We Grieve Too: One Inpatient Oncology Unit’s Interventions for Recognizing and Combating Compassion Fatigue

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Oncology nurses frequently care for patients who are dying or near death, leading to emotional distress, compassion fatigue, and staff turnover. Providing appropriate social and professional support to nursing staff is imperative to maintaining satisfaction and decreasing turnover. Inpatient and outpatient oncology staff should identify the signs of compassion fatigue and know how to perform self-care to combat it. The experiences of nursing staff and patients with cancer and their families can be improved if nurses feel satisfaction with, and confidence in, performing end-of-life care. The current article discusses the success of helping the staff in the fight against compassion fatigue by implementing bereavement interventions in a community hospital’s oncology unit. The program can be applied to many oncology settings and practices to help keep valuable oncology nurses in their careers.

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Causing for patients with cancer can be complex when faced with high acuities, high volumes, and decreased staffing levels (Medland, Howard-Ruben, & Whitaker, 2004). Oncology nurses interact in intense, caring relationships with those patients and families, which may eventually lead to an emotional burden (Wenzel, Shaha, Klimek, & Krumm, 2011). One recurring element of that intense relationship can be caring for patients who die (Wenzel et al., 2011). Providing care to patients with cancer increases the risk of stress and psychological disorders, including compassion fatigue (CF) (Dorz, Novara, Sica, & Sanavio, 2003). CF is a traumatizing emotional state experienced by nurses and other caregivers who are preoccupied with the suffering and distress of those they are caring for (Figley, 2002); for many, CF is difficult to recognize and combat.

Lancaster General Hospital is a 540-bed Magnet®-designated community hospital in Pennsylvania, with a 26-bed inpatient medical-surgical oncology unit. The inpatient unit’s nurses administer a wide range of care to patients from diagnosis and treatment to the end of life. By caring for patients with cancer, the staff consistently is exposed to patients at the end of life, some to whom the nursing staff felt particularly close. The unit’s turnover rate was evaluated to determine the effect of CF on the nursing staff. In fiscal year 2009, the unit’s staff turnover rate was 5.5%; however, in fiscal year 2010, the RN-only turnover rate had increased to 12.1%. The nursing staff was leaving the unit and verbalizing emotional struggles with providing quiet time, space, and a sense of meaning to benefit patients and families at end of life. When nurses lose meaning and an ability to provide high-quality end-of-life care, it contributes to compassion fatigue (Wenzel et al., 2011). For that reason, the unit believed its nurses were battling CF, even if they could not put a name to it.

Causes of Compassion Fatigue

Oncology nurses often are recognized for the quality of compassionate care they provide. Compassion is the regard and respect for fellow humans, including the bearing of another’s suffering and a desire to relieve it (Figley, 2002). Compassionate caring has certain emotional consequences that result from helping or wanting to help a suffering person. Sustained compassionate nursing practice can lead to CF and emotional exhaustion (Aycock & Boyle, 2009).

Dorz et al. (2003) found greater emotional exhaustion in oncology healthcare professionals than in healthcare professionals caring for patients with HIV or AIDS. Negative consequences of emotional exhaustion can include burden, depression, anxiety, fear, apathy, desire to quit, and helplessness (Coetzee & Klopper, 2010). An overall decline in nurses’ immune systems and quality of life can result from CF (Figley, 2002). A variety of physical symptoms related to CF are experienced by nurses as well, including forgetfulness, headaches, stomachaches, high blood pressure, weight gain, anger, stiff neck, fatigue, and disrupted sleep (Aycock & Boyle, 2009). Coetzee and Klopper (2010) described symptoms that start as weariness, but progress to a loss of physical strength and endurance once CF has developed fully, leading nurses suffering from CF to become more accident-prone.
Nurses experiencing CF demonstrate harmful behaviors. They frequently will attempt to fight CF on their own, most commonly by leaving their work setting permanently or ignoring the situation altogether (Yoder, 2010). If they remain in the work setting, CF and a lack of support can lead nurses to increased absenteeism and a loss of productivity (Medland et al., 2004).

**Combating Compassion Fatigue**

Given the turnover rate, the unit felt compelled to address the psychological stress and CF symptoms the staff was experiencing. The goals for the unit were to better support the nursing staff, patients, and families throughout end-of-life care and, ultimately, to significantly reduce the unit’s CF. A bereavement support program was launched in October 2009. The unit’s initiatives were to provide the inpatient oncology team with methods to combat CF and provide a universal symbol for the unit to bring awareness to the patients receiving end-of-life care.

A consistent theme in the literature was enhancing professional and social support so that staff can speak openly about their feelings (Figley, 2002). To address this, a remembrance tree was created on the unit (see Figure 1). The tree was placed on a bulletin board in a staff-only area of the unit and was changed with each passing season. Names and obituaries of patients who recently passed away are placed on the board. The remembrance tree acknowledged the passing of these patients in a communal area where staff could discuss memories of the patients together, and, hopefully, find some peace and closure. Aycock and Boyle (2009) found that the use of a counselor or psychologist is helpful, but loses effectiveness in the time it takes to get an appointment.

Figley (2002) noted that one way to combat CF was to instill in the nurses feelings of satisfaction and achievement when helping their patients. The use of journals and bereavement cards proved effective in providing closure for nursing staff by reminding them of the impact they had on their patients. Bereavement cards were sent to the families of patients who have passed away, and journal entries were written by staff members about patients with whom the unit was particularly close. The staff wrote fond memories, funny anecdotes, and well wishes to the patient’s loved ones. After a few weeks of entries, the journal was mailed to the family of the lost patient. Taking the time to think about what to say and actually writing it can provide a moment of self-reflection and self-care for the nurses (Aycock & Boyle, 2009).

Another way to battle CF is by providing nurses the opportunity to participate with the family in end-of-life care and bereavement support (LeBáron & Moore, 2007). To accomplish that, two specific measures were implemented. A magnet with a picture of a dove on it was placed on the outside door frame of rooms where a patient was being provided with end-of-life care. That dove signified to interdisciplinary staff that quiet and privacy is of the utmost importance in and around those rooms. Also, a bereavement care package program was established and care packages were given to the families of dying patients to use while they were with their loved one in the hospital. The packages were kept in the nursing unit and contained a variety of items that could be helpful to family members of a patient at the end of life, including CDs with soothing music, a CD player, bibles, blank journals, an empty picture frame, ceramic angel figurines, a plug-in candle, rosary beads, and a stress-ball squeezer.

**Effectiveness of the Program**

Evaluation of the effectiveness of the interventions was conducted, in part, by observing staff behavior and informally discussing with staff about how things were progressing. The nursing staff verbalized an improved ability to recognize and talk about their thoughts and feelings related to the passing of patients. In addition, a survey with open-ended questions was distributed to staff (N = 50) in February 2010; 25 staff members from all levels of nursing responded. Questions addressed if closure was being brought to staff, if the contents of the bereavement package were sufficient, and how families were responding. The majority of responses received were positive about all components addressed. Twenty-two of the respondents (88%) said that the initiatives helped bring them some closure. In addition, fiscal year 2011 showed an improved RN-only turnover rate of 7.5%, reflecting the helpfulness of the program in relation to the previous fiscal year.

The importance of defining CF and bringing heightened awareness to its symptoms cannot be stressed enough. The nursing staff needed to recognize and discuss CF to avoid it. Overall, the CF interventions have been overwhelmingly positive. They have brought the nursing unit closer together in many ways. Nurses can help maintain a long, healthy career in oncology by performing self-care and self-reflection, preventing or recognizing the onset of CF, and seeking guidance and support to limit its effects and prevent future occurrences.
References


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