Meaningfulness, appropriateness and effectiveness of structured interventions by nurse leaders to decrease compassion fatigue in healthcare providers, to be applied in acute care oncology settings: a systematic review protocol

Lori Hodge MSN, RN, OCN, NEA-BC
Suzy Lockwood, PhD, MSN, OCN, CHPN

1. Texas Christian University Center for Evidence Based Practice and Research: a collaborating centre of the Joanna Briggs Institute

Corresponding author
Lori Hodge
lhodge54@sbcglobal.net

Review question/objective

The specific review question is:
In the acute care oncology setting, can structured interventions implemented by nurse leaders decrease compassion fatigue among healthcare providers?

More specifically, the objectives are to identify: the effectiveness of structured interventions by nurse leaders to decrease compassion fatigue in healthcare providers in acute care oncology settings.

The quantitative objective is to identify the effectiveness of structured interventions on compassion fatigue.

The qualitative objectives are to identify the meaningfulness and appropriateness of structured interventions on compassion fatigue.

Background

The art of nursing has at its core the concept of compassion, which Straughair attributes to scriptural roots from a God who has instructed us to be kind and compassionate to one another.¹ The term “compassion” is not easy to define due to its subjective nature and is often confused with such concepts as sympathy, empathy and caring. When shown in the true sense of the word, compassion can be the nursing profession’s most valuable and precious asset; yet when absent can diminish the value of nursing and have detrimental effects on the profession.²

While there is little debate that compassion is a fundamental value in nursing, there is increasing debate about its existence in contemporary nursing. Nurses are less often citing their motivation for entering the profession as ‘a calling’ or to fulfill a desire to care for others and more often citing such alternatives as attractive salaries or job security.² As a result, the profession may place more emphasis on the technical
skills and measurable outcomes and allow the virtues of compassionate nursing care to erode. Recent reports support this possible lack of compassionate healthcare by highlighting negative patient outcomes, poor quality standards, compromised nursing care and in worse case scenarios, a disregard for basic human dignity. This is not to say that prospective nurses enter the profession with a disregard for high-quality compassionate care; compassion may instead be an aspiration they hope to acquire rather than a quality they possess which drew them into the profession.1

One deterrent to the provision of compassionate care may be directly linked to compassion fatigue, a term used to describe the physical, emotional and spiritual effects from repeated or overwhelming exposure to patients facing life-threatening or life-altering illnesses or accidents. Emergency departments and first responders to crisis situations are particularly vulnerable to compassion fatigue, as are those in oncology settings where there is frequent exposure to pain, suffering, death and dying. Nurses suffering from compassion fatigue tend to depersonalize their care, which may be perceived as a lack of compassion.2 Other signs and symptoms of compassion fatigue range from irritability and mild sleep disturbances to anger and depression and can progress to serious physical ailments.3 Post-traumatic stress syndrome is an extreme manifestation of compassion fatigue often observed in war zones.

Healthcare organizations can be seen as both a cause and a victim of compassion fatigue; likewise, healthcare organizations can be part of the problem and potentially part of the solution. Potter, et al.,4 recognize the organizational structure and the social environment of organizations as relevant contributors to compassion fatigue. The culture of a healthcare organization is a determining factor for the impact of compassion fatigue; a culture that is focused on profitability at the expense of poor staffing levels will not value time spent at the bedside and will minimize the opportunities to provide compassionate care. In addition, an organizational culture that is insensitive and unresponsive to the individual needs of the patients will be reflected in tolerant attitudes by the employees toward poor standards of care. Findings from a study indicated what appeared to be a lack of compassion by caregivers represented instead inherent staffing issues and organizational cultures that hindered the caregiver’s ability to adequately perform their caring and compassionate roles.1

Compassion fatigue is not limited to individuals; entire organizations may experience compassion fatigue as evidenced by high rates of turnover from burnout, excessive absenteeism and decreased productivity. Each of these symptoms will produce a negative impact on patient satisfaction.4 Organizations suffering from compassion fatigue may experience constant changes in co-worker relationships, thus jeopardizing the ability for teams to work well together and build positive momentum towards quality outcomes. Negativity towards leadership is another symptom of compassion fatigue, as employees become less tolerant of change, less respectful of rules and policies and less intent on meeting deadlines and completing assigned tasks. Compassion fatigue can result in a workforce that is unable to effectively meet productivity or patient satisfaction standards, further straining a financially overburdened healthcare system.3

The literature suggests multiple strategies, such as debriefing and the promotion of self-care that can lessen the risk and impact of compassion fatigue on the individual caregiver and on the organization as a whole. The Indiana State Nursing Association Bulletin5 recognizes that the very nature of those attracted to professional caregiver roles may enter the field with some degree of compassion fatigue stemming from an inherent tradition of caring for other’s needs before caring for their own.3 Under this
assumption, it is suggested that interventions be focused on the role of ‘self’ through self-awareness, self-care and self-compassion. One study suggests that interventions should be targeted towards those staff at risk; in this case the healthcare providers in the acute care oncology setting. Focused education to increase the awareness of compassion fatigue, specifically the risks, causes, signs for early detection and available resources to combat the detrimental effects of compassion fatigue should be considered with this caregiver population.

Recent nursing literature has identified a strong relationship between a perceived lack of compassionate care, negative patient outcomes and the financial impact on healthcare organizations. Nurse leaders are well aligned to lead the transformation back to the delivery of compassionate patient care. Examination of the Cochrane Library, JBI Library of Systematic Reviews, CINAHL and other relevant databases failed to produce current or planned reviews on the topic of the impact of interventions that can be implemented by nurse leaders to decrease compassion fatigue. A systematic review to include literature from emergency and trauma care, psychology, behavioral health and spiritual counseling in addition to oncology and hospice nursing will be used to identify multiple strategies and recommendations for the prevention and management of compassion fatigue. The identified strategies will be further examined to determine the impact that implementation will have in the acute care oncology setting. The information will prove valuable for nurse leaders seeking to guide caregivers toward the provision of compassionate patient care and guide healthcare organizations towards a culture that endorses the concept of compassion and supports efforts to proactively combat compassion fatigue. The review will focus on interventions that are appropriate for healthcare providers in the acute care oncology setting recognizing that: 1) all healthcare providers in this setting including unlicensed assistive personnel and health unit coordinators are at risk for compassion fatigue, and 2) the workplace environment for this caregiver population holds unique challenges when compared to outpatient oncology settings.

In conclusion, it is evident the contemporary nursing profession needs to refocus on the concept of compassion. Recent reports citing negative patient outcomes and poor quality standards from the possible lack of compassion should motivate nurses to take action and redirect their professional path. Compassion fatigue should be defined and incorporated in nursing education and nursing practice to allow nurses to recognize and combat its negative effect on patient outcomes. Through supportive leadership and corporate strategies that consider the influence of the organizational culture and environment, the negative impact of compassion fatigue on the organization can be effectively minimized. By refocusing on the nursing profession’s most valuable and precious asset, we can return to the use of compassionate care to deliver true high-quality patient care and patient outcomes.

Keywords
Compassion; compassion fatigue; altruism; compassionate care; self-awareness; self-care; self-compassion; burnout; grief; traumatic stress disorder

Inclusion criteria
Inclusion criteria

Types of participants

The quantitative component of this review will consider studies that identify changes in outcomes in healthcare providers in the acute care oncology setting, as the result of applied structured interventions to decrease compassion fatigue. The qualitative component of this review will consider studies that assess the experiences of healthcare providers in the acute care oncology setting that identify changes in outcomes as the result of applied structured interventions to decrease compassion fatigue and the appropriateness of these interventions.

Types of intervention

The quantitative component of the review will consider and compare studies that utilize a compassion fatigue scale to evaluate the effectiveness of structured interventions implemented by nurse leaders to decrease compassion fatigue.

Phenomena of interest

The qualitative component of this review will consider studies that investigate the meaningfulness and appropriateness of structured interventions by nurse leaders to decrease compassion fatigue among healthcare providers in acute care oncology settings.

Types of outcomes

This review will consider studies that include the following outcome measures: those identified as directly attributable to structured interventions by nurse leaders for the purpose of decreasing compassion fatigue among healthcare providers in acute care oncology settings. Specific outcomes may include improved patient satisfaction, staff retention, employee engagement, morale, rates of absenteeism, quality, productivity, employee relationships, team concept and organizational cultures.

Types of studies

The quantitative component of the review will consider both experimental and epidemiological study designs including randomized controlled trials, non-randomized controlled trials, quasi-experimental before and after studies, prospective and retrospective cohort studies, case control studies and analytical cross sectional studies for inclusion. The quantitative component of the review will also consider descriptive epidemiological study designs including case series, individual case reports and descriptive cross sectional studies for inclusion. The qualitative component of the review will consider interpretive studies that draw on the experiences of healthcare providers with compassion fatigue including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

In the absence of research studies, other texts such as expert opinion, discussion papers and position papers will be considered for inclusion in the review.
Search strategy

The search strategy aims to find both published and unpublished studies. A three-step search strategy will be utilized in this review. An initial limited search of MEDLINE and CINAHL will be undertaken, followed by analysis of the text words contained in the title and abstract and of the index terms used to describe the article. A second search using all identified keywords and index terms will then be undertaken across all included databases. Thirdly, the reference lists of all identified reports and articles will be searched for additional studies. Studies published from 1980 to July 2013 will be considered for inclusion in this review, as the term ‘compassion fatigue’ was initially used in 1981 in reference to events surrounding the United States Immigration Policy. The databases to be searched include: CINAHL, MEDLINE, PsychINFO, ProQuest Nursing, Allied Health Source and EMBASE.

The search for unpublished studies will include:

ProQuest Dissertations and Theses

Initial keywords to be used will be:

Compassion, compassion fatigue, compassion fatigue scale, compassionate care, self-awareness, self-care, self-compassion, burnout, grief, traumatic stress disorder, oncology and intervention.

All studies identified during the database search will be assessed for relevance to the review based on the information provided in the title, abstract, and descriptor/MeSH terms. A full report will be retrieved for all studies that meet the inclusion criteria (see appendix I). Studies identified from reference list searches will be assessed for relevance based on the study title and reported within a checklist in the appendices.

Assessment of methodological quality

Quantitative papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) (Appendix 1). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Qualitative papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review, using standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix 1). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Textual papers selected for retrieval will be assessed by two independent reviewers for authenticity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI) (Appendix 1). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.
Data collection

Quantitative data will be extracted from papers included in the review using the standardized data extraction tool from JBI-MAStARI (Appendix 2). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Qualitative data will be extracted from papers included in the review using the standardized data extraction tool from JBI-QARI (Appendix 2). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Textual data will be extracted from papers included in the review using the standardized data extraction tool from JBI-NOTARI (Appendix 2). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Data synthesis

Quantitative papers will, where possible be pooled in statistical meta-analysis using JBI-MAStARI. All results will be subject to double data entry. Effect sizes expressed as odds ratios (for categorical data) and weighted mean differences (for continuous data) and their 95% confidence intervals will be calculated for analysis. Heterogeneity will be assessed statistically using the standard chi-square test and also explored using subgroup analyses based on the different quantitative study designs included in this review. Where statistical pooling is not possible, the findings will be presented in narrative form including tables and figures to aid in data presentation where appropriate.

Qualitative research findings will, where possible, be pooled using JBI-QARI. This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings (Level 1 findings) rated according to their quality and categorizing these findings on the basis of similarity in meaning (Level 2 findings). These categories are then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesized findings (Level 3 findings) that can be used as a basis for evidence-based practice. Where textual pooling is not possible, the findings will be presented in narrative form.

Textual papers will be pooled using JBI-NOTARI. This will involve the aggregation or synthesis of conclusions to generate a set of statements that represent that aggregation, through assembling and categorizing these conclusions on the basis of similarity in meaning. These categories are then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible, the conclusions will be presented in narrative form.

Conflicts of interest

No conflict of interest is anticipated.

Acknowledgements

None to declare.
References


Appendix I: Appraisal instruments

QARI appraisal instrument

**JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unclear</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there congruity between the stated philosophical perspective and the research methodology?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is there congruity between the research methodology and the research question or objectives?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there congruity between the research methodology and the methods used to collect data?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is there congruity between the research methodology and the representation and analysis of data?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is there congruity between the research methodology and the interpretation of results?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is there a statement locating the researcher culturally or theoretically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is the influence of the researcher on the research, and vice-versa, addressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are participants, and their voices, adequately represented?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall appraisal: □ Include □ Exclude □ Seek further info. □

Comments (Including reason for exclusion)

---

doi: 10.11124/jbisrir-2013-1027
NOTARI appraisal instrument

JBI Critical Appraisal Checklist for Narrative, Expert opinion & text

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unclear</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the source of the opinion clearly identified?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the source of the opinion have standing in the field of expertise?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are the interests of patients/clients the central focus of the opinion?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is the opinion's basis in logic/experience clearly argued?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is the argument developed analytically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is there reference to the extant literature/evidence and any incongruency with it logically defended?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is the opinion supported by peers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall appraisal: Include [ ] Exclude [ ] Seek further info [ ]

Comments (including reason for exclusion)

_________________________________________________________________________
Appendix II: Data extraction instruments

QARI data extraction instrument

**JBI QARI Data Extraction Form for Interpretive & Critical Research**

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Year</td>
</tr>
<tr>
<td>Journal</td>
<td>Record Number</td>
</tr>
</tbody>
</table>

**Study Description**

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete

Yes ☐

No ☐
<table>
<thead>
<tr>
<th>Findings</th>
<th>Illustration from Publication (page number)</th>
<th>Evidence</th>
<th>Unequivocal</th>
<th>Credible</th>
<th>Unsupported</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Extraction of findings complete: Yes ☐ No ☐
NOTARI data extraction instrument

**JBI Data Extraction for Narrative, Expert opinion & text**

Reviewer .......................... Date ..........................

Author .......................... Year .......................... Record Number ..........................

**Study Description**

Type of Text: ____________________________

Those Represented: ____________________________

Stated Allegiance/ Position: ____________________________

Setting: ____________________________

Geographical: ____________________________

Cultural: ____________________________

Logic of Argument: ____________________________

Data analysis: ____________________________

Authors Conclusions: ____________________________

Reviewers Comments: ____________________________

Data Extraction Complete  Yes ☐ No ☐
<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Illustration from Publication (page number)</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Unequivocal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Include: Yes ☐ No ☐