

Can we prevent burnout and compassion fatigue in the oncology nursing population?

Findings from a Systematic Review

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March 24, 2018

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Abstract

Oncology nurses care for high-acuity patients on a regular basis. High patient-demands combined with exposure to patient mortality can lead to complicated grieving. When nurses are not included in grief resolution strategies, burnout may ensue resulting in negative outcomes for the nurses and their hospitals of employment. Interventions such as bereavement support groups, end-of-life education programs, and promotion of positive work environments have been proven effective in managing the consequences of unresolved burnout. Future work in developing more interventions that support nurses' physical and mental health are warranted.

Case Study

Anna has been an RN on a surgical oncology unit in a major medical center for almost one year. In the past month, two of her patients died in her care. Anna formed a close relationship with one of the patients and his family over the past few months, so when he died it was difficult for Anna. Since the surgical oncology unit is busy, there was a new patient in the deceased patient's room within a few hours of his passing. Anna was also caring for three other patients that day so she did not have time to grieve. Lately Anna has found herself dreading going to work and feeling fatigued and irritable at times. She is thinking of applying for a position on a different unit. This literature review addresses the issues of burnout and compassion fatigue among oncology nurses. Throughout this review, readers will learn what burnout and compassion fatigue are, how they manifest clinically, and what interventions can be used to prevent and manage the complications of burnout and compassion fatigue. Questions that correspond with this case study can be found in Appendix A.

Introduction

Patient mortality is an inevitable component of oncology nursing. Nurses often form relationships with oncology patients and their families at the time of diagnosis and throughout treatment. As a result of repeated exposure to patient deaths, nurses may experience complicated grieving which can lead to burnout and compassion fatigue (Aycock & Boyle, 2009). This decreased emotional availability may in turn contribute to less than optimal care being delivered to other patients on the unit (Potter et al., 2010). It is important for oncology nurses to feel comfortable caring for patients who are in the final stages of life. Historically, research has been focused on helping patients and families cope with the end of life. More recently the focus has shifted in order to determine effective ways for caregivers to deal with grief so burnout can be avoided. Many of the studies included in this literature review were conducted as a result of the authors noticing high turnover rates of nursing staff, low patient-satisfaction scores, and nursing staff displaying clinical manifestations of compassion fatigue and burnout. The authors recognized the need for these issues to be addressed. The goal of this literature review is to explore the existing research on the topic of grief management in the oncology nursing population and to make recommendations based on the evidence for preventing burnout and compassion fatigue related to patient mortality.

Background

The Professional Quality of Life (ProQOL R-IV) scale will be discussed at various points in this literature review, as it was incorporated into some of the studies in order to address the needs of nursing staff. According to Stamm (2009), “Professional quality of life incorporates two aspects, the positive (Compassion Satisfaction) and the negative (Compassion Fatigue).” Burnout is considered a subcategory of compassion fatigue (Stamm, 2009). The ProQOL R-IV scale

should be used to observe trends over time, rather than at a single point in time, to ensure the responses are not influenced by events occurring on the given day the survey was administered (Potter et al., 2010).

Complicated grief is the phenomenon that occurs when the grieving process does not occur as anticipated, but rather becomes prolonged and disrupts the normalcy of life for the bereaved (Toftthagen, Kip, Witt, & Mcmillan, 2017). Oncology patients often have numerous prolonged admissions to the hospital during the course of their treatment. This facilitates the formation of bonds between patients and unit staff. Due to the inevitability of death on oncology units, nurses are at increased risk for complicated grief.

Maslach and Leiter (2000) define burnout as “a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity.” Oncology nurses are at high risk for burnout due to organizational factors such as high patient acuity, severity of patient illness and symptoms, and repeated exposure to patient death (Potter et al., 2010). Nurses experiencing burnout feel as if their emotional resources have been depleted and they are more likely to provide care to patients with a lack of empathy, contributing to decreased patient satisfaction (Maslach & Leiter, 2010). Aycock and Boyle (2009) consider burnout an outdated term and suggest replacing it with compassion fatigue, a term that is more encompassing to include the emotional turmoil nurses experience and the resulting negative consequences in the workplace.

Conversely, compassion satisfaction is defined as the positive feelings an individual derives from delivering care to others (Stamm, 2009). These terms will be used frequently throughout this review to discuss the need for interventions in the workplace and to assess the

effectiveness of the interventions post-implementation. These terms are also defined in Appendix B.

Methods

A search of the literature was conducted using the databases CINAHL, PubMed, and PsychINFO with search terms related to *nurse, oncology, cancer, “attitude to death,” “attitude to illness,” perception, death, and “terminally ill.”* To be included in this literature review, articles had to be primary research reports or systematic literature reviews, written in English, published no earlier than 2008, and focus on oncology nurses’ perceptions of death and dying. Two international studies were included as they contain pertinent information for this review and they meet the inclusion criteria. Articles focused on pediatric oncology nursing were excluded in order to maintain more rigorous focus on adults with cancer. Additionally, editorials, dissertations, abstracts and case studies were excluded. The article selection process is depicted in Figure 1 below. This literature review consists of 10 articles of various study designs including descriptive, cross-sectional, and literature reviews (see Table 1).

Findings

The findings presented in this review address oncology nurses’ perceptions of patient mortality and the associated burnout and compassion fatigue that often occur as a result of inadequate coping mechanisms. Interventions to aid in prevention of burnout and compassion fatigue will also be discussed. All of the articles included in this review agree upon the necessity of ensuring the availability of resources in order to enhance professional support. The studies make recommendations for interventions of varying effectiveness.

Ensuring Availability of Resources

In response to the lack of research on the phenomenon of compassion fatigue in oncology nursing, Nancy Aycock and Deborah Boyle conducted a national survey to take inventory of resources oncology nurses have available to aid in coping with patient deaths (2009). The goal of this study is to draw attention to the lack of resources readily available to nurses and to facilitate the implementation of interventions on oncology units throughout the country. About 22% of nurses who responded to the survey indicated the availability of counselors or psychologists, but stated there is a lag time between requesting an appointment and meeting with a specialist, which increases the risk for complicated grieving (Aycock & Boyle, 2009). The survey respondents commented that visits with the specialists were limited and required a fee after an allotted number of visits were used (Aycock & Boyle, 2009). Nurses that denied having access to a counselor or psychiatrist reported reliance on collegial support. A small percentage of respondents (about 5%) reported exposure to support groups but indicated that they were formed only for short periods of time and had a low attendance rate (Aycock & Boyle, 2009). 17% of respondents reported no formal interventions set in place to facilitate healthy coping following the death of patients (Aycock & Boyle, 2009). In addition to making psychological support more accessible to nurses, Aycock and Boyle (2009) recommend instituting education programs pertaining to care at the end of life and specialized retreats for staff members.

Support Groups and Debriefing Sessions

Four of the studies indicate the implementation of bereavement debriefing sessions with colleagues (Aycock & Boyle, 2009; Hildebrandt, 2012; Wittenberg-Lyles, Goldsmith, & Reno, 2014; Zajac, Moran, & Groh, 2017). Wittenberg-Lyles et al. (2014) explored the perceived benefits and barriers of monthly support groups. Participants reported having improved self-care

and an “emotional recharge” as a result of the opportunity to reflect on deceased patients with a group of individuals who understand and can relate to the nature of the work (Wittenberg-Lyles et al., 2014). Perceived barriers include scheduling conflicts and the need for a formal group leader, made difficult by the lack of incentive offered (Wittenberg-Lyles et al., 2014).

Hildebrandt (2012) explains that nurses who are given an opportunity to discuss the loss of a patient are less likely to carry their grief home. Zajac et al. (2017) implemented a quality improvement project within a cancer center in Michigan in order to address the issue of lower quality patient care caused by compassion fatigue. Levels of burnout, compassion fatigue, and compassion satisfaction were measured using the ProQOL R-IV scale before and after implementation of the project, which consisted of bereavement debriefing sessions for staff members (Zajac et al., 2017). The scores revealed a decrease in compassion fatigue following implementation of the intervention, but showed no change in burnout levels. Staff responses to qualitative surveys, also administered pre- and post-intervention, indicated that attendees found the sessions helpful (Zajac et al., 2017).

End-of-Life Education Programs

Four of the articles suggest the implementation of educational programs pertaining to end-of-life care (Aycock & Boyle, 2009; Hildebrandt, 2012; Lange, Thom, & Kline, 2008; Gama, Barbosa, & Vieira, 2014). The educational programs are intended to provide nurses with the confidence to care for patients near the end of life, as well as strategies to facilitate healthy coping following the loss of a patient. Hildebrandt (2012) discusses the emphasis end-of-life education places on the patient and family and states that it neglects to consider the feelings of the nursing staff providing care. Hildebrandt (2012) calls for the incorporation of grief training

into end-of-life education programs in a timely manner, preferably before the nurse is exposed to patient mortality.

Lange et al. (2008) recommend implementing an education program at the time of new-staff orientation geared toward end-of-life care in order to build the confidence of newer nurses in their ability to care for terminal patients. These educational programs are intended to, “Foster more positive attitudes in younger and less experienced nurses by providing them with a strong background in palliative care and coping skills, instilling in them higher levels of palliative care competency, and exposing them to various end-of-life scenarios they will encounter in the oncology population” (Lange et al., 2008).

Promotion of a Positive Work Environment

Two of the articles’ themes pertain to ensuring a positive work environment (Hildebrandt, 2012; Potter et al., 2010). Due to the inevitability of death on oncology units, nurses will experience grief at some point in their career. According to Hildebrandt (2012), a supportive workplace is one that acknowledges this component of oncology nursing and provides grief resolution interventions regularly. This ties into Aycock and Boyle’s (2009) study, which draws attention to the lack of resources readily available to oncology nurses. Hildebrandt (2012) found that supportive work environments played a key role in improving quality of care delivered to patients and perceived job satisfaction of nurses, as well as decreasing the likelihood that nurses on the unit will experience burnout or compassion fatigue. Potter et al. (2010) argue that a workplace which promotes psychological well-being of staff-members plays an integral role in retaining oncology nurses on a given unit.

Ensuring Balanced Patient Assignments

Two of the articles indicate the need to ensure a balanced patient load (Hildebrandt, 2012; Gama et al., 2014). This grief management strategy is intended to reduce the number of patients that nurses provide end-of-life care to subsequently. The grieving process may be complicated by repeated exposure to patient death (Hildebrandt, 2012). In their review of the literature, Gama et al. (2014) include studies that support the theory that organizational factors in the workplace, such as high patient acuity, contribute to high levels of burnout. Oncology nurses participating in this study reported one of the greatest contributing factors to their heightened stress levels included large patient loads resulting in lack of time to deal with the psychological hardships of caring for dying patients (Gama et al., 2014). Therefore, balanced patient loads should be assigned in order to ensure both the needs of the patients and the nurse are met during the shift.

Tailoring Interventions to Meet Specific Staff Needs

Four of the articles advocate for tailoring interventions to better meet the needs of staff members based on demographic data (Potter et al., 2010; Zajac et al., 2017; Lange et al., 2008; Gama et al., 2014). Potter et al. (2010) conducted a descriptive, cross-sectional study within a cancer center in order to address high turnover rates of nursing staff. This was done using the ProQOL scale. In addition, trends corresponding with different staff demographics were noted in order to better inform development of appropriate interventions. A statistically significant relationship between work setting (inpatient vs outpatient unit) and compassion satisfaction was found. Nurses employed on inpatient oncology units had higher-risk compassion satisfaction scores compared to nurses in outpatient oncology services. Although no significant relationship was found between years of oncology nursing experience and any of the ProQOL subscales

(burnout, compassion fatigue, and compassion satisfaction), oncology nurses with 11- 20 years of experience consistently had the highest percentages of high-risk scores across all three subscales (Potter et al., 2010). This trend contradicts the findings of Zajac et al. (2017), who found nurses under the age of 40 with less than 10 years of experience are at highest risk for compassion fatigue. Trends noted in regards to education level included nurses with associate's degrees having the highest percentage of high-risk compassion satisfaction scores, bachelor's prepared nurses having the highest risk for compassion fatigue, and graduate-level nurses having the highest risk for burnout (Potter et al., 2010).

Lange et al. (2008) and Gama et al. (2014) found that oncology nurses with more years of experience generally had more positive attitudes towards patient deaths. It was noted that levels of depersonalization were higher among younger nurses with less than 4 years of experience, the male gender, and nurses who have a marital status of single or divorced (Gama et al., 2014). When compared to nurses from palliative care units, oncology nurses were found to have statistically significant higher emotional exhaustion and depersonalization scores and lower personal accomplishment scores (Gama et al., 2014). Gama et al. (2014) recommend incorporating targeted training strategies as part of undergraduate and postgraduate training for nurses. As demonstrated by the findings in this section, demographic factors vary from one population to another. There is value in determining the correlation between demographic factors of a nursing population and levels of burnout and compassion fatigue in order to better inform development of interventional programs.

Other

Three of the reviewed articles identify interventions that do not fall under the aforementioned categories (Fetter, 2012; Tofthagen et al., 2017; Granek, Ariad, Shapira, Bar-

Sela, & Ben-David, 2016). Fetter (2012) aimed to standardize end-of-life care on a medical-surgical oncology unit in Pennsylvania by aiding nursing staff in healthy coping mechanisms to decrease compassion fatigue. The support program consisted of various interventions including ensuring professional and social support for staff, helping staff recall feelings of achievement and satisfaction in their care of the patient, and allowing nursing staff to participate in end-of-life care along with the family. Program interventions included the creation of a remembrance tree in a staff-only area to encourage staff reflection and encouraging staff to engage in journal writing (Fetter, 2012). End-of-life care was standardized by placing a magnet of a dove outside the room of a patient that was actively dying or had already passed away. Families of dying patients were also given care packages consisting of items such as bibles, rosary beads, candles, and blank journals (Fetter, 2012). Fetter (2012) feels that this program can be easily replicated and would be of value in other oncology settings.

Tofthagen et al. (2017) explore factors that predispose nursing staff to and protect from complicated grief. Risk factors include having a close relationship to the deceased, personality traits such as low self-esteem and insecurity, poor coping skills, history of psychiatric illness, and some socioeconomic factors (Tofthagen et al., 2017). Psychological well-being, spirituality and religious practices, and socioeconomic factors such as financial stability can be protective against complicated grief (Tofthagen et al., 2017). Interventions to manage complicated grief once an individual is showing clinical signs include referral to a mental health professional for cognitive behavioral therapy and individual interpersonal therapy (Tofthagen et al., 2017). Pharmacologic interventions, such as antidepressants, may also play a role since psychiatric comorbidities are likely to occur simultaneously with complicated grief (Tofthagen et al., 2017). Preventative interventions have not demonstrated the same efficacy as treatment interventions

(Tofthagen et al., 2017). Education regarding preventative measures should be incorporated into end-of-life training programs and should include known protective behaviors, recognition of signs and symptoms, and appropriate treatment (Tofthagen et al., 2017). Similarly, Granek et al. (2016) explored facilitators and barriers to coping with patient mortality.

Behavioral activities, such as engaging in hobbies, and spiritual activities, such as partaking in meditation and religious practices, were found to facilitate the coping process (Granek et al., 2016). Additionally, compartmentalization or enforcing boundaries between home and work life proved effective in minimizing emotional disparity following the death of a patient (Granek et al., 2016). Boundaries, as perceived by participants in this study, included lack of access to emotional support, inability to express emotions due to gender expectations, and maintaining professional boundaries (Granek et al., 2016). Granek et al. (2016) found that one of the most common complaints among participants was the lack of resources available, a finding consistent with Aycock and Boyle's study. Granek et al. (2016) recommend developing targeted interventions for oncology staff in order to provide a mechanism for healthy coping.

Discussion

Recommendations

Further research is needed on compassion fatigue and burnout in the oncology nursing population with a focus on demographic risk factors. Many of the existing studies are qualitative and are the beginning stages (descriptive pilot) of larger research studies. As these studies are expanded upon, findings will be more conclusive. Though numerous interventions have been recommended in this literature review, all with evidence to support their effectiveness, they are generalized. There is no one intervention that will solve the issues of burnout and compassion fatigue for all oncology nurses. It is the responsibility of nurse managers to use existing research

and recommendations to tailor interventions to the specific needs of their nurses. Furthermore, institutions should conduct their own studies to determine the best way to meet the needs of their own staff members. Other related factors that should be studied include differences in demand between inpatient and outpatient oncology units and differences between adult and pediatric oncology nursing.

Implications for Nursing Practice

When nurses are repeatedly exposed to patient death and not given an opportunity to grieve, the physical and mental effects are detrimental. Burnout that is left unaddressed leads to negative outcomes including increased staff turnover on the unit and decreased patient satisfaction with the quality of care being provided to them. The interventions explored in this literature review have been found to be effective in preventing and managing the effects of burnout.

Feasibility

Many of the interventions explored in this literature review are highly feasible and require little resources to implement. A simple cost-benefit analysis shows increased retention rates of oncology nurses due to increased job satisfaction, lower stress levels, and increased confidence in abilities to deliver end-of-life care to patients and families. Other benefits include decreased levels of compassion fatigue and burnout in nursing staff, increased patient satisfaction due to increased quality of care delivered by nurses, higher employee productivity, and fewer sick days (Wittenberg-Lyles et al., 2014).

Limitations

Studies included in this literature review were mostly qualitative and consisted of relatively small sample sizes that ranged from 10 to 360 participants. As discussed in the recommendations section, additional research should be conducted in a focused manner.

Conclusion

While burnout itself is an unpleasant experience for nurses, the negative outcomes that follow are the reason for concern. Burnout can lead to decreased staff retention rates, lower quality of care delivered to patients, and hostile work environments. Every nurse is an investment to his or her unit, so it is the responsibility of unit leadership to ensure measures are taken to prevent and address burnout when it occurs. Effective interventions have been identified and discussed in this literature review. Any combination of these interventions can be selected for implementation on a unit. The negative consequences of burnout are too great of a risk for hospitals to assume. In order for patients to receive optimal care, oncology nurses must be provided opportunities and resources to manage their grief.

Lessons Learned from the Review

Throughout my time in nursing school my professors discussed burnout and compassion fatigue during various lectures. Even after learning about these issues, I was sure they would never happen to me. This review has made me aware that burnout and compassion fatigue are more prevalent than most caregivers think. It also drew my attention to the lack of resources available to address these issues, which results in a negative cascade of events for nurses and the units on which they work. As a nursing student who has accepted a new graduate RN position on a surgical oncology unit, I hope to bring an increased awareness of these issues to my future colleagues. I plan to work with my nurse manager to ensure there are interventions in place to

prevent and address burnout and compassion fatigue. The findings of this literature review will be useful in deciding which interventions to adopt on my oncology unit. In Anna's situation (see case-study above), she is likely in the beginning stages of burnout. It is important that Anna recognizes this and seeks out resources to address the issue before it becomes more serious. While seeking professional assistance may be necessary, Anna can also engage in activities that she enjoys, such as hiking or meditation, to help alleviate her emotional burden.

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Table 1

Summary of Articles Included in Literature Review

Author/ Year	Geographical Location	Purpose	Design	Sample Size	Findings	Implications for Clinical Practice
Zajac, Moran, & Groh, 2017	Midwestern United States	Develop an intervention to reduce compassion fatigue in oncology nurses and assistive personnel	A mixed-methods sequential design was used to determine factors contributing to lower patient satisfaction scores on the unit of interest	117 RNs and 69 assistive personnel eligible for participation; 108 employees completed pre-intervention survey; 136 completed post-intervention survey (42 employees who completed post-survey participated in intervention)	Pre-intervention PROQOL indicated average level of compassion satisfaction and low levels of burnout; Post-intervention scores revealed decreased levels of compassion fatigue, however, there was no significant difference between those who participated in the intervention and those who did not; Staff found the debriefing sessions helpful; patients' perceptions of care were improved following the implementation of	Risk factors for developing compassion fatigue include younger age of caregivers and less experience. Additional research needs to be conducted on the topic.

					debriefing sessions	
Hildebrandt, 2012	N/A	Identify grief resolution strategies that have been proven effective in the oncology nursing population	Literature Review	18 articles selected for review (6 qualitative studies, 5 quantitative studies, 4 journal reports, 2 descriptions of implemented programs, and 1 literature review)	Effective interventions for grief resolution fell into four themes: positive work environment, debriefing sessions, End-of-life education and grief training, and altering patient-care assignments	These interventions can be implemented on oncology units in order to offer grief resolution to caregivers
Aycock & Boyle, 2009	N/A	Determine what resources are available to oncology nurses to combat compassion fatigue and to determine whether nurses take advantage of these resources	Surveys regarding availability of grief management resources sent to ONS Chapter Presidents for distribution to members	231 surveys sent out, 103 responses received	Small percent of oncology nurses have resources available	Interventions discussed in this article were proven to be effective, they need to be implemented in oncology facilities nation-wide
Fetter, 2012	Lancaster, Pennsylvania	Determine the effectiveness of a bereavement support program in reducing compassion fatigue of the inpatient	Comparison of RN-turnover rates on the unit of interest pre and post intervention; Informal discussion with staff about	Nursing staff on the 26-bed inpatient medical-surgical oncology unit of Lancaster General Hospital; 50 surveys distributed, 25	Twenty-two of the survey respondents felt the program helped bring closure; Nursing staff verbalized increased ability to	Oncology nurses should be aware of symptoms associated with compassion fatigue and how to address the issue; Nurses

		oncology team	progress after implementation of the program; Open-ended question survey inquiring about staff perceived closure	responses received	discuss feelings related to patient death; Lower RN-turnover rate post-intervention	should advocate for the implementation of grief resolution interventions on their units to minimize compassion fatigue
Potter et al., 2010	Midwestern United States	Measure compassion fatigue, compassion satisfaction, and burnout levels among nursing staff in a cancer center; Examine the relationship between compassion fatigue, compassion satisfaction, and burnout and staff demographics in order to aid in the development of an intervention tailored to specific staff needs	Descriptive, cross-sectional survey of 153 healthcare providers within a cancer center	448 survey packets distributed, 153 were completed and returned (34% response rate)	Percentages of high-risk scores for compassion fatigue were relatively equal among inpatient and outpatient staff; Providers with 11-20 years of general healthcare experience had highest percentage of high-risk compassion fatigue scores as compared to those with less experience; Providers with 11-20 years of oncology experience had the highest percentages of high-risk compassion	Analysis of relationship between demographics and levels of compassion fatigue, compassion satisfaction, and burnout can facilitate appropriate intervention development

					fatigue, compassion satisfaction, and burnout; Nurses with a bachelor's degree had the highest percentage of high-risk scores for compassion fatigue; Nurses with advanced degrees had the highest percentage of high-risk scores for burnout	
Tofthagen, Kip, Witt, & Mcmillan 2017	N/A	Discuss the implications of complicated grief on oncology nurses	Explore existing research on resources available to oncology nurses experiencing complicated grief		Some forms of therapy have been proven effective in managing complicated grief, but these are not readily available to all oncology nurses	Early interventions should be provided to oncology nurses to address complicated grief
Lange, Thom, & Kline, 2008	New York	Assess oncology nurses' attitudes toward caring for dying patients; Explore the relationship between nurses' attitudes and	Descriptive quantitative study within 432-bed comprehensive cancer center	Convenience sample of 355 inpatient and outpatient oncology nurses	Years of nursing experience and age were found to most likely impact nurses' perceptions of death and dying; RNs with more work	Oncology nurses with minimal experience should be offered education programs and coping interventions to better

		demographic factors			experience tend to have more positive attitudes toward death and dying	handle patient mortality
Wittenberg-Lyles, Goldsmith, & Reno, 2014	N/A	Explore the benefits and barriers associated with oncology nurse support groups and the effect the support groups have on self-care	Qualitative descriptive-Participants interviewed	10 oncology nurses from the cancer center's outpatient chemotherapy infusion unit	Participants reported decrease in stress related to end-of-life care; Support groups promoted self-care among nurses	Oncology nurses benefit from support groups; Peer support groups are a feasible intervention that oncology units can implement to reduce burnout in oncology nurses
Granek, Ariad, Bar-Sela, Shapira,& Ben-David, 2016	Israel	Explore barriers and facilitators to oncology providers' coping abilities to patient death	Grounded theory-participants interviewed	22 oncology providers from three adult oncology centers were interviewed	Facilitators to coping included cognitive, behavioral, relational, professional, and spiritual coping strategies. Barriers to coping included accessing social support, gender stereotypes and expression of emotion, and emotional boundaries following patient death.	Oncology nurses can be encouraged to partake in some of the coping strategies that were found to be effective. The article recommends more targeted approaches be developed.

Gama, Barbosa, & Vieira, 2014	Lisbon, Portugal	Identify characteristics that oncology nurses possess that contribute to increased levels of burnout	Participants answered socio-demographic and professional questionnaires , as well as the Maslach Burnout Inventory, Death Attitude Profile Scale, Purpose in Life Test and Adult Attachment Scale.	360 nurses from internal medicine, oncology, hematology and palliative care departments from five healthcare facilities	No significant difference in burnout scores found between different departments. Palliative care nurses were found to have the lowest levels of emotional exhaustion and depersonalization.	Factors that may protect nurses against burnout include meaning and purpose in life and comfortable attitude towards death.
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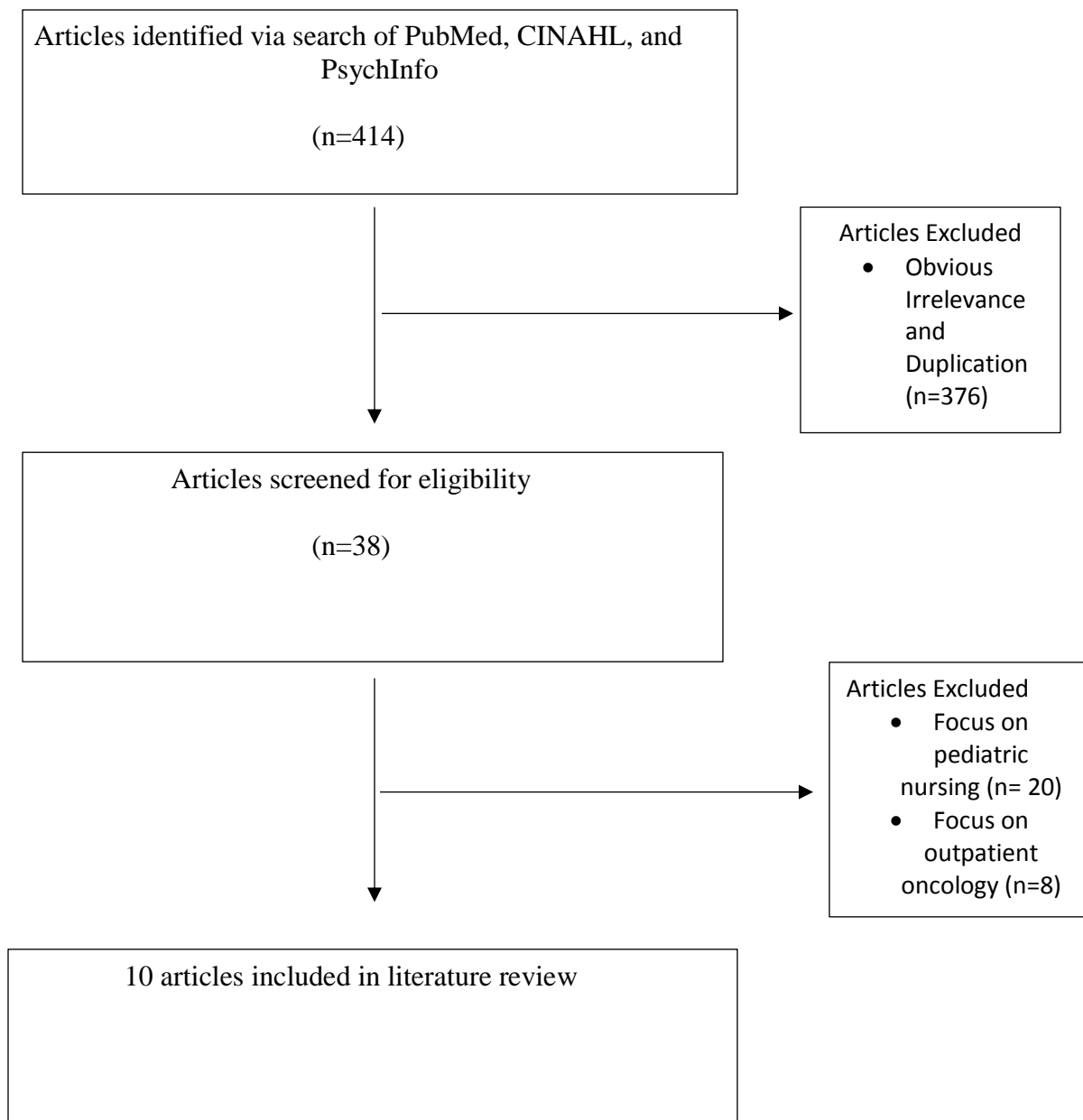


Figure 1. Article Selection Process

Appendix A

Case-Study Questions

- 1) After reading this literature review, do Anna's symptoms suggest she is experiencing burnout and/or compassion fatigue? What other symptoms might she be experiencing?
- 2) Whose responsibility is it to prevent burnout and compassion fatigue from occurring?
- 3) What are some interventions that Anna's nurse manager should implement in order to prevent other employees from becoming burnt out?
- 4) What are some activities that Anna can engage in that will help her better manage her grief?

Appendix B

Relevant Terminology

Burnout- “A psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity” (Maslach & Leiter, 2010).

Compassion Fatigue- “The emotional turmoil nurses experience and the resulting negative consequences in the workplace” (Aycock & Boyle, 2009).

Compassion Satisfaction- “The positive feelings an individual derives from delivering care to others” (Stamm, 2009).

Complicated Grieving- “The phenomenon that occurs when the grieving process does not occur as anticipated, but rather becomes prolonged and disrupts the normalcy of life for the bereaved” (Tofthagen, Kip, Witt, & Mcmillan, 2017).