

## SOURCES

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feel 50,” Ansley says. (*For more information about Flower Angels, see “Would you like to reduce your weekend calls by 66%?” Hospice Management Advisor, August 2010, p. 85.*) ■

## Program to combat ‘compassion fatigue’

*Stressed providers cannot offer optimal care*

The Woman’s Hospital of Texas, based in Houston, is offering caregivers in several units a “compassion fatigue” program, designed to target a little-known stress disorder that its proponents say prevents providers from giving their patients optimal care.

“Compassion fatigue [CF] is a stress disorder that was first identified in the 1950s, primarily among vocations that provide care for people in crisis,” says **Bruce G. Coe**, MDiv, chaplain, quality resource management at the hospital. “When I came here three years ago, I quickly determined a goodly number of our staff was under the disorder. I tried to get some interest at the time and did not get what I hoped for, but due to recent situations and circumstances in the country, hospital leadership began to pick up on it — and this program is something you can offer.”

Exactly what is compassion fatigue? “Compassion fatigue is the gradual lessening of a person’s ability to provide compassion,” Coe explains. “Each nurse, doctor, or other caregiver only has so much compassion. The textbook definition says it comes on gradually, but one crisis can drain the will, and providers can find themselves unable or unwilling to provide care.”

When a provider suffers from compassion fatigue, “quality of care suffers,” says **April Spre-**

**eman**, LMSW, a social worker involved in the program. “We have to have a lot of compassion to build rapport with patients and make connections.”

Coe agrees. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a publicly reported survey of patients’ perspectives of care, “not only demands that we provide good clinical care, but we know that people want those warm, fuzzy feelings,” he says. “If we do not have them, that will reflect on our scores and cause even more stress.”

The condition not only affects the ability to show compassion, but also begins to show up in clinical care, he says. “I had unit managers come to me several times telling me that nurses who never had issues or events are having them,” Coe shares. “We believe it’s directly related to stress levels in their lives at work and at home. If it goes unchecked, it shows up in clinical care; they begin to not do some things or do things they’ve not done before.”

Lack of compassion is an attitude, he says. “These people are tired, unmotivated, not giving prompt care,” says Coe. “They may not be making clinical mistakes, but they are not providing normal, effective care.”

Accordingly, Spreeman adds, staff compassion fatigue was beginning to affect HCAHPS scores. “I talked with our patient advocate and said if you want to improve those scores you need to look at CF,” she recalls. “She did not know about the condition. Very few people in the medical profession are aware of it.” Spreeman learned about it in a previous position in hospice. Ultimately, its HCAHPS scores became a selling point for the program.

### How the program works

The program itself is, by and large, a “self-care” program, explains Coe.

“We provide a lecture for nursing units consisting of a plan for them to develop,” he says. “We provide a framework,”

The lectures are built into their monthly meetings. A computerized graphic presentation is used that present a definition of CF, and symptoms are discussed. “One of the biggest steps is self-awareness,” says Spreeman. For example, she says, staff members might avoid a particular patient on purpose because they know he or she is difficult. “Another is irritability with patients and with co-workers,” she says. Additional symptoms, she

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notes, include extreme nervousness or anxiety, and even physical symptoms such as constipation.

Coe says, "The point is for them to first acknowledge they have the condition. Then, we ask them to make a promise to care for themselves. Our responsibility is to ask them if they are keeping their promise."

The promise is that staff members will do something for themselves once a day, he says. "I wrap up the session by sharing how my day is spent hearing stories about death, disease, discouragement, and despair — imagine what I'd be like at the end of day if I did not decompress?" he says. "It might be as simple as meeting a buddy at a restaurant and having a cup of coffee, or taking a long walk when I get home. Once a week I plan something big so I can look forward to it. That's how simple it is."

The program has been offered in nine units over a couple of months, and "it could not have been better received," says Coe. "Our administration is trying to build this in as a more regular part of our lecture series and orientation for employees. We've even had another hospital make inquiries about what we're doing." ■

## Aiding transition from hospital to hospice

### *Care continuity still necessary*

**H**ospitalized patients with terminal illnesses often feel abandoned by their physicians at the end of their lives. Their physicians might experience a lack of closure that is unsettling.

While no physician plans to abandon a dying patient, this situation is often what happens, particularly when the patient's crisis leads him or her to the hospital. Here's a case study example: A 72-year-old woman entered a hospital emergency department with complaints of acute pain caused

by metastatic cancer. The woman had no family in her Arizona community, and she was admitted only after she claimed to be unable to care for herself at home. Her community physician was out of town and unavailable.

The hospital provided treatment for her pain and begins to prepare for surgery, but it soon was discovered that the cancer was too widespread to warrant surgery. The hospital prepared to discharge the woman to a cancer specialty center that could identify the origin of her cancer, but the patient declined this transfer. She said she did not want to be transferred for further tests and could not withstand the pain or take care of herself if she were sent home.

Meanwhile, the patient expressed feelings of anger and abandonment by her physician and the hospital. The physician did not interrupt his vacation to check on her condition after she was hospitalized, and, from her perspective, the hospital seemed eager to get rid of her.

The solution ended up being a transfer to a residential hospice center that had inpatient, acute care beds. The woman's Medicare benefit paid for the acute care stay, and the woman did not live long enough to be discharged back to the community.

This type of situation is all too familiar to oncologists and other physicians who try to help patients make an end-of-life transition, according to a study about abandonment of patients at the end of life.<sup>1</sup> "The main finding of our study was that although physicians were conscious of not abandoning their patients at the end of their lives, the patients still could be abandoned because they were sent to hospice and there was no follow-up by the doctor," says **Anthony Back**, MD, a professor of medicine at the University of Washington, Fred Hutchinson Cancer Research Center and a gastrointestinal oncologist at Seattle Cancer Care Alliance in Seattle. "At the time of the patient's death, the patient might not hear from the physician, and that led family members to feel like they had been abandoned. Physicians said it felt like a lack of closure for them, but they didn't recognize the effect it had on their patients."

For example, one family member interviewed by researchers was crying and saying, "Gee, I know he's busy and has lots of patients, but we had been through so much together that I was surprised we didn't hear from him at the time of death," Back recalls. "The physician said, 'I was out of town when the patient died, and when I got back in

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