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Taking Care of Care Providers: A Wellness Program for Pediatric Nurses

Sima Zadeh, MA¹, Nicole Gamba, RN, BSN, CPON², Caroline Hudson, BSN, RN, CPON², and Lori Wiener, PhD¹

¹National Cancer Institute, National Institutes of Health, Bethesda, MD, USA

²NIH Clinical Center, Bethesda, MD, USA

Abstract

The cumulative effect of professional stress and compassion fatigue within the health care profession has been receiving increasing attention. The impact can be especially worrisome for nurses who work with chronic illness populations, such as oncology. While interventions targeted at reducing nurses stress and promoting wellness are cited as necessary, they are often lacking in busy medical environments. In this article, the authors describe a newly developed 10-session wellness program that was offered on 2 occasions to both inpatient and outpatient nursing staff. The nursing staff chose the content areas, and each session used a combined approach of hands on and didactic learning. A description of the activity offered during each session along with the core competency and objectives measured are provided. Overall, staff found the wellness series very helpful to themselves and to their ability to positively change their job performance.

Keywords

staff wellness; oncology nursing; compassion fatigue; education; burnout

Background

The World Health Organization (2006) defines health to be a state of complete physical, mental, and social wellbeing. Recently, overall health has become synonymous with the term *wellness*. Swarbrick, D'Antonio, and Nemec (2011) describe 8 dimensions of wellness: physical, spiritual, social, intellectual, emotional, occupational/leisure, and financial. Clinicians, such as medical staff, nurses, and counselors, who work diligently to provide health-promoting care to others are often not as successful in taking the time to incorporate wellness behaviors in their own life. Over time this could contribute to *compassion fatigue*, a term that refers to the loss of ability to provide the same level of compassion and care for another person following prolonged, continuous, and intense contact with patients (Coetzee

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Corresponding Author: Sima Zadeh, National Cancer Institute, National Institutes of Health, 10 Center Drive, Pediatric Clinic, 1-5460, Bethesda, MD 20892, USA, zadehsl@mail.nih.gov.

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& Kloppe, 2010) due to a depletion of the practitioner's emotional and physical energy toward work (Figley & Gould, 2005). With increasing attention to the effects of compassion fatigue, staff wellness programs have become an important component of caring for professional staff. Symptoms of compassion fatigue include emotional exhaustion, cynicism, and a low sense of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). Continued compassion fatigue leads to burnout. The intense atmosphere of ongoing losses, an understaffed workforce, and a high-stress environment make nurses particularly vulnerable to both compassion fatigue and burnout (Medland, Howard-Ruben, & Whitaker, 2004).

No one would argue that hospital-based pediatric nursing offers the potential of a challenging and meaningful career, yet it also involves unique challenges related to repeated exposure to serious illness, trauma, pain, suffering, and death (Coetzee & Kloppe, 2010). These experiences combined with frequent heavy workloads, staff shortages, inadequate management support, uncompetitive remuneration, poor working conditions, a lack of resources to work effectively, limited career opportunities, and unstable work environments all affect nurses' emotional well-being, personal health, and, potentially, their ability to provide appropriate patient care (Buchan, 2006). These factors also place pediatric nursing staff at risk for emotional exhaustion.

Moreover, nurses, by way of their role in patient care, can develop strong attachments to patients and their families. Consequently, they may experience an intense sense of loss if a patient dies. Studies show that nurses are more likely to suffer extended mental anguish while caring for a dying patient (Engler et al., 2004) and internalize their grief symptoms (Hinds et al., 1994). Their grief has been shown to result in personal changes in energy, sleep patterns, and appetite (Hinds et al., 1994). Guilt, sadness, anger, shock, and relief at the passing of their patient have also been noted, but frequently nurses do not have or are unaware of available supports to cope with these emotions (Spencer, 1994). Less experienced nurses are found to be at a greater risk for increased anxiety and distress at the death of a patient (Hinds et al., 1994). Care has also become increasingly complex due to the need for nurses to learn new technologies, along with having the skills to sensitively communicate with families with multifaceted psychosocial needs. Additionally, pediatric nurses are often heavily invested in their patients and work, which can lead to difficulties with boundaries and work-life balance (Swetz, Harrington, Matsuyama, Shanafelt, & Lyckholm, 2009). Although nursing and other health care leaders recognize that nurses experience grief when their patients die, most nursing curricula include limited education on coping with loss and grief experienced in the work setting or the skills needed to maintain professional boundaries (Chan et al., 2008; Engler et al., 2004; Spencer, 1994; Wright & Hogan, 2008), which can leave early career nurses particularly vulnerable.

In 1997, the International Council of Nurses mandated that nurses have a unique and primary responsibility for ensuring that at the end of life individuals experience a peaceful death. The group made recommendations regarding the competencies necessary for nurses to provide high-quality care to patients and families during the transition to end-of-life care. The identified competencies include recognizing one's own attitudes, feelings, values, and expectations about death and the individual, cultural and spiritual diversity existing in these

beliefs and customs. The purpose of the competency statements was to assist nurse educators in incorporating end-of-life content into nursing curricula. Educational preparation for end-of-life care has been inconsistent and sometimes neglected within nursing curricula (International Council of Nurses, 1997).

Previous studies highlight strategies clinical staff have identified as ways to reduce burnout, namely, maintaining their own physical well-being and self-care, having supportive professional relationships, engaging in spirituality, and talking with others (Hinds et al., 1994; Spencer, 1994; Swetz et al., 2009). Despite staff acknowledging the usefulness of these strategies, nurses frequently report inadequate time to incorporate them into their personal or professional life (Spencer, 1994). Many pediatric hospitals have programs for patients and their families designed to reduce distress (Flannigan, 2010), yet few have established intervention programs for nursing staff to counter the emotional components, maintain balance, and help prevent physical and emotional exhaustion (Aycock & Boyle, 2009). Of the intervention programs that have been studied, nursing staff indicate positive reactions both immediately following the intervention and at a 6-month follow-up (Hinds et al., 1994).

The National Institutes of Health (NIH) Clinical Research Nursing Model of Care provides a framework for the delivery of high-quality nursing care to research participants. Dimensions within the Model of Care include the provision of direct nursing care and support, coordination of research and clinical activities, maintenance of informed consent/assent, participant safety, and protocol integrity. Clinical research nurses (CRNs) in the pediatric program at the NIH Clinical Center care for pediatric research participants with various diagnoses and differing levels of complexity. Multiple institutes of the NIH (eg, National Institute of Allergy and Infectious Disease; National Heart, Lung and Blood Institute; and the National Institute of Child Health & Human Development) enroll pediatric patients on research protocols. Some of these protocols include children who may be in good health who are enrolled as healthy volunteers, while most other protocols enroll children with life-threatening illness and refractory disease. Children enrolled on phase I trials are a vulnerable population, who frequently require long-term hospitalizations and pose specific physical, emotional, and psychosocial challenges. CRNs play a pivotal role in care coordination of the pediatric patient while maintaining protocol integrity.

With the intensity of multiple long-term patients and an increased number of pediatric patient deaths, staff began expressing feelings of emotional isolation, burnout, and compassion fatigue. In response, members of the psychosocial program of the Pediatric Oncology Branch of the National Cancer Institute (LW, SZ) collaborated with the nursing leadership to develop a Wellness Series for the nursing staff. The proposed goal of this program was to promote self-care, education, and teambuilding; develop proactive strategies to enhance staff wellness; and to provide a forum for the staff to discuss patient–staff interactions and more complex care giving scenarios. This article describes the overall wellness program, objectives for each session, evaluation outcomes, and provides recommendations for future programs.

Setting

The pediatric program of care at the NIH Clinical Center includes a 22-bed pediatric inpatient unit, an outpatient pediatric day hospital, and an outpatient pediatric clinic. Pediatric patients enrolled on a clinical research trial are cared for in 1 of the 3 patient care areas.

Program Development

Prior to initiation of a wellness programs, sessions for each series were developed based on nurses' requests. Along with a form for nurses to indicate topics of interest, a suggestion box was also provided in nursing stations. This was created so that nurses could suggest topics anonymously. Ten specific topics were requested, and the psychosocial support group recruited experts from throughout the National Institutes of Health, including members of our own team, to lead each of these individual sessions. The wellness program has now been implemented twice. During the first series, each session was held once in the morning and once in the evening to accommodate both daytime and evening staff. The second series was held once on the inpatient unit and once in the outpatient clinic to accommodate all pediatric care staff.

Sessions were formatted to include a verbal educational component, a hands-on activity or interactive discussion, reading materials related to the topic, as well as time for staff to ask questions or present a case related to the wellness topic (see Table 1). Formal evaluations were conducted at the end of each session. Nursing staff completed a brief evaluation that asked the following: (a) Did the session provide new information, ideas, and discussion about areas that can potentially impact my work? (b) Did the session elicit participation from those who attended? (c) Was the overall quality of the instructional process an asset to the activity? (d) Will participation enhance your personal effectiveness? (e) Will you change your practice as a result of attending this session? Staff was also asked whether the wellness series should continue and to provide any comments/feedback as well as suggestions for future topics.

Results

In total, 126 evaluations were completed. The majority of the staff found the sessions to be effective in providing new information that they felt would enhance their work skills. More than 75% reported that the sessions would change ("completely" and "considerably") the way they performed their job (see Figure 1).

In addition to ranking session utility, staff participants were provided open space to leave feedback on the sessions. The majority of comments related to the quality of the information provided: "This was informative and helpful," "Excellent presentation. I enjoy learning new methods of self-care," "This is the first time I've had to come to terms with one of my patient's passing away. Thank you for educating and making me feel more at peace with the situation." Positive feedback was also received regarding the format of the session: "Great activities—liked having an activity, discussion, reading, etc. Great for teambuilding, please continue," "I thought it was an exceptional session for a short 1 hour—lots brought out with

positive discussion and excellent facilitation of comments. Thanks very much.” The only negative comments provided were during sessions that entailed less didactic discussion. Most of these comments were similar (eg, “This was good, but getting us to talk with each other is crucial.”)

Discussion

We were able to successfully implement a Wellness Program for inpatient and outpatient pediatric nursing staff. Success for the program may be associated with staff involvement in providing the topics to be addressed; the combination of hands-on activities, didactic teaching, and case presentations; and the provision of new “tools” to be taken away from each session.

Several factors must be in place for the implementation of an ongoing staff support program to be successful. Assessment of staff needs is critical in identifying potential relevant topics or areas of concern. Content experts are needed to facilitate sessions and provide tools and resources related to each topic. It is also essential that hospital administrators acknowledge and support the need for wellness activities focused on the caregivers. At the unit level, time away from the bedside is required so that staff can be fully engaged in sessions without interruption.

Conclusions

Caring for critically ill and terminally ill children can generate grief reactions, stress, high staff turnover, difficulty concentrating, professional loneliness, and a sense of hopelessness when not addressed. In complex patient care settings where nurses are at risk for compassion fatigue and burnout, it is necessary to provide supportive care, offer educational opportunities, and teach new coping strategies on an ongoing basis.

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Biographies

Sima Zadeh, MA, is a postdoctoral fellow in the Behavioral Science Core of the Pediatric Oncology Branch of the National Cancer Institute.

Lori Wiener, PhD, is codirector of the Behavioral Science Core of the Pediatric Oncology Branch of the National Cancer Institute and Head, Psychosocial Support and Research Program in the Center for Cancer Research.

Nicole Gamba, RN, BSN, CPON, is the nurse manager of the Pediatric Inpatient Unit and Day Hospital in the NIH Clinical Center.

Caroline Hudson, BSN, RN, CPON, is the clinical manager of the pediatric unit at the Clinical Center of the NIH.

Figure 1.
Staff evaluation of wellness sessions

Table 1

Overview of Wellness Sessions

Session Title	Core Competency Objectives	Activity
Series 1		
Resiliency (Art Therapy)	To learn at least 3 methods that can promote resiliency.	Staff members created a pocket-sized collage as resiliency reminders, emphasizing strengths and coping mechanisms.
Teambuilding (Psychosocial Services)	To identify barriers to successful teambuilding and key components to satisfying working relationships.	Games were used to (a) illustrate how “assumptions” about coworkers could reduce teamwork and (b) build rapport between staff members.
Communication with an International Family (Psychiatry)	To recognize at least 3 means of reducing language and culture barriers to care.	Targeted integrating cultural awareness into care via discussion of case scenarios.
Communication (Psychosocial Services)	To have knowledge of 6 effective communication strategies.	Games and case scenarios were used to (a) emphasize importance of effective communication in the workplace, (b) identify common causes of miscommunication, (c) teach methods of nonverbal communication, and (d) demonstrate use of effective communication strategies.
Creating Awareness and Developing Relaxation Tools (Pain & Palliative Care Team)	To learn guided imagery techniques that can promote relaxation.	Staff members participated in developing a relaxation script, which was then practiced and recorded in session and then distributed to staff.
Creative Ways to Assess and Treat Pain (Pain & Palliative Care Team)	To become familiar with 3 or more effective methods of assessing pain in pediatric patients, as well as 4 methods of pain reduction and alternatives to medication.	Staff members participated in discussion surrounding a variety of case examples and were provided with teaching related to effective pain assessment and management.
“I Don’t Want To!” Working with Those Who Push More than the Call Button (Psychosocial Services)	To learn a model of care directed at diffusing tension and enhancing effective communication between the provider and the patient/caregiver was presented.	Staff members were collectively asked to identify examples of difficult patients. Scenarios of difficult patients/caregivers were provided to initiate discussion on effective patient/caregiver management. Staff were taught 4 strategies in working with difficult patients/caregivers.
Transition from Curative to Palliative Care (Pain & Palliative Care Team)	To identify 3 effective ways of communicating with patients receiving palliative care.	Staff were invited to discuss personal experiences of difficult scenarios and group discussion was held on how to effectively manage discussing palliative care with patients.
Blurry Boundaries (Psychosocial Services & Ethics)	To identify common boundary issues, learn 4 appropriate methods of communicating boundaries and 5 self-monitoring techniques.	Case scenarios were used to (a) illustrate how boundary crossings can interfere with care and (b) impact professional role.
Anxiety, Depression, and Passive Suicidal Ideation: Warning Signs and How to Help (Psychiatry)	To identify at least 3 signs/symptoms of anxiety, depression, and suicidal ideation.	Staff were engaged in discussion of case examples demonstrating “normal” and “problematic” symptoms within a hospital setting.
Series 2		
Using an Interpreter to Communicate with Patients and Families (Interpretive)	To name at least 3 reasons to use an interpreter during communication with non-English speaking families.	Case scenarios of miscommunication were discussed and staff were encouraged to problem-solve methods of improving

Session Title	Core Competency Objectives	Activity
Services)		communication.
Teambuilding (Psychosocial Services)	To identify barriers to successful teambuilding and key components to satisfying working relationships.	Games were used to (a) illustrate how “assumptions” about coworkers could reduce teamwork and (b) build rapport between staff members.
Making the Connection: Understanding the Treatment Experience of International Families (Social Work and a Professional Medical Translator)	To gain knowledge of 5 common challenges that international families face and to identify at least 3 areas for intervention.	Findings of a current study evaluating the treatment experiences of those families who travel to the United States for care were discussed. Options for intervention were provided.
Communication with Patients (Psychosocial Services)	To learn at least 3 components of effective nurse–patient communication as well as behaviors to avoid.	Staff discussed case scenarios to facilitate understanding and problem-solve potential difficulties.
Medical, Psychosocial, and Ethical Needs: The Role of the Nurse at Time of Patient Death (Psychosocial Services & Department of Bioethics)	To be able to identify 3 signs of impending death that families find most stressful, interventions to support the child and family at the time of death, and post death communication tools.	The presentation of a case where the parent was perceived to have changed her mind about the DNR order. Medical facts, ethical considerations, psychosocial factors were explored while examining possible outcomes with different approaches. Three key journal articles on end-of-life care were provided.
Patient Knowledge of Prognosis (Psychosocial Services)	To be able to identify 6 developmentally appropriate steps when discussing prognosis with a patient.	A training video was shown around which discussion was generated regarding discussing prognosis and how to meet the patient/family where they are as prognosis worsens.
Nursing Role in Transitioning to Palliative Care (Pain & Palliative Care Team)	To name 3 effective ways of communicating with patients receiving palliative care.	Staff was invited to discuss personal experiences of difficult scenarios and group discussion was held on how to effectively manage discussing palliative care with patients.
The Boundaries of Social Media (Psychosocial Services & Ethics)	To gain knowledge of 6 published guidelines on appropriate use of social media in nursing care.	Case scenarios were used to facilitate staff discussion about boundaries related to use of social media, including Facebook and CaringBridge.
Assessment and Management of Patient and Caregiver Mood (Psychiatry)	To learn at least 3 appropriate and effective means of assessing patient and caregiver mood and to identify at least 2 interventions.	Several case examples were presented to facilitate staff discussion.
Massage for Stress Reduction (Massage Therapy)	Staff members were taught methods of self-massage for stress reduction.	Massages were provided to staff in 10-minute intervals as a means of providing a relaxation activity.