotional.

Vicarious Trauma: Saakvitne & Pearlman (1996): A transformation of the helper’s inner experience, resulting from empathic engagement with client’s trauma material.

Secondary Stress; Salston and Figley (2003) note that the terms compassion fatigue, burn out, vicarious traumatization, traumatic countertransference and secondary traumatic stress refer to near identical processes whereby caregiving individuals experience indirect traumatization that can manifest itself in emotional and cognitive exhaustion, job dissatisfaction, depersonalization and traumatic reactions such as anxiety, depression and changes in eating or sleeping.

Compassion Satisfaction. Hudnall Stamm (2009) the satisfaction that comes from caregiving that can offset the negative effects of fatigue and burnout.
- The “Zealot” Phase
- The Irritability Phase
- The Withdrawal Phase
- The “Zombie” Phase

Pathology vs. Renewal/Maturation

adapted from D. Fakema by J. Eric Gentry and Lisa Schmitt
Compassion Fatigue Prevention and Resilience
THE ZEALOT PHASE

• Committed
• Idealistic
• Enthusiastic
• Extra mile without prompting
• “I’ll do that!”
THE IRRITABILITY PHASE

- Cut Corners
- Avoidance
- Low tolerance for frustration
- Avoidance
- Defensive
- Mood swings
- Problems sleeping
- Problems concentrating
THE WITHDRAWAL PHASE

- Enthusiasm sours
- Patients become a blur
- Forgetfulness
- Tired all the time
- Neglect work and home
- Hopelessness
- Attention problems
THE ZOMBIE PHASE

- Hopelessness and anger
- “the system is against me”
- Impatience
- No sense of humor/loss of pleasure
- Others are incompetent/ignorant
- Dislike for/contempt for people
- Sense of numbness
WHAT TO DO?

Stress Reduction Kit

Bang Head Here

Directions:
1. Place kit on Flat surface.
2. Follow directions in circle of kit.
3. Repeat step 1 as necessary, or until unconscious.
4. If unconscious, use stress reduction activity.
Pathology and Victimization vs. Maturation and Renewal
- Overwhelmed/Leave the Profession
- Somatic illness
- Perpetuity of symptoms

OR:
Recovery/learning/growing/healing/wisdom
HOSPICE AIDE PROJECT

- **Settings:** VNAGP Hospice and St Vincent Hospice
- **Population:** Hospice Aides
- **Time:** 3 months
- **Intervention:**
  - Monthly bereavement support
  - Education and awareness
  - Coping strategies
- **Outcomes:**
  - Statistical reduction in levels of burnout and compassion fatigue by 60%
  - Statistically significant increase in compassion satisfaction (57%), productivity (20%) and retention (66%)
Develop a quantifiable, effective Chaplain Intervention Program (ChIP) to address compassion fatigue, reduce the effects of burnout and post traumatic stress in ED nursing staff, as well as increase patient satisfaction and support. ChIP was implemented January 2015-March 2015, with validated pre- and post-test measures to assess effectiveness.

The aim: a) to provide spiritual care to patients and families in the ED, reduce anxiety in patients, and stress in nursing staff; b) to provide direct staff support through intentional and regular rounding on ED workers.

Transition from current “on call” state to proactive daily rounding at “peak times” to meet the emotional and spiritual needs of patients and staff, integrating the chaplain into the team of and standard work of the ED.

The Professional Quality of Life Scale, ProQOL 5 [8], administered prior to ChIP and after ChIP, measured staff compassion fatigue (burnout and secondary traumatic distress) as well as compassion satisfaction.

Statistical Results-Staff

Chaplain Intervention Project (ChIP) demonstrated that an interdisciplinary approach to care in the ED is effective for both patients and staff well-being.

ChIP led to a statistically significant improvement in the key performance indicators for staff well-being (KPIs) of 38-40% and of patient satisfaction HCAHPS scores which increased by 83.34%.

The Chaplain Intervention Project demonstrated that “soft issues” could be converted to measurable outcomes which could be impacted by redesigned approach for Chaplains.

Chaplains are well suited to address the emotional and spiritual needs of all key stakeholders in healthcare including patients, care givers, and healthcare providers.
Chaplain Intervention Project (ChIP)

Prepare

- Define ED Project Scope
  (Who, What, Where, Why)
  - Timing
  - Team
  - Deliverables
  - Data

Diagnose

- Statistical Problem
  - Can it be quantified?
  - Is it statistically significant?
- Practical Problem
  - Are you fatigued?
  - Are you burned out?
  - Are you taking this home?
- Practical Solution
  - Did we make a real difference?
  - Is it sustainable?
  - Can it be spread to other KentuckyOne EDs?
  - Can it be adapted to other areas?

Treat

- Statistical Problem
  - Can it be quantified?
  - Is it statistically significant?
- Practical Solution
  - Did we make a real difference?
  - Is it sustainable?
  - Can it be spread to other KentuckyOne EDs?
  - Can it be adapted to other areas?

Sustain

- Practical Solution
  - Did we make a real difference?
  - Is it sustainable?
  - Can it be spread to other KentuckyOne EDs?
  - Can it be adapted to other areas?
- Practical Problem
  - Are you fatigued?
  - Are you burned out?
  - Are you taking this home?
- Statistical Problem
  - Can it be quantified?
  - Is it statistically significant?

- Get buy-in from stakeholders
- Review with CPE Coach
- Complete Statistical Analysis
- Monitor Benefits

Spread to other CHI EDs
Adapt ChIP model to high LOS patient populations
Optimize ChIP routine
Finalize standard work
Celebrate Results

-Optimize ChIP routine
-Finalize standard work
-Spread to other CHI EDs
-Adapt ChIP model to high LOS patient populations
-Celebrate Results
<table>
<thead>
<tr>
<th>Statistical Questions</th>
<th>ChIP Impact</th>
<th>Results Statistically Significant? (p &lt; .05)</th>
<th>% Improvement from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did it reduce the trauma level?</td>
<td>P = .006</td>
<td>YES</td>
<td>40.2% reduction</td>
</tr>
<tr>
<td>Did it reduce burn out?</td>
<td>P = .001</td>
<td>YES</td>
<td>37% reduction</td>
</tr>
<tr>
<td>Did it improve your sense of mission?</td>
<td>P = .002</td>
<td>YES</td>
<td>38.6% improvement</td>
</tr>
</tbody>
</table>
IF YOUR COMPASSION DOES NOT INCLUDE YOURSELF, IT IS INCOMPLETE.

JACK KORNFIELD

WWW.VERYBESTQUOTES.COM
Caregiver Bill of Rights

I have the right... to take care of myself. This is not an act of selfishness. It will give me the capability of taking better care of my relative.

I have the right... to seek help from others even though my relatives may object. I recognize the limits of my own endurance and strength.

I have the right... to maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things just for myself.

I have the right... to get angry, be depressed and express other difficult feelings occasionally.

I have the right... to reject any attempts by my relative (either conscious or unconscious) to manipulate me through guilt and/or depression.

I have the right... to receive consideration, affection, forgiveness and acceptance from my loved one for what I do, for as long as I offer these qualities in return.

I have the right... to take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my relative.

I have the right... to protect my individuality and my right to make a life for myself that will sustain me in the time when my relative no longer needs my full-time help.

I have the right... to expect and demand that as new strides are made in finding resources to aid physically and mentally impaired persons in our country, similar strides will be made towards aiding and supporting caregivers.

Adapted from the book, CareGiving: Helping an Aging Loved One, by Jo Horne, published in 1985 by the American Association of Retired Persons.
REFERENCES


