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The Watson room: Mitigating compassion fatigue in oncology nurses

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The Watson Room: Mitigating Compassion Fatigue in Oncology Nurses

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A clinical research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Nursing Practice

School of Nursing

May 2020

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Dedication

This work is dedicated to my three children Jamie, Patrick, and Michael for their

unconditional love and support.

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Abstract

Aim: The aim of this project was to plan, develop, and implement "The Watson Room" or "Quiet Room" in an inpatient oncology nursing population and evaluate changes in Professional Quality of Life (ProQOL).

Background: Oncology Nurses are at high risk for compassion fatigue (CF), burn-out (BO), and secondary traumatic stress (STS) related to the effects of living the traumas of oncology patients and their families through their cancer journey and the innate stress in a complex and intense workplace. High levels of compassion fatigue, burn-out, and secondary traumatic stress that are poorly managed reduces the nurse's ability to self-regulate their empathy and compassion leading to negative sequela for organizations, patients, and nurses. Preventative and restorative measures accessible in the workplace will aide nurses to manage and remediate the negative aspects of compassion fatigue experienced through the care of oncology patients and their families.

Methods: Utilizing the Precede-Proceed Model, relief of compassion fatigue, burnout, secondary traumatic stress, and compassion satisfaction was measured before and after utilizing the "The Watson Room" in a pre- post-test design. Outcomes were measured with the Professional Quality of Life version V Survey (ProQOL-V).

Results: The pre-surveys indicated below average scores in CS (37.20; avg score 50), BO (22.60; avg 50), and STS (25.65; avg 50) and post-survey results were not appreciably different (CS 35.82, BO 23.65, STS 24.82). Of the interventions it was found that Modeling Clay and the Buddha Board had the most significant number of participants and were found to be moderately or extremely effective.

Implications: Although the results did not demonstrate an appreciable difference, it did show an interesting finding. The interventions used in "The Watson Room" showed that when modalities were easily accessible, they were utilized.

Conclusion: "The Watson Room" is a concept first conceived as a "Quiet Room". C. Crewe (2016) renamed the room as the "The Watson Room" in honor of nursing theorist, Jean Watson. Her intention was to connect the use of the room to the importance of self-care.

Keywords: Compassion Fatigue, Burnout, Secondary Traumatic Stress, Compassion Satisfaction, Oncology Nursing

Introduction and Background

From the Human Genome Project to targeted cell therapies, cancer treatments have greatly benefited from knowledge gained in the fields of science and technology resulting in innovative, complex, and intense treatment regimens that give additional years of life to patients. A common entity between these life-giving therapies is the physical and emotional toll on the patient where it is known that patients become sicker before getting better. Anticipation of a cure, or at least a reprieve from the disease, serves as a beacon of light for the patient, family, and nurse through the course of therapy. This can also be a source for compassion fatigue (CF) for oncology nurses supporting patients and families through physically and emotionally intensive treatments.

Constant exposure to stress and potentially traumatic experiences inherent in oncology nursing, has been shown to contribute to the onset of negative nursing outcomes, having grave impact on organizations (Kutluturkan, Sozeri, Uysal, & Bay, 2016; Hegney, Rees, Eley, & Osseiran-Moisson et al., 2015; Potter, Pion, & Gentry et al., 2015; Li et al., 2014). Turnover of Registered Nurses (RN's) secondary to CF results in loss of intellectual capital, negatively affecting quality and safety, decreasing patient satisfaction, and having negative sequelae on nurse's mental and physical health (Potter et al., 2015; Hegney et al., 2015; Kutluturkan et al., 2016). In contrast, compassion satisfaction is the pleasure derived from being able to do the work well (Stamm, 2010). A recent study (Mooney, Fetter, Gross, Rinehart, Lynch, & Rogers, 2017) concluded that low Professional Quality of Life V (ProQOL-V) scores may be more prevalent in certain nursing specialties, including oncology nursing.

Nurses practicing from 1 to 5 years are most vulnerable to the effects of chronic stress and are typically affected more by CF (Naholi, Nosek & Somayaji, 2015; Naholi et al., 2015; Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, Norris & Olsen, 2010; Hylton Rushton, Batcheller, Schroeder, & Donohue, 2015; Wahlberg, Nirenberg & Capezuti, 2016; Ko & Kiser-Larson, 2016). Generationally, newer nurses flock from the bedside either to leave the profession or find roles less stressful. Others may stay but bear witness to the long-lasting effects of unresolved CF on emotional and physical well-being (Ko & Kiser-Larson, 2016; Wahlberg et al., 2016; Hersch, Cook, Deitz, Kaplan, Hughes, Friesen & Vezina, 2016).

Compassion satisfaction is the positive result of helping people. CS and CF have an inverse relationship. Oncology nurse's compassion satisfaction is derived from utilizing knowledge, skills, and therapeutic use of self while helping patients through their cancer journey (Stamm, 2010). Enjoyment in work and satisfaction with the oncology profession are signs of care providers CS (Yilmaz & Üstün, 2018). CS has been shown to be predictive factor of nurse caring and correlates with positive patient satisfaction and quality outcomes (Mooney et al., 2017; Li et al., 2014).

The significance of low levels of CF and high CS is recognized by the oncology nursing profession and interventions have been developed to support CS. Educational interventions are predominantly offered in classroom settings, but attending these events requires a change in schedule that interferes with work-life balance and/or time away from the bedside which is difficult to accommodate related to the nursing shortage and budgetary constraints. Time away from the bedside and balancing work/life responsibilities are the top reasons that nurses state impedes their ability to attend educational programs aligned

to enhance CS (Hersch et. al., 2016; Potter, Desbields & Rodriguez, 2013; Drury, Craigie, Francis, Aoun & Hegney, 2014). It is imperative that nursing find creative alternatives to traditional interventions to manage CF and find ways to bring resources to units that aide nurses to sustain compassion satisfaction in all phases of their careers, supporting preservation of intellectual capital, oncology nurse's health and well-being, and delivery of high quality, safe, and holistic nursing care.

Utilizing the Precede-Proceed Model, a health promotion planning tool that accounts for the multiple factors that influence health and quality of life, this program provided a pilot intervention for inpatient oncology nurses to improve their Professional Quality of Life. The Precede phase of the model sets priorities that leads to quantitative objectives that become goals and targets in the implementation phase of Proceed (Community Toolbox, 2018). This phase of the model informs the intervention(s) and maximize benefits to oncology nurses. The Proceed phase integrates the program into the culture of the organization leading to a successful implementation.

Problem Statement

Oncology nurses are particularly vulnerable to CF by experiencing secondary traumatic stress (STS) while caring for patients and their families as they live through the cancer journey. Workplace job intensification continues to increase with the complexity of healthcare delivery, frequent changes in technology, intricate drugs and treatment plans, and higher nursing turnover, resulting in CF and STS (Wahlberg, 2016). CF and STS have a significant negative effect on the provision of safe, reliable, patient care and patient satisfaction. Nursing turnover and retention is negatively affected by high levels of CF; however, improving the lived experiences of nurses and providing access to tools

reducing CF supports prevalence of CS. CS has a positive effect on "joy at work" aiding recruitment and retention efforts.

The inherent nature of CF and STS in oncology nursing makes it important that interventions are developed supporting CS and sustained by the organization to mitigate CF impact on the nurse and patient care. Systematic prevention and treatment efforts should include education and readily accessible interventions for nurses (Potter et al., 2013). Studies by Potter et al., 2013; Crewe, C. 2016; Houck et al., 2014, have explored CS, CF and STS interventions; however, best practice has not been determined.

Clinical Question

The clinical question asked was, "For Oncology Nurses working in a Community-Based Acute Care Hospital setting, does implementation of "The Watson Room" create changes in Professional Quality of Life-V (ProQOL-V).

Aims and Objectives   The aim of this project was to plan, develop, and implement "The Watson Room" or "Quiet Room" in an inpatient oncology nursing population and evaluate changes in Professional Quality of Life (ProQOL).

The objectives are as follows: After the oncology nurses' participation in The Watson Room program for two weeks, the participants would:

- increase levels of Compassion Satisfaction by 15%.

- decrease levels of Burn Out by 5%

- decrease levels of Secondary Traumatic Stress by 10%

Definitions

Professional Quality of Life

Professional quality of life (ProQOL) is "the quality one feels in relation to their work as a helper" (Professional Quality of Life, 2019). Professional quality of life (ProQOL) has dimensions of compassion satisfaction, compassion fatigue which includes BO and STS (Professional Quality of Life, 2019). The quality felt in relation to work as a helper defines ProQOL (Professional Quality of Life, 2019).

Compassion Fatigue

Carla Joinson (1992) first introduced compassion fatigue into the literature and identified the significance in oncology nursing. Figley's (1995) research with patient's suffering from Post-Traumatic Stress Disorder (PTSD) dovetailed into Joinson's research by furthering the knowledge of caregiver compassion fatigue and their lived experiences through care of the patient. Charles Figley later coined the term as "the cost of caring", to describe the vulnerability of the caregiver to experience compassion fatigue while caring for patients.

Compassion Satisfaction

Compassion satisfaction is the positive result of helping patients (Yilmaz & Üstün, 2018). Oncology nurses are exposed to working with patients in stressful work environments and many find deep satisfaction and genuine appreciation working with patients living through a cancer diagnosis (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014). Finding joy in work is what creates compassion satisfaction, reducing compassion fatigue and muting BO and STS (Yilmaz & Üstün, 2018). Joinson and Figley recognized

that caregivers with strong traits of empathy and compassion flourished when able to
self-regulate and sustain mental placidity (Joinson 1992; Figley 1995).

Secondary Traumatic Stress

Posttraumatic stress disorder (PTSD) was first listed in the *Diagnostic and
Statistical Manual of Mental Disorders-III* in 1980 (American Psychiatric Association,
1980) and Veterans of the Vietnam War were the first persons diagnosed with this
disorder (Beck, 2011). It was later realized that health care professionals caring for
traumatized individuals are at risk for STS; a natural consequence of caring for
individuals enduring a distressing experience (Figley, 1995). RN's experience STS by
helping or wanting to help a traumatized or suffering person.

Burnout

The concept of Burnout (BO) was initially identified in the 1970's by
Freudenberg (1974) who depicted BO as the outcome of a person who works hard,
abandons work/life balance, and feels that they are not adequately recognized or
rewarded (Emold, Schneider, Meller & Yagil, 2011). Burnout was later defined by
Maslach and Jackson (1981) as a three-dimensional syndrome which includes emotional
exhaustion, depersonalization, and reduced personal accomplishment (Maslach &
Jackson, 1981). Burn out occurs over time and is most notable for behaviors and
attitudes that become negative toward work, and potentially coworkers in response to job
strain (Li et al, 2014). Symptoms associated with BO include frustration, powerlessness,
and inability to meet work goals. Burnout culminates in ineffectiveness and feeling
overwhelmed, often leading to intent to leave profession or organization (Neumann et al.,
2017).

Watson Room

Crystal Crewe (2016) developed the concept of The Watson Room based upon the work of Nursing Theorist, Dr. Jean Watson. Watson's theory of "human caring" advocates for relationship-based nursing, substantiating that nurses should care for themselves, so they can better care for others (Crewe, 2016). The Watson Room is a "Quiet Zone" that exists close to the nursing unit (s), and outfitted to provide a relaxing, soothing environment where nurses can take a brief respite from work-place stress.

Figure 1

Compassion Satisfaction and Compassion Fatigue Model
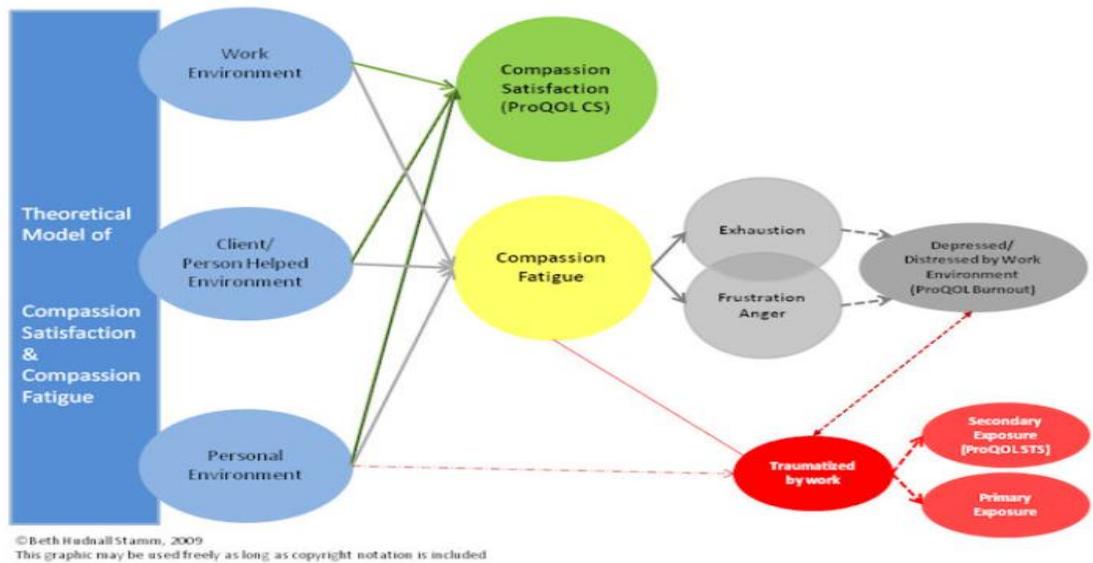
(Used with permission from Professional Quality of Life: Elements, theories, and measurement. (2019). Retrieved from https://proqol.org/)

Review of the Literature

Constructs of Compassion Fatigue

Cancer patients are aware of their vulnerabilities and thankful for the care received which makes them inimitable in the healthcare arena. The unique qualities of cancer patients' can easily lead to compassion fatigue in nurses (Raingruber & Wolf, 2015). Nurses come to know the patient and family through multiple cycles of chemotherapy and/or transplantation and utilize compassion and empathy to connect and guide patients through their cancer journey (Duarte & Pinto-Gouveia, 2017). Patients come in all ages and socioeconomic groups, bringing their family and extended family with them to the hospital, thus furthering the likelihood that connections will be formed amongst the nursing team, increasing chances of blurring of nurse/patient-family boundaries. The conundrum is that oncology nurses stay in the field because of the compassion satisfaction they feel in caring for this patient population; however, they also leave when compassion satisfaction gives in to CF and BO.

Research has become more robust in understanding the psychological constructs of stress and compassion fatigue and how it relates to nurse's capacity to effectively cope. In Figley's (1995) research in Post-Traumatic Stress Disorder (PTSD) discovered that individuals (family, friends, health care providers) close to the person who experienced a trauma, may themselves become traumatized through secondary exposure. The constructs of PTSD are nearly identical to those with STS and occur out of caring and wanting to help the traumatized person (Figley, 1995). Much research has been done in the field of traumatology that has provided insight into the constructs of CS and CF in oncology nursing.

Compassion fatigue has two components: STS and BO. Compassion fatigue is experienced by nurses who bear witness to the sorrows of patients and families and typically has abrupt onset (Hersch et al., 2016; Peters 2018; Pfaff, Freeman-Gibb, Patrick, DiBiase, & Moretti, 2017; Naholi 2015). In 2013, Potter et al., estimated compassion fatigue to be somewhere between 32% to 40%. Current studies support that the prevalence of compassion fatigue among oncology nurses remains unchanged (Neumann et al., 2018, Pfaff et al., 2017; Wu, Singh-Carlson, Odell, Reynolds, & Su 2016).

Living the experiences of patients and families can be stressful for nurses. Secondary traumatic stress is often described as a natural consequence of helping others (Yilmaz & Üstün, 2018). In a study by Grech, Depares, & Scerri (2018), found that nurses caring for patients at end of life, created in nurses a heightened awareness of mortality by associating the patient with themselves or a family member, thus experiencing STS through another. Symptoms of STS are increased negative arousal, intrusive thoughts/images of another's traumatic experience, difficulty separating work from personal life, lowered frustration tolerance, increased out bursts of anger or rage, dread of working with certain individuals, depression, ineffective and /or self-destructive self-soothing behaviors, hypervigilance, decreased feelings of work competence, diminished sense of purpose/enjoyment with career, lowered functioning in non-professional situations, and loss of hope (Figley, 1995).

Oncology nursing has been described by many as one of the most stressful specialty areas (Naholi et al., 2015; Potter et al., 2013). Literature contextualizes this by pointing to the very nature of cancer care. Oncology nurses care for patients and their

families over long periods of time, administer complex therapies, delivered though intense, therapeutic use of self; leaving nurses vulnerable to STS and BO. Understanding the work of oncology nurses will support development of effective programs.

Age, Experience & Gender

Multiple studies have found significant correlation between age, experience, stress, and compassion fatigue (Duarte & Pinto-Gouveia, 2017; Jang, Kim, Y.& Kim, K., 2016; Poulsen et al., 2015; Mooney et al., 2017). Oncology nurses age 40 years and younger have the highest prevalence of stress and compassion fatigue (Wu et al., 2016; Duarte, Pinto-Gouveia & Cruz, 2016, Yu, Jiang & Shen, 2016, Neumann et al., 2018). It has been found that high distress scores correlate to intent to leave the specialty area and/or profession (Wu et al., 2016; Duarte et al., 2016, Yu, Jiang 2016).

More experienced nurses are at risk for burnout which accounts for a significant amount of turnover and loss of intellectual capital (Duarte & Pinto-Gouveia, 2017). Oncology nurses utilize the experienced nurses to gain the competency and skills required to manage patients/families through their cancer journey, learn to care for the dying patient, and develop skills to manage their own grief (Finley & Sheppard 2017; Rice, Bennett & Billingsly 2014, Li et al., 2014). Loss of the experienced nurses through natural attrition such as retirement, and newer nurses staying in the field for often less than 5 years, informs the loss of intellectual capital and furthers CF in the workplace. Often this leaves newer nurses confronted with the problem of relying on novice nurses to guide their practice. Research study by Neumann et al. (2018), showed that age was significantly associated with depersonalization (phenomenon of Burnout) and increased for every decade past 40 years of age. Burnout results after prolonged chronic job-related

emotional and interpersonal stressors, characterized by emotional exhaustion, depersonalization, and perceived lack of social accomplishment (Maslach, Schaufeli & Leiter, 2001). Burned out nurses are less likely to share knowledge and more often the catalyst for negativity in the workplace; aiding in the loss of compassion satisfaction (Li et al., 2014).

Studies that examine gender differences as it relates to compassion fatigue are becoming more prominent in the literature as men join the workforce in increasing numbers. The studies in this Literature Review were predominantly female participants; however, several studies did examine gender specific differences in compassion fatigue and coping. Studies found that male nurses reported significantly lower levels of compassion fatigue than female nurses and higher levels of compassion satisfaction (Mooney et al., 2017; Naz, Saeed & Muhammad 2015). Naz et al., (2015) found a difference in coping strategies between the sexes with males mostly utilizing, positive reframing, planning, and self-distraction, and female's religion, instrumental support, and emotional support. Male sample sizes were small in these studies and therefore cannot be generalized; however, it is a starting place into exploring gender differences in compassion satisfaction and compassion fatigue.

Mediating Factors

The literature review suggests that there are several mediating elements in compassion satisfaction and include empathy, self-compassion, mindfulness, and psychological flexibility (Duarte et al. 2016,2017[b]). These elements, if held in balance, check the scourges of stress and development of compassion fatigue. Stress lies at the cornerstone, tickling the underbelly of compassion fatigue by off balancing the

individual's ability to self-regulate leading to declining empathetic ability, emotional exhaustion, diminished endurance/energy, and helpless/hopelessness (Peters, 2018). An oncology nurse's ability to manage stress would be through strengthening the constructs of compassion satisfaction: empathy, self-compassion, mindfulness, psychological flexibility, and self-regulation.

Interventions

Jean Watson (Watson Caring Science Institute, 2018) developed the Caring Science Theory integrating the art and science of nursing into a caring model of human care and kindness. It was here that nursing began the journey to better understand the role of compassion, self-compassion, empathy, psychological flexibility, and self-regulation as it relates to resiliency. The interconnectedness of the constructs can help inform choices of programs to implement.

Several studies (Wu et., al, 2016; Potter et al., 2013; Hersch et al., 2016) found that even the offering of educational programs support compassion satisfaction by acknowledging the lived experience of the nurse. Even still, the content of programs are important considerations. A meta-analysis done by Richardson and Rothstein (2018) found that stress interventions had a medium to large effect on psychological, physiological and organization outcomes, closely followed by relaxation interventions.

Other authors (Smith et al., 2016; Hersch et al., 2016; Potter et al., 2013; Grech et al., 2018; Kubota et al., 2016; Rice et al., 2014) found value in incorporating self-grief and grieving, conflict resolution with nurses and physicians, and psychosocial care of the patient/family in program offerings. Providing the opportunity to the nurse to master skills and competency, strengthens a nurse's self-efficacy and resiliency.

The medium in which programs have been offered were creative and diverse. Hersch et al., 2016 and Jakel et al., 2016 utilized mobile apps that incorporated education and tools to assess/reduce stress. Additionally, Jakel and company offered a one-day educational seminar in conjunction with the mobile application. A meta-analysis done by Stratton et al. (2017) of eHealth interventions demonstrated a small positive effect at post intervention and follow up; however, Mindfulness based interventions showed larger effects than the Cognitive Behavior Therapy based, followed by stress management interventions suggesting that there may be a place for mobile applications in program development.

A unique study utilized "Second Life" as the modality to facilitate peer storytelling with grieving oncology nurses (Rice et al., 2014). Quantitative and qualitative data showed nurses and facilitators perceived a benefit in using peer storytelling in Second Life to express and process grief (Rice et al., 2014). The study was prompted by a literature review that indicated nurses often utilize peers to debrief as a support group.

Other programs reviewed offer in-person didactic instruction lasting one day or over a series of days. Notable is that attrition is more often associated with in-person classes (Potter, 2015). Recent educational offerings have combined in-person classroom time that is reinforced with mobile applications (Hersch et al., 2016; Jakel et al., 2016).

Nursing Theorist Dr. Jean Watson has engaged the nursing community to consider self-care as important to the patient as it should be for the nurse. A study by Nelson (2014) utilizing Jean Watson's Theory of Human Caring, demonstrated a significant correlation between nursing staff member's care for self, job satisfaction, and perceived competence in caring for patients. Health care organizations (HCO) recognize that

supporting the nurse in self-care, translates into a healthier workforce that is better

equipped and competent in the care of the oncology patient.

Some HCO are developing "Quiet Rooms" or "The Watson Rooms" into current

structures, such as Virginia Commonwealth University Health System (VCUhealth) who

has placed "The Watson Room" throughout the patient care units (Crewe, 2016).

Findings from this study demonstrated a statistically significant increase in compassion

satisfaction, decreasing BO and STS (Crewe, 2016). VCUhealth has plans to incorporate

"The Watson Room" into the new patient care tower under development.

Hozak, Gregory, & Nelson (2016), performed an evidence-based study that paired

architecture and nursing in understanding perception of major architectural designs on

perceptions of nursing self-care and caring for others utilizing the Ten Dimensions of

Caring espoused by Watson's Caritas Theory. The development of patient care units

included "The Watson Rooms" and "The Watson Boxes". The Watson Boxes included

items to promote self-care, meditative music, mindfulness activities, and aromatherapy

(Hozak, Gregory, & Nelson, 2016). Findings from the study demonstrated that the "The

Watson Room" and "The Watson Boxes" had a statistically significant impact on caring

for self and caring for others (Hozak, Gregory, & Nelson, 2016).

Summary of Literature Review Findings

The literature is rich with the necessity of compassion satisfaction and resiliency

programs and their integration into organizations. There is much that requires further

study such as the relationship of men and compassion satisfaction/compassion fatigue.

Although this review did not specifically look for male oriented studies, it is clear by the

paucity of literature in this review that there is a need. Educational approaches tend to

incorporate a single approach to all age groups and sexes. Younger and older nurses may require a different approach to stress management, resiliency, and compassion fatigue.

     Mobility of nurses and work-life balance continues to haunt the professions ability to ensure nurses can attend educational offerings. Mobile applications show much promise; however, studies are needed to determine dose recommendation, long-term implications, and optimal effect through combination of modalities with in-person didactic education. Second Life offers flexibility of place but demands commitment and synchronization of time. An enticing medium since it would allow the nurse to sign in from home, reducing travel time and expense.

     Building compassion satisfaction in oncology nurses requires the nurse to develop and sustain compassion, self-compassion, empathy, psychological flexibility, and self-regulation. These components are integral to one another and exist in mutuality. Additionally, it will be necessary in furthering understanding of how age and gender inform compassion satisfaction and aide in the development of effective educational offerings. Interprofessional educational programs seem to increase feelings of vulnerability within groups and therefore, require further study to determine program effectiveness.

     Research has expanded understanding of compassion fatigue and compassion satisfaction. Many researchers have determined what is important to sustaining compassion satisfaction, furthering the work of Joinson, Figley, and Stamm. Compassion fatigue has become supplanted with compassion satisfaction and researchers are looking for interventions that can be focused through decades of an oncology nurses' professional career. It is concerning the loss of intellectual capital with retiring oncology nurses and

attrition from compassion fatigue, stress, and burnout. Often novice nurses are left to rely on novice nurses for support and education. Interrupting the downstream effect of compassion fatigue may be the key to sustaining and growing intellectual capital and supporting nurses through their career.

Theoretical Model

The framework identified for this project was the PRECEDE/PROCEED model See Figure 2. This model helps develop a comprehensive plan to address a problem instead of navigating blindly (Community Toolbox, 2018). PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation (Community Toolbox, 2018). PROCEED stands for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development (Community Toolbox, 2018). PRECEDE represents the process that precedes, or leads up to, the intervention, while PROCEED describes how to proceed with the intervention itself. A Logic Model was used to carry out the project to ensure that elements were incorporated at the appropriate time (see Appendix A).

Figure 2

Precede-Proceed Model
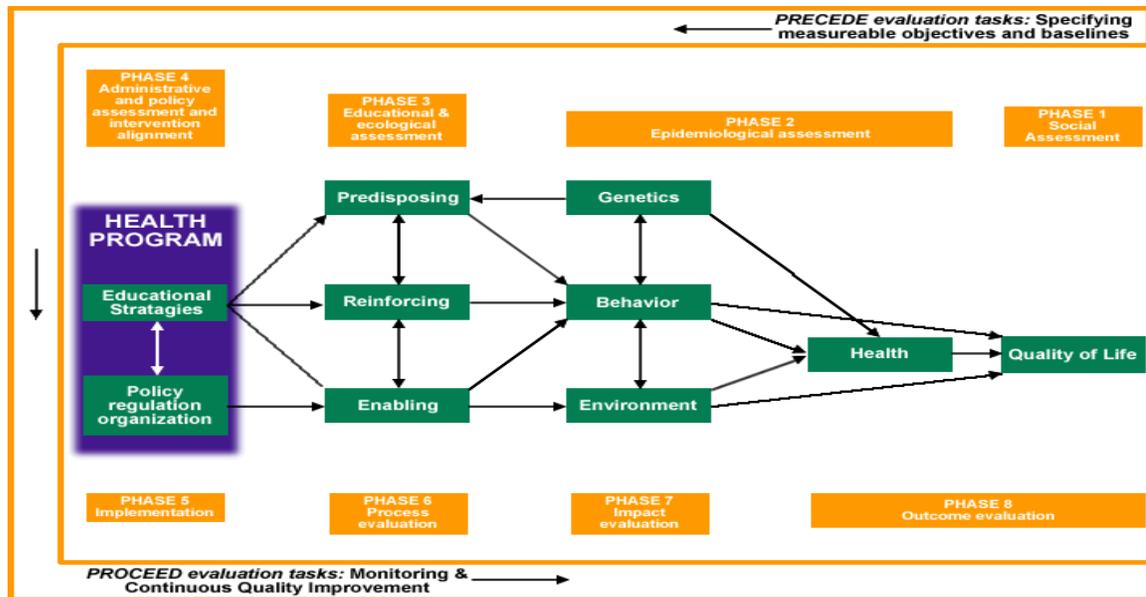
(Green, L.W. & Kreuter, M.W. (1999), Health Promotion Planning, an Educational and

Ecological Approach, Third Edition; Mayfield Publishing Co. Retrieved from:

https://ctb.ku.edu/en/table-contents/overview/other-models-promoting-community-

health-and-development/preceder-proceder/main)

Setting

The site for this project was a community-based acute care hospital in an

oncology inpatient-outpatient setting.   This hospital is one of nine hospitals in a large

healthcare system Healthcare System and the largest provider of healthcare services in

the South Texas region. The hospital has close to 1000 inpatient beds with occupancy in

the 90th percentile, making beds almost always at a premium. It has a robust "Safety

Always" program to reduce preventable harm to patients, visitors, and staff and has

created several programs to support the mission and vision. These include stand-alone

inpatient adult and pediatric rapid response team, community educational events,

dedicated individuals to support and enhance the patient experience, incentivized health

care plan to encourage physical and mental health, and programs to provide population

health to the underserved in the South Texas region (Methodist Health, 2019b).

Precede/Proceed Model

Phase 1: Social Assessment

Effective management of CF and Secondary Traumatic Stress (STS) are important

skills oncology nurses should master to improve self-efficacy. Awareness and

management of CF and STS creates a higher level of competency in the provision of

patient care, improves communication among disciplines, making patient care safer

(Boyle, 2015; Traeger, Park, Sporn, Repper-DeLisi, Convery, Jacobo & Pin, 2013).

Empowering oncology nurses with effective skills and easy to access interventions will

lead to a more agile and resilient workforce. It allows the Registered Nurse (RN) to

manage CF and STS and continue to use themselves to create therapeutic and positive

interactions (Pipe, Buchda, Launder, Hudak, Hulvey, Karns & Pendergast, 2012; Potter et

al., 2015).   A taskforce, "Oncology Fitness Initiative Taskforce" (ONCFit), was formed

and meetings explored the problem of CF, BO, and STS to understand the breath of CF

and STS as well as the feasibility of successful adoption of an intervention.

Phase 2: Epidemiological Assessment

The epidemiological assessment included separation data from nursing turnover

in the Oncology (ONC) and Blood Cancer Unit (BCU) from December 2017 and 2018

and an Employee Engagement survey from May 2018.

Nursing Turnover. Turnover and vacancy rates increase instability in the nursing

practice environment and further supports prevalence of CF. Factors affecting STS in the

Oncology Nursing Community are dynamic stages of illness and suffering, long working hours, decision making under pressure, and changing and competing priorities (Potter et al., 2013). Staffing inadequacy, unrelenting stress, and a compassion-fatigued workforce perpetuate nursing turnover.

Nursing Turnover is a costly problem for organizations and with the changes in reimbursement, more emphasis has been placed on RN retention. Besides the loss of intellectual capital and productivity, health care organizations must spend money to advertise, recruit and retrain new nurses. Estimated cost of nursing turnover for an organization is $856 million dollars (Li & Jones, 2013).

Retention and turnover of nursing staff is of concern in the oncology nursing community. Training to achieve competence of the HSCT/Oncology nurse takes as much as eighteen months; therefore, high vacancy rates and RN turnover within the first-year exhausts and demoralizes the remaining RN's. Additionally, it can lead to additional turnover as the leaving RN will romanticize their new place of employment, inciting discontent amongst remaining staff.

 Oncology (ONC) and Blood Cancer Unit (BCU) December 2018, turnover was 6.8% and 77.4%, respectively. (see chart 1, Appendix B). Annualized RN voluntary and involuntary rolling 12-month separation rate for ONC, BCU, Bone Marrow Transplant (BMT), and BSCTC as of December 2018, are 19%, 19.2%, 14.5%, and 0%, respectively. (see chart 2, Appendix B). RN total turnover for MH as of December 2018, for 1st year RN's was 50% and 20.6% for all RN's (Methodist Hospital, 2019a). (see Chart 3, Appendix B). Chart 4, Appendix B provides a comparison of the Oncology Division and overall turnover for 1st year RN's, compared to all RN's within the organization. The

national average for turnover rates is 28% for bedside nurses in their first year of practice

and 16.8% for all RN's (Nursing Solutions, 2018).

Employee Engagement. Employee Engagement is an amalgamation of attitudes

and priorities that has a consistent and predictable impact on behavior (Press Ganey,

2018). The attitudes that signify employee engagement are satisfaction, commitment,

pride, loyalty, a strong sense of personal responsibility, and willingness to advocate for

the organization (Press Ganey, 2018). Four key questions influence the Employee

Engagement Index: Overall, I am extremely satisfied with this facility as a place to work;

I would recommend this facility as a great place to work; I am proud to be working for

my company; I rarely think about looking for a new job with another organization (Press

Ganey, 2018). Employees who are engaged are better able to weather times of lower

work satisfaction and stay committed. There is a strong correlation between employee

engagement and patient experiences or satisfaction (Potter et al., 2015). Results of the

employee engagement scores demonstrated an increase except in BMT (see Figure 3).

Table 1

Employee Engagement 5/2017 to 5/2018

Employee Engagement and Participation			
	May-18	**May-17**	**Participation**
Oncology Service Line	⬆ 61%	51%	73%
ONC	⬆ 74%	57%	71%
BCU	⬆ 53%	39%	71%
BMT	⬇ 52%	58%	75%

Behavioral Assessment. The behavioral assessment of the oncology RN is complex and intense, created by the necessity to knowledgeably administer intricate chemotherapy, biotherapy, and immunotherapy regimens, as well as have a thorough understanding of the transplant/hematology-oncology continuum of care. A subtle change in a patient's clinical condition may be the only notice of an adverse event. Complicated by this is the intense, therapeutic patient-nurse relationship that is as much of a critical element of care as clinical aptitude.

Patients and families can spend anywhere from 1 to over 30 days inpatient and then care is released to the BMTC (Bone Marrow Transplant Clinic) or other hematology/oncology privately held clinics. Subsequent readmissions are targeted to the appropriate inpatient unit. This improves patient continuity of care when they return for the next cycle of chemo/biotherapy, relapsed disease, and/or transplant complications, such as graft versus host disease (GvHD), for months, and often years. The RN forms relationships that challenge the boundaries of a professional relationship that forms over subsequent readmissions and sometimes years of treatment.

Stressors that lead to stress and CF are compounded by nursing's own set of unofficial rules such as completing all the work before leaving, skipping meals to get work done, and prioritizing charting to last. Nurses are notorious for putting on a brave and strong face and denying the need for help (Harris & Griffin, 2015). The nurse provides compassionate care but rarely gives it to himself or herself. Nurses expedite patient care; however, this is often at the expense of creating an environment of interdisciplinary cohesion, time management, and patient flow.

Environmental Assessment. Environmental factors that influence stress and CF are universal in the nursing world. They include, staffing, manager/employee relationships, collegiality with physicians, teamwork, and autonomy of practice (Bakker et al., 2013). Staffing and scheduling and teamwork have been noted to be the largest contributors of nurses leaving the profession (Toh et al., 2013; Hegney et al., 2015; Pipe et al., 2012). Facilitating adequate stress management and coping through interventions to improve CS has not typically been incorporated into the Nursing Community; thus, increasing the likelihood of unmitigated STS and CF, resulting in negative consequences for individuals and organizations.

Phase 3: Educational and Ecological

Predisposing Factors. Predisposing factors include increased complexity of healthcare, staffing challenges with changing acuity, new and more complex chemotherapy/biotherapy regimens sometimes resulting in more and acute symptomology requiring frequent intervention, and lastly, helping families through the sometimes-rocky cancer therapy experienced by their loved one. Cumulative elevated levels of occupational stress and the compassionate nature of the oncology nurse intensifies CF (Rees et al., 2015; Houck, D., 2014). Additional predisposing factors are staffing challenges, patient/caregiver expectations, teamwork, and effective communication skills between disciplines (Pipe et al., 2012; Drury et al. 2014, Harris & Griffin, 2015). The cumulative levels of STS that leads to the phenomenon of CF is insidious and not readily apparent to the individual. Some nurses believe that CF will never affect them and fail to proactively utilize resources or educate themselves on strategies to proactively manage CF and improve CS.

Blurring of nurse-patient boundaries increases nurses' vulnerability to STS and CF, a significant predisposing factor in oncology nursing. Unit culture and norms reinforce the behavior. Those in oncology nursing derive satisfaction from therapeutic use of self and these innate beliefs and values support the practice. Interventions to address maintaining healthy patient-nurse boundaries and self-care will lessen effects of STS and CF, increase self-efficacy, and enhance compassion satisfaction.

Enabling Factors. Healthcare organization's awareness of the negative effects of CF and the positive effects of CS has become a national focal point and recognized as important to retention and recruitment efforts. Association of American Critical Care Nurses (AACN) has developed a Healthy Work Environment (HWE) Toolkit to raise awareness nationally and internationally regarding the importance of achieving and sustaining an HWE. Leaderships' recognition of the negative sequela of STS and CF is a strong enabling factor and has promoted staunch supporters of proposed interventions. Another enabling factor is the established Shared Governance (SG) leadership methodology that connects RN (Registered Nurse) satisfaction with quality outcomes.

Reinforcing Factors. Reinforcing factors were determined based upon the elements that support joy at work in response to the "The Watson Room" intervention. Education, feeling joy at work and tools to reduce the effects of CF and enhance CS, are known to support the lived experiences of nursing. These factors helped to determine elements that improve nursing ProQOL.

The Oncology Nursing Units have strong social networks such as the local Oncology Nursing Society monthly socials and educational dinners. The values and mission of the healthcare system reinforce self-care and the strong chaplaincy services

are often utilized to alleviate unit and/or RN grief. Social workers, both inpatient and outpatient, provide additional support to the Oncology Nursing community. Universally, Oncology Nurses report that when stressed, they primarily rely on friends and families, but are less likely to use other resources to help reinforce stress management strategies related to access or personal preferences (Houck, D., 2014).

Organizational and individual acknowledgment of STS and CF normalizes the phenomenon and encourages nurses to avail themselves of resources without feeling stigmatized (Harris & Griffin, 2015). Bringing awareness of the impact of STS, BO, and CF to shared governance committees, staff meetings, and leadership forums allowed for a fuller dissemination of information to the organization. Creating workplace awareness provided a health-related social platform for a positive response to stress management and coping strategies and assisted in valuing and incentivizing behavioral interventions.

Phase 4: Administrative and Policy Assessment

This phase included an organization assessment of the policies of the healthcare organization related to mission and values, employee assistance programs, and asset mapping. In developing this project, it was noted that the number one barrier cited in the literature to enable participation in stress management and CF interventions/programs was time away from the bedside (MH Internal Data, 2018a, Potter et al., 2015; Hegney et al., 2015). Interventions that are multimodal have been found to have a greater chance of success with adoption of strategies by individuals to manage stress and improve self-care (Hersch et al., 2016; Jones et al., 2013). Web-based programs have been shown to be effective educational tools as stand-alone or combined with other modalities (Jones et al., 2013; Hersch et al., 2016; Clark et al., 2012). This project was a multi-modal

intervention that included interventions within "The Watson Room "or "Quite Zone" and was a space designed to provide a tranquil Feng Shui in the hospital environment (Crewe, 2016)

Phase 5: Implementation

The "The Watson Room" is a concept first conceived as a "Quiet Room". C. Crewe (2016) renamed the room as the "The Watson Room" in honor of nursing theorist, Jean Watson. Her intention was to connect the use of the room to the importance of self-care. The concept of the "The Watson Room" or "Quiet Room" has been introduced into several hospital settings as a place that can provide privacy to destress and center oneself (Crew, 2016). The room needs to be readily accessible to nursing staff and foster the use and practice of using stress management and coping techniques to thwart CF and manage STS.

The room is designed to be quiet and peaceful where staff could reflect or meditate. "The Watson Room" often consist of a massage chair, warm colors, soft lighting, soothing music, and interventions such as guided imagery and breathing exercises that can be utilized by staff to destress and ameliorate CF and STS.

Phase 6: Process Evaluation

After receiving approval through the James Madison University Institutional Review Board and the participating healthcare organization (see Appendix C), participants were solicited from all three Oncology Units (BMT, BCU, and ONC).

Measures.

Demographics. Demographics (see table 1, Appendix D) were created by the

DNP candidate and collection information included age, gender, race or ethnicity, level of

RN preparation, years as an RN, years in oncology, and nursing certification.

Professional Quality of Life Version 5. The ProQOL-V (Stamm & Yoder, 2010)

is a 30-item scale and is the most commonly used measure of the negative and positive

effects of helping others experienced by professional healers. Survey participants were

presented positive and negative questions and asked to rate them (1-never, 2-rarely, 3-

sometimes, 4-often, 5-very often). ProQOL-V addresses the separation of burnout and

secondary traumatic stress, and burnout (see Appendix E). The construct validity and

reliability coefficients range from 0.71-0.9) Potter et al., 2013).

Questionnaire post-intervention. Each intervention was listed, and participants

were asked what they utilized and their perception of effectiveness. The participants

were asked how often they utilized the room over the 2-week period. A text box was

provided to list additional interventions used and/or things that they chose to share about

their experience (see table 1, Appendix F).

Recruitment and Data Collection. Flyers and handouts were sent out through

email and posted on information boards. Information about "The Watson Room" project

was shared in staff meetings and at shared governance meetings. Initially, 33 individuals

signed up to participate; two were excluded because they were patient care technicians.

Pre-Surveys were sent out via Qualtrics and participants were asked to create a unique

use ID using the first initial of their mother's last name and the last 4 digits of the Social

Security Number. The Pre-Survey was completed the week of October 19th, 2019 to

October 27th, 2019. Participants completed the pretest ProQOL-V and a demographic

survey after receiving informed consent via an electronic survey. Post-intervention, the

ProQOL-V and a short questionnaire were electronically sent out to identify podcasts,

apps, and art kits that were accessed while in the room. Participants were asked to access

the room at a minimum of twice a week for 10 to 15 minutes for 2-weeks. Participants

were requested to do one meditative or anti-stress intervention, but this was not

mandatory. The pilot project concluded after 2-weeks. Privacy was maintained by a

confidential identifier that linked the pre/post survey results.

Inclusion criteria: RN 18 years of age of age or older

                         Currently employed in three inpatient oncology units at Methodist

                         Hospital.

Exclusion criteria: Unable to complete the 2-week program with completion of pre

                         and post surveys

   "The Watson Room" was open for 14 days, from October 27th, 2019 to November

9th, 2019. During this period, participants were asked to utilize the room twice a week.

At the end of the two weeks, post-surveys were completed the week of November 10th,

2019 to November 17th, 2019. This timeline was extended to November 39th, 2019 to

facilitate data collection.

   Available Resources.

   The Watson Room decorations included soft lighting, a peaceful wall mural (see

figure 4), soothing scents, comfortable seating, and a waterfall. Art kits and a list of

Podcasts were provided to participants to use while in "The Watson Room". The four art

kits were developed to reduce stress and encourage self-reflection/meditation and

included: Writing Journal Prompts, Zentangle, Model Magic, and Gratitude Notes/Cards.

A Buddha Board was also included for use by participants. The Buddha Board is inspired

by the Zen idea of living in the moment where individuals can paint on the surface with

water and the drawing comes to life. As the water slowly evaporates, the art magically

disappears leaving a clean slate and a clear mind. "The Watson Room" was available 24

hours a day with easy swipe badge access entry. A light snack was available to

participants.

Figure 3

"The Watson Room" Mural

		"The Watson Room" room and furnishings were paid through the organization's

commitment. A data analyst was available to students of James Madison University.

Conference room space was negotiated with the organization for the ONCFit meetings.

Program materials and the cost of surveys remained a part of the final budget.

Twenty-two participants completed the pre-surveys. Two of these were duplicates or incomplete and excluded.

Phase 7: Impact Evaluation

"The Watson Room" had the potential to reach approximately 70 RN's who worked on the three inpatient oncology units. Thirty RN's (43% response rate) expressed interest in participation and 20 completed the pre-survey and 17 the post-survey. There were 12 matched pre- and post-surveys. Some of the post-survey ID's appeared made up i.e. M1234 so it may be that some participants were uncomfortable using the last 4 numbers of their Social Security Number. Therefore, perhaps more of the pre- and post-surveys were matched, but that is unable to be determined.

It was found that the last question of the ProQOL IV survey was left off; which pertains to compassion satisfaction. Therefore, a full analysis of compassion satisfaction cannot be rendered, but only a generalization to the pre- and post-survey results.

Startup costs for "The Watson Room" was $3500 (see table 1, Appendix G) which was paid for by the healthcare organization and the expense was allocated to the office equipment-minor medical operating costs of the BMT, BCU, and Oncology Units. Ongoing costs was estimated at approximately $100 per month for the Art Kits and snacks. For the initial operating costs, the snacks were donated by the project leader. "Hearts Need Art", a hospital-based volunteer program, invoiced the hospital for expenditures for the Art Kits and Buddha Board.

Excluding start-up costs, ongoing expense will be approximately $3/RN, assuming approximately "The Watson Room" is used on average 39 times per month. (see table 2, Appendix G). Impact can continue to be evaluated using number of badge

swipe entrances and evaluation tools. The start-up costs are a one-time expense.

Ongoing expense of Art Kits and snacks can be offset by sharing the cost amongst the

three inpatient units and/or developing a funding source through a grant process and/or

voluntary donations. The cost of onboarding a new RN is approximately $10,000 (Lingo,

A., 2017). Mitigating the effects of compassion fatigue in this vulnerable nursing

population would reduce the need for this expenditure by incorporating a robust stress

management, compassion fatigue program.

Phase 8: Outcome Evaluation

  Demographics Participants Were predominantly white (66.7%) (see figure 1,

Appendix H) 50% of participants were between the ages of 19-29 (see chart 1, Appendix

H), predominantly white (see chart 2, Appendix H), Bachelor of Science in Nursing

(BSN) prepared (see chart 3, Appendix H), with 0 to 5 years in nursing and oncology

nursing (52.4% and 61.9% respectively) (see chart 4 & 5, Appendix H) Three individuals

were Oncology Certified Nurses (OCN) (14.3%), three held other certifications (14.3%),

and one was a Blood and Marrow Certified Transplant Nurse (BMTCN) (4.8%) (see chart

6, Appendix H). Three males completed the pre-survey (15%) and 17 females (85%) (see

chart 7, Appendix H).

  Intervention Outcome Evaluation. The interventions (Art Kits, Buddha Board,

and Podcasts) utilized in "The Watson Room" were evaluated to provide understanding

of effectiveness and future utilization. The information was a starting place for future

intervention offerings (see figure 1, Appendix I). There were 36 total responses from 17

participants who completed the post-survey questionnaire (see chart 1, Appendix I).

Modeling Clay and the Buddha Board had the most significant number of participants and were found to be moderately or extremely effective. Modeling Clay was the most utilized with the second being the Buddha Board (Modeling Clay n=12 responses, 33%; Buddha Board n=8 responses, 22%). The Gratitude Card was shown to be moderate to very effective with three people feeling it was slightly effective or not effective (n=7 responses, 19%). The writing journal had the fewest uses (n=4 responses, 11%) with ratings of moderately to not effective in managing stress (see chart 2-7, Appendix I).

Podcasts were not as popular (n=18 total responses); however, the majority found "Let's Meditate" to be either very effective or extremely effective (n=6 responses, 33%). "Head Space" was found to be either moderately effective or extremely effective (n=4 responses, 22%). "Fabulous had 3 responses (16%) and was described as slightly effective or not effective (see chart 8, Appendix I).

ProQOL IV Outcome Evaluation-Results

Table 2

Descriptive ProQOL- V

	Pre-Test		Post-Test
n = 20	Mean/SD	**n = 17**	Mean/SD
CS	37.2/3.93	**CS**	35.82/5.15
BO	22.6/4.65	**BO**	23.65/5.04
STS	25.6/4.94	**STS**	24.82/4.76

Table 2 represents the results of the Descriptive ProQOL-5 results. The average ProQOL-V score was 50.

Table 3

Paired ProQOL Two Tailed t-Test

	Pre-Test		Post-Test		
n = 12	Mean/SD	n = 12	Mean/SD	t-value/df	p-value
CS	37.5/3.68	CS	36.33/5.228	0.235/11	p = .126
BO	22.83/5.68	BO	22.33/4.658	0.913/11	p = .609
STS	25/4.93	STS	24.67/4.519	0.935/11	p = .764

Table 3 represents the results of the twelve surveys that were able to be paired for analysis based upon confidential identifier matches. In a two tailed t-test analysis the *p* values for CS, BO, and STS were *p*=.126, *ns*; *p*=.609, *ns*, *p*=.764, *ns*, respectively. Raw scores for the 12 paired surveys were CS (37.50, avg 50), BO (22.83, avg 50), and STS (25.00, avg 50). Post-survey raw scores were CS 36.33, BO 22.33, and STS 24.67, with the average score of 50. The scores and corresponding *p*-values in the independent and dependent two tailed *t*-test analysis do not demonstrate appreciable differences.

Discussion and Implications

Practice. The wide-ranging effects of compassion fatigue significantly impacts the life and career of the Oncology RN; however, finding interventions to ameliorate CF are difficult to implement in a climate of acuity, complexity, limited down-time and personnel. The implementation of "The Watson Room" was well received, with great anticipation by the staff. The reality of finding 15 minutes to use the room 4 times in a 2-

week period was a difficult achievement and only one person utilized the room more than

what was required. The majority (6 of 17 participants) utilized the room 2 times in a two-

week period. Oncology nurses, and nurses in general often skip breaks and reduce lunch

time to 15 minutes. Culprits to missed breaks and lunches are workload and the

unspoken expectation that all work should be completed by the end of the shift, and none

left for the following shift. This creates great stress in the RN and workplace. The

formal and informal rules of a unit and workload should be evaluated to determine

elements affecting CF. It is important practice areas understand the cultural norms of a

unit that may mitigate or intensify CF/CS.

Policy. At the beginning of the year, Washington State mandated that all RN's

take three 15-minute breaks and one 30-minute lunch break that are assigned at the

beginning of a 12-hour shift. A community hospital in Spokane, Washington, found a

great deal of resistance implementing the mandate; however, as RN's became accustomed

to the new norm, they used this time connecting with family, listening to podcasts, or

working on a puzzle or game. It would be valuable to understand how this changes

CF/CS as it compares state to state with ones that have initiated changes and those who

have not. Compelling RN's to take breaks may be a policy to explore and study

especially as the Washington mandate is in its early phases.

Policies should also include that new health care buildings include architectural

designs that support health and wellness for the patient and the nursing staff. Inclusion of

"The Watson Room" in the design of each floor would provide for a place for nursing to

re-center and re-energize. Other recommendations were ensuring that the building is

built around the work of the nursing and nursing personnel.

Research. Interventions were utilized in "The Watson Room" a total of 39 times by the 16 of the 17 participants, or 2.4 interventions per person. The high usage of art kits, Buddha Board, and Podcasts bodes the question of what the difference in CF/CS would be if the interventions were not offered. Keeping modalities close to the point of use could be part of the answer to CF/CS. Additionally, future studies should look at the advantage of a layered approach of interventions based upon proximity to the RN.

In evaluating use of "The Watson Room" and the interventions accessible in the room, it showed that 2 of the 3 male participants utilized "The Watson Room" 3 times, and 1 one time. However, all the males used the mindful interventions with 2 out of 3 using a combination of podcasts, 'Art Kits', and Buddha Board and one participant used the 'Art Kits' and Buddha Board only. The interventions were used 4 to 6 times in the two-week period. These results cannot be There is a paucity of research regarding CF and CS with a male only cohort, but several studies have indicated that males and females respond to CF and CS differently. Research studies have uncovered a difference in coping behaviors between the sexes. Studies that could be replicated may better define elements between genders that can be harnessed to develop interventions specific to the sexes.

Education. Concerning is the number of experienced RN's leaving the work force to be replaced with younger nurses. This has created a void in experienced RN's, impacting knowledge sharing that is critical in nursing. The demographics of participants reflects this changing paradigm. All three units had predominantly RN's in their first 5 years of practice in oncology and nursing with 4 out of 20 in the 18-23 years of age, and 5 out of 20 between the ages of 24-29. The lack of experience lends itself to early compassion fatigue related to the limited number of role models exist that can foster the

less experienced RN's to navigate the highly intense specialty area. Future projects

should evaluate this critical element in nursing and determine best practice in knowledge

sharing in this changing landscape. A better understanding of the experience of

knowledge sharing and fostering behaviors should be included in nursing education to

encourage early skill development that can be taken into the practice area.

Table 4

Clinical Implications

Education: **Curriculum changes**	• Knowledge sharing skills • Self-care weaved throughout the curriculum
Practice: **Standards of Care**	• Understand informal culture of unit that permits/restricts breaks and lunch • Integrate self-care into orientations and at various career points • Have multiple modalities to promote CS
Policy Changes	• Evaluate current states that have created laws to ensure breaks/lunch for effectiveness • Architectural designs of new buildings should include elements for self-care i.e. "The Watson Room"
Research	• Difference in gender coping • Interventions that are gender/age specific • Apps that can be used as stand-alone or in conjunction with classroom education • Use of Second Life to debrief critical events i.e. codes, difficult or multiple deaths

	• Value and/or limitations of interprofessional CF/CS interventions i.e. classroom or shared activities

Discussion. Outcomes of the intervention were not achieved in reduction of CS, BO and STS Although CS could not be assessed, BO and STS did not demonstrate an appreciable change. This may be secondary to the amount of time "The Watson Room" was open, acuity, staffing, and/or unstable leadership. Nursing leadership stability had not been achieved in more than 2 years and turnover rates remained high with continued vacant nurse manager, nursing, and nursing assistant support positions. Although the Employee Engagement results for 2017 and 2018 did not bear out signs of CF, it should be taken into consideration that the survey is a moment in time. Turnover spans the continuum. Education of the importance of managing CF and CS throughout the RN's career should be emphasized as well as consistent use of different modalities. Specialty areas known to be susceptible to CF, should ensure that a vibrant program is maintained to ameliorate CF, enhance CS, and build resiliency. This will assist the Oncology RN to remain in the specialty area while maintaining and/or enhancing well-being.

Table 5

Limitations

Bias	• Small sample size • Convenience Sample • Computer based (unable to access work email from home)

	• Did not have a representative sample of males • Project completed from a distance
Generalizability	• Unable to be generalized to the oncology nursing population • Unable to determine if CS, BO, STS would change over time
Reliability and Validity	• Question left off ProQOL-V that represents CS; therefore, unable to evaluate CS • Some participants made up unique identifiers reducing ability to match pre- post-surveys • Limited time "The Watson Room" was open

Conclusion

Although the outcomes of this project did not demonstrate a significant impact on CF, CS, BO, or STS, it does shed light on components that would benefit from further research. Potter, Deshields, & Rodriguez (2013) remind us that providing ways to knowledge share validates the lived experience of nurses. Perhaps the significance of the project was not apparent in the results; however, it may be evident in the validation felt by the oncology nurse.

Our world is constantly shifting with new stressors that impact the life and well-being of oncology nurses. Promoting healthy behaviors provides a blanket of protection

around vulnerable nursing specialties. Being prepared for the "what ifs" will proactively

protect the workforce from CF, improve CS, and resiliency so that oncology nurses can

manage through the inevitable crises to come.

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