

Article

Snack and Relax®

A Strategy to Address Nurses' Professional Quality of Life

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Purpose and Design: Snack and Relax® (S&R), a program providing healthy snacks and holistic relaxation modalities to hospital employees, was evaluated for immediate impact. A cross-sectional survey was then conducted to assess the professional quality of life (ProQOL) in registered nurses (RNs); compare S&R participants/nonparticipants on compassion satisfaction (CS), burnout, and secondary traumatic stress (STS); and identify situations in which RNs experienced compassion fatigue or burnout and the strategies used to address these situations. **Method:** Pre- and post vital signs and self-reported stress were obtained from S&R attendees ($N = 210$). RNs completed the ProQOL Scale measuring CS, burnout, and STS ($N = 158$). **Findings:** Significant decreases in self-reported stress, respirations, and heart rate were found immediately after S&R. Low CS was noted in 28.5% of participants, 25.3% had high burnout, and 23.4% had high STS. S&R participants and nonparticipants did not differ on any of the ProQOL scales. Situations in which participants experienced compassion fatigue/burnout were categorized as patient-related, work-related, and personal/family-related. Strategies to address these situations were holistic and stress reducing. **Conclusion:** Providing holistic interventions such as S&R for nurses in the workplace may alleviate immediate feelings of stress and provide a moment of relaxation in the workday.

Keywords: *nurses (basic); stress management/relaxation; caring-healing practices and processes; health promotion; holistic nursing; quality of life*

Chronic stress in nursing and health care employees has been shown to affect the quality of patient care and employee satisfaction (Tang, Tegeler, Larrimore, Cowgill, & Kemper, 2010). Compassion fatigue (CF), a type of stress, is defined as a combination of physical, spiritual, and emotional depletion when caring for patients in significant physical and emotional distress. CF has also been described as encompassing burnout and secondary traumatic

stress (STS) as a result of caring for distressed patients (Lombardo & Eyre, 2011). Burnout, a component of CF, occurs with prolonged emotional and

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interpersonal work stressors, while STS is vicarious exposure to others experiencing traumatic stressful events (Cuneo et al., 2011; Diaz-Rodriguez et al., 2011; Stamm, 2010). In contrast, compassion satisfaction (CS) is described as the pleasure derived from being able to do one's work well and helping others in a positive way (Stamm, 2010).

Background

The registered nurse (RN) workforce is the leading occupation in projected job growth through the year 2020. Employed nurses are predicted to increase from 2.74 million in 2010 to 3.45 million in 2020, an increase of 26%. About 10% of the growth in the RN workforce is from RN positions in general and from surgical hospitals where the annual turnover rate for RNs averages 14% (KPMG Healthcare & Pharmaceutical Institute, 2011). Nursing satisfaction will be a key focus as nursing recruitment and retention escalates to fill the needed positions. Nurses' self-care with regard to stress management and physical activity is often lacking. Health promotion strategies for nurses could be encouraged by knowledge of and exposure to holistic therapies (McElligott, Siemers, Thomas, & Kohn, 2009).

Over the past 30 years, researchers have addressed the efficacy of holistic practices to reduce pain and anxiety and produce relaxation (Anderson & Taylor, 2011; Bost & Wallis, 2006; Diaz-Rodriguez et al., 2011; Medina, González, & Westerlund, 2012). Almost half the nurses participating in a massage therapy study ($N = 58$) complained of headache, fatigue, muscle tension, and joint pain (Bost & Wallis, 2006). These nurses were randomly divided into an intervention and a control group. The intervention group received a 15-minute back massage once per week for 5 weeks; the control group did not receive any intervention. Urinary cortisol, mean arterial pressure, and state and trait anxiety were compared pre- and postintervention. No significant pre-post differences were found with regard to urinary cortisol or mean arterial pressure. Both state and trait anxiety significantly decreased in the intervention group over the 5 weeks. Reiki significantly reduced diastolic blood pressure in nurses with burnout and significantly increased secretory immunoglobulin alpha, a first-line defense against pathogenic microorganisms found in mucosal surfaces (Diaz-Rodriguez et al., 2011). Healing Touch was

shown to decrease blood pressure, heart rate, breathing, and worry while increasing emotional role function in participants studied in five randomized controlled trials (Anderson & Taylor, 2011).

Very few studies to date have examined the effects of holistic therapies on nurses' well-being and health. Touch therapy such as Reiki can provide the means to promote patient healing, while also reducing the physiologic and psychological stress of the nurse (Cuneo et al., 2011). A more balanced, less stressed nurse can provide better patient care and increased compassion in the nurse-patient interaction, while suffering less fatigue and burnout (Yoder, 2010).

Snack and Relax® Program

In an effort to address CF in health care professionals, a large multidisciplinary team of hospital employees formed a Holistic Care Committee (HCC) in 2009. The main goal of this committee was to discuss, plan, and initiate holistic care (treating the person as a whole: mind, body, emotion, and spirit) for fellow staff members throughout the health care organization. Most HCC members were trained in relaxation modalities such as Reiki, Healing Touch, Massage Therapy, Jin Shin Jyutsu, and Guided Imagery. One of the programs developed by this committee was "Snack and Relax" (S&R). S&R was instituted as a monthly program to provide hospital staff with a brief relaxation period away from their nursing units/offices. The primary goal of S&R was to decrease CF (e.g., anger, apathy, indifference, lack of energy, and absenteeism) and to increase CS among health care workers in the hospital setting. S&R was an innovative holistic, staff-supported program provided voluntarily by an interdisciplinary group of nurses, chaplains, technicians, and administrative assistants. There were two components to S&R: healthy snacks and holistic relaxation treatments.

S&R sessions were advertised via e-mail and posted flyers that indicated the date, time, and place of the S&R program. The location and times varied monthly to make the program available to as many staff members as possible. S&R sessions occurred in a comfortable space away from the employees' usual work environment (e.g., classroom space or conference room). Generally, at least five practitioners were available to provide the holistic modalities with two volunteers controlling the flow of participants. The practitioners were certified or licensed in one or more holistic modalities.

After signing into S&R, attendees rated their stress level (0 = no stress, 10 = very high stress). Vital signs (blood pressure, heart rate, and respiratory rate), age, gender, and professional discipline were recorded on a standardized form by a volunteer practitioner. Identifying data (name, unit) were not recorded. Participants were then provided with healthy snacks (e.g., fruits, vegetables, herbal tea, and water). Handouts explaining the different modalities were available to participants who then chose their preferred modality. The modality was performed for 5 to 10 minutes by a certified volunteer practitioner in a quiet dimly lit room with aromatherapy and soft instrumental music in the background. Afterward, attendees completed a postevaluative stress assessment, and vital signs were recorded. Attendees were also able to provide written feedback about the experience. The entire S&R session lasted between 10 and 15 minutes; most employees attended during their break time.

Swanson's (1993) theory of caring guided the S&R program. This theory is grounded in the idea that "nursing is informed caring for the well-being of others" (p. 354). Caring includes nurturing, commitment, responsibility, and relating to others. Through offering the healing modalities, the practitioner demonstrates the practice of self-care and nurturing to other nurses. Swanson's theory of caring's five components are applied in the S&R program as follows. "Maintaining Belief," which is foundational to nursing practice and to caring, is the belief in the ability of people to work through events and face a meaningful future. In "Maintaining Belief," the S&R practitioner makes a commitment to serve others by maintaining a faith in the healing and caring relationship. In "Knowing," the practitioner is skilled in the holistic modality, centers him or herself, and skillfully engages self and participant in a caring interaction. "Being With" refers to the participant understanding that he or she matters to the practitioner and that the practitioner is providing a healing time, authentic care, presence, and responsiveness to the participant. "Doing For" is providing to others what they would do for themselves if possible. In the context of S&R, "Doing For" is skillfully applying holistic modalities and care to participants who are not trained to tap into their innate potential for healing. "Enabling" is facilitating others to achieve well-being, and occurs as practitioners provide nurturing options and self-care advice in a time and space dedicated to stress management. Through these processes, caring is

demonstrated and well-being is promoted to those involved in this nurturing program.

In the spring of 2012, a member of the HCC introduced the S&R program to the Integrative Medicine task force team at a sister hospital. Hospital administrators agreed to support the implementation of S&R in that facility during 2013. Five S&R programs were offered between January and August 2013. The evaluation data from these five S&R sessions were analyzed to assess the immediate impact of the program. There were 210 total attendees at the five S&R sessions. The number of attendees ranged from 15 to 70 per session. The majority of S&R attendees were female (97%); 45% were nurses. The average age was 42 years ($SD = 12.9$, range 19-70 years). About one third (32%) reported having received Healing Touch during the S&R session, 63% had Reiki, and 25% had Massage Therapy. Significant decreases in self-reported stress levels, respiratory rate, and heart rate were noted after the S&R session (Table 1). Although blood pressure decreased after S&R participation, differences were not statistically significant. When data from only nurses attendees ($n = 90$) were analyzed, the findings were similar with significant decreases in the heart rate, self-reported stress level, and respiratory rate. No significant differences were noted in the diastolic or systolic blood pressures.

Nurses' Professional Quality of Life

While the evaluation of the immediate impact of the S&R program provided the participant with useful information, it was unclear if S&R had a more comprehensive impact on nurses' self-reported professional quality of life (ProQOL). ProQOL includes both CS and CF. A compassionate nurse is a caring nurse whose practice is grounded in the five components of Swanson's (1993) theory of caring. A cross-sectional survey was completed at the same hospital during August 2013 to determine the status of nurses' ProQOL. The specific research questions were the following:

Research Question 1: What percentage of RNs exhibit CS, burnout, and STS?

Research Question 2a: Are there differences in CS, burnout, and STS by participation in the S&R program?

Table 1. Snack and Relax Participants' Blood Pressure, Respiratory Rate, Heart Rate, and Self-Reported Stress Levels ($N = 210$)

Variable	<i>M</i> (<i>SD</i>)	<i>p</i>
Systolic blood pressure ($n = 205$)		
Pre	125.0 (16.0)	.17
Post	123.8 (17.1)	
Diastolic blood pressure ($n = 204$)		
Pre	76.6 (10.3)	.28
Post	75.9 (10.3)	
Respiratory rate ($n = 176$)		
Pre	17.6 (2.8)	.001
Post	16.8 (2.4)	
Heart rate ($n = 204$)		
Pre	74.7 (12.0)	<.001
Post	72.3 (9.7)	
Self-reported stress level ^a ($n = 192$)		
Pre	5.4 (2.3)	<.001
Post	3.0 (2.3)	

^aStress level assessed on 0-10 scale with 0 = no stress and 10 = high stress.

Research Question 2b: Are there differences in CS, burnout, and STS by demographic factors?

Research Question 3: In what situations do RNs experience CF and burnout and what strategies are used to address these situations?

Participants

Participants were a convenience sample of RNs at least 18 years old and employed at the hospital. There were 158 survey respondents out of the approximately 700 RNs employed (22% response rate). Most participants were older than 40 years, female, Caucasian, had earned at least a baccalaureate degree, had over 10 years of experience as an RN, and were staff nurses working in a variety of units (Table 2). Twenty-eight percent of the participants attended at least one S&R session (range 1-4 sessions, $M = 1.5$, $SD = 0.8$).

Measures: Professional Quality of Life

The ProQOL Scale, Version 5 (ProQOL V5) assesses the quality that those in the helping professions feel in relation to their work (Stamm, 2010). The ProQOL V5 includes two constructs: CF and CS. CS, as previously noted, is the gratification derived from being able to do one's work well

(Stamm, 2010). CF has two aspects: burnout and STS. Burnout is defined as having feelings of hopelessness and having difficulties dealing with work or working effectively. STS addresses exposure to individuals in the workplace who have had stressful traumatic events. The ProQOL V5 is a 30-item instrument using a 5-point Likert-type scale (1 = *never*, 5 = *very often*). ProQOL V5 items assess how frequently in the past 30 days the respondent has experienced the situation in the workplace (e.g., "I feel connected to others," "I feel 'bogged down' by the system"). Each subscale includes 10 items. Construct validity for the ProQOL V5 has been established. The reported alpha reliabilities are CS: $\alpha = .88$, burnout: $\alpha = .75$, and STS: $\alpha = .81$. A higher score on the CS subscale indicates greater satisfaction from work. Higher scores on the burnout and the STS subscales indicate increased difficulties related to job effectiveness (Stamm, 2010).

Two open-ended questions were included asking respondents to describe any situation in which they had experienced CF or burnout and strategies used to deal with the situation (Yoder, 2010). Demographic data collected included attendance at an S&R session, the type of relaxation modality received, age category, work experience, work unit, position, education, race, and ethnicity.

Procedures

After approval by the institutional review board, recruitment occurred via multiple venues. Informational e-mails were sent to all RNs, flyers were placed in areas frequented by RNs (e.g., nurses' lounge, bathrooms), and research team members verbally informed RNs about the study using a scripted message. One week after the initial informational emails were sent, a follow-up e-mail was sent to all RNs. Data were collected anonymously using two methods: hard-copy survey packets and online using Survey Monkey®. Survey packets (cover sheet, survey) were available on all nursing units in congregate areas such as break rooms, nurses' stations, nurses' lounges, the cyber lab, and classrooms. Surveys were not placed in areas specifically designated for patient care. Surveys were available for completion both in hard copy and in electronic format during the same 2-week period. Eighty-four (53%) of the 158 participants completed the web-based survey, and 74 (47%) completed the hard-copy survey. The nursing area with the highest percentage

Table 2. Participant Characteristics, Compassion Satisfaction, Burnout, and Secondary Traumatic Stress *t* Scores (*N* = 158)

Characteristic	<i>N</i> (%)	Compassion satisfaction, <i>M</i> (<i>SD</i>)	Burnout, <i>M</i> (<i>SD</i>)	Secondary traumatic stress, <i>M</i> (<i>SD</i>)
Age, years				
18-39	55 (35.7)	49.9 (10.2)	50.7 (10.6)	49.8 (9.9)
40-55	73 (47.4)	50.7 (9.9)	49.6 (9.6)	49.3 (9.8)
>56	26 (16.9)	49.8 (9.4)	48.5 (10.0)	51.7 (10.7)
Sex				
Females	147 (94.8)	50.4 (9.9)	49.7 (9.8)	49.9 (10.2)
Males	8 (5.2)	45.6 (13.9)	51.8 (13.7)	48.8 (5.6)
Education				
Associate degree	51 (35.4)	50.2 (9.2)	50.6 (11.1)	49.7 (11.2)
Bachelors/masters degree	93 (64.6)	49.4 (10.6)	49.3 (9.8)	49.6 (9.3)
Experience, years				
<5	25 (16.1)	48.5 (10.5)	50.9 (11.4)	50.3 (8.5)
6-10	34 (38.1)	52.7 (10.0)	48.8 (10.9)	49.2 (10.7)
11-20	30 (19.4)	51.6 (10.2)	50.0 (9.2)	47.7 (9.3)
>20	66 (42.6)	48.4 (9.7)	50.1 (9.6)	51.1 (10.6)
Race				
Caucasian	146 (94.2)	49.6 (9.7)*	50.1 (9.9)	49.8 (10.0)
Other	9 (5.7)	58.5 (9.9)*	45.0 (11.5)	50.0 (10.2)
Current position				
Staff nurse	120 (78.9)	49.6 (10.3)	49.9 (10.1)	50.2 (9.9)
Other	32 (21.1)	50.5 (8.8)	51.0 (9.4)	50.7 (9.7)
Work unit				
Surgical services	54 (34.8)	50.6 (10.0)	46.4 (9.7)*	47.0 (9.8)
Mothers and babies	28 (18.1)	48.9 (10.3)	52.1 (10.9)	49.7 (9.7)
Emergency department	19 (12.3)	48.9 (10.1)	52.6 (11.3)	52.2 (11.5)
Intensive/telemetry care	18 (11.6)	49.5 (10.5)	53.1 (9.7)*	52.6 (10.0)
Medical/surgical units	18 (11.6)	49.4 (9.3)	51.7 (8.7)	53.0 (6.8)
Other	18 (11.6)	52.4 (10.9)	49.0 (7.7)	51.5 (11.0)
Attended snack and relax				
Yes	44 (28.2)	49.2 (7.8)	51.4 (9.1)	51.8 (8.5)
No	112 (71.8)	50.3 (10.8)	49.3 (10.4)	49.2 (10.5)
Total	158 (100%)	50.0 (10)	50.0 (10.0)	50.0 (10.0)

Note: Subscale scores are presented as *t* scores with *M* = 50 and *SD* = 10. Burnout in surgical service participants differed significantly from those in intensive/telemetry care. Compassion satisfaction in Caucasian participants differed significantly from those of "Other" participants.

**p* < .05.

of respondents (total number of respondents/total number of RNs working on that unit) received a healing basket (e.g., diffuser, herbal teas, aroma therapy products, and healthy snacks)

Analysis

Hard-copy surveys were entered into a SPSS-PC database and the web-based surveys were downloaded in SPSS and merged with the SPSS file

containing the hard-copy surveys. Using the SPSS-PC computer code provided by Stamm (2010), the ProQOL V5 designated items were reverse scored, subscale items were summed, and raw scores were converted to *t* scores with a mean score of 50 and a standard deviation of 10. This conversion, which is new to the ProQOL V5, allows for comparisons across subscales. The distribution of low, moderate, and high CS, burnout, and STS was determined using the Stamm (2010) cut scores.

Table 3. Distribution of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Scores (N = 158)

	Compassion satisfaction, <i>n</i> (%)	Burnout, <i>n</i> (%)	Secondary traumatic stress, <i>n</i> (%)
Low	45 (28.5)	45 (28.5)	38 (24.1)
Moderate	74 (46.8)	73 (46.2)	83 (52.5)
High	39 (24.7)	40 (25.3)	37 (23.4)

Note: Low, moderate, and high cut scores were set at the 25th and 75th percentile as determined by Stamm (2010).

There were 0 to 3 missing data points per ProQOL V5 items (0%-2%). No patterns for the missing data were evident. The modal response was imputed into missing ProQOL V5 items. Data were initially analyzed using descriptive statistics. Pearson correlations were calculated to determine the relationships between CS, burnout, and STS. Differences in mean subscale scores by participation/nonparticipation in S&R and by demographic subgroups were analyzed using one-way analysis of variance and Tukey's method of post hoc analysis when appropriate. Alpha was set a priori at .05.

Responses to the two open-ended questions were independently reviewed and content analyzed by two research team members. Discrepancies were discussed until 100% agreement was reached.

Results

CS, Burnout, and STS in RNs

Table 3 displays the percentage of participants with low, medium, and high CS, burnout, and STS. Approximately one quarter of the participants had low CS scores, high burnout scores, and high STS scores. A significant negative correlation was found between CS and burnout ($r = -.662, p < .001$) and between CS and STS ($r = -.241, p = .002$), indicating those with higher CS had lower burnout and lower STS scores. A strong positive correlation was found between burnout and STS ($r = .491, p < .001$), indicating those with higher burnout scores also had higher STS scores.

Differences in CS, Burnout, and STS by Subgroups

Exploration of differences between CS, burnout, and STS based on participation in S&R revealed no

significant differences in scores on the three subscales (Table 2). CS was found to be significantly greater for non-Caucasian participants compared to Caucasians ($p = .008$). Burnout scores were significantly lower for participants working in surgical services compared to those working in intensive care/telemetry units ($p = .015$). There were no other significant differences by participant demographic factors.

CF Situations and Strategies to Address CF

Seventy (44%) of the participants provided written responses to the open-ended questions asking respondents to describe a situation in which they experienced CF or burnout and strategies used to deal with the situation. Three types of situations in which participants experienced CF or burnout were identified: (1) patient-related situations (43 comments; 61.4%), (2) work-related situations (20 comments; 28.6%), or (3) personal/family-related situations (7 comments; 10%).

Patient-Related Situations. Participant comments provided examples of patient-related situations that were physically and emotionally demanding. One participant questioned whether she should continue working as a nurse or not, "since I am getting older and feeling the stress of caring for overweight and obese patients." Another comment was "I have felt 'burned out' when dealing with particularly demanding . . . patient whom I have been unable to make comfortable despite hours of one-on-one care." Caring for patients with varying diagnoses (e.g., terminal cancer, psychiatric disorders, and neonatal abstinence syndrome) and different age-groups, from the elderly to the very young, was noted as when CF or burnout occurred. One participant wrote with regard to babies with neonatal abstinence syndrome that "no matter what you do you cannot console them" and "they are hard on you emotionally." Several participants commented about caring for terminally ill patients:

A patient had been newly diagnosed with stage 4 cancer and was beginning to understand the depth of their illness. I had the position to be able to explain things better to them, but to also bear their burdens and concerns for how this would affect their personal life.

Another participant noted,

I took care of a patient who had had a huge blood loss. She was very anxious and needed lots of reassurance. She was terribly uncomfortable and despite all my efforts I could never seem to get her comfortable. Caring for her took the majority of my time, and although I knew she needed it, it was very difficult to balance the needs of my other patients. I was completely worn out by the end of my shift.

Overall feelings of frustration were noted in comments such as “[It’s] very disheartening to deal with particular patients [when it] seems nothing I can do will truly change/affect their lifestyle for the better.” Participants noted the difficulties in caring for patients that are emotionally demanding “patient and family who are all very anxious and overbearing—especially patients with panic attacks . . . exhausting to care for and be patient with.”

A commonly identified strategy to address patient-related situations was talking with coworkers. A few respondents identified accessing other multidisciplinary resources within the hospital such as the social worker and chaplain. Other strategies were holistic and self-care activities (e.g., exercise and massage), and, as one nurse stated, a “care plan for me.” Taking deep breaths and prayer were also strategies used when presented with patient-related situations.

Work-Related Situations. Work-related situations include short staffing, a perceived lack of administrative support, and non-patient-related work demands. *Short staffing* is a common term indicating the time required to complete patient assignment and working over their assigned shift to fill staffing voids. Exemplary statements included the following:

Coming in and getting a heavy load of 6 demanding patients. By demanding I mean lots to do like antibiotics, blood, pain meds, dressings, etc. Trying to be there for everyone, yet leaving the end of the shift feeling like I barely hung on and wondering what I am doing here.

Feeling like I can’t do enough, that I’m not good enough because I can’t get everything done.

A second work-related situation addressed the time taken from direct patient care to perform tasks

required for health care initiatives. One participant wrote,

It’s not so much in relation to the patients, its more in relation to all the stuff—the initiatives, rollouts, go live, changes, etc. at the facility and within that I find it difficult to fully focus on patient care.

Participants indicated they used prayer, distractions like gardening, music and television, and stress reduction techniques like humor and exercise to address work-related situations.

Personal/Family-Related Situations. The third type of situation experienced by participants that resulted in feelings of CF or burnout dealt with personal and family-related concerns. One participant noted, “Between the demands of work and school, I feel fatigued on a daily basis.” Caring for an ill family member was noted by several participants as contributing to CF:

Being a primary caregiver to a relative with Alzheimer’s disease. Busy days at work from working the floor or even in the operating room, you seem to just go on auto-pilot not knowing exactly how you got through the day.

Strategies used to deal with personal/family-related concerns included prayer, resting, talking with friends and family, and self-help activities such as exercise and staying busy. One participant noted that “rest and relaxation on a day off, talking to others who can understand” was beneficial.

Discussion

Hospitals need a healthy, qualified, caring, and satisfied nursing workforce as they move forward with new initiatives to provide quality health care in the wake of health care reform. Youngson (2012) identified the importance of the interrelationship between practitioner satisfaction and patient satisfaction and the immediate positive rewards to both the staff and the patient in an optimal, compassionate health care environment. This study attempted to address CF in nurses by offering S&R—a unique program that includes healthy snacks and holistic modalities such as Reiki, Healing Touch, Massage Therapy, and Jin Shin Jyutsu. Hospital employees who participated in S&R overwhelmingly expressed

positive comments. Similar to other studies, we found a statistically significant immediate reduction in self-reported stress, respiratory rate, and heart rate after participants received a holistic modality (Bost & Wallis, 2006; Diaz-Rodriguez et al., 2011; Medina et al., 2012). While these findings are important, we also sought to determine if we could identify a more comprehensive impact of the S&R program on nurses' self-reported ProQOL.

While we did not find statistically significant differences between RNs participating in S&R and those that did not, we did find that participants working in surgical services had significantly lower burnout scores compared with those in intensive care/telemetry units. These findings are similar to those of Young, Derr, Cicchillo, and Bressler (2011), who found significantly higher levels of CS and lower levels of burnout for those working in the intermediate care area compared with intensive care units. Yoder (2010) reported significantly higher CS scores for nurses working in intensive care units compared to those in ED while Hooper, Craig, Janvrin, Wetsel, and Reimels (2010) did not identify differences in CS, burnout, or STS by nurses work unit. Neither Yoder (2010) nor Hooper et al. (2010) specifically included nurses working in surgical services in their surveys. Our findings of higher burnout in nurses working in intensive care/telemetry units compared to surgical services may reflect the complex technology, changing patient assignments, conflict with patients, or end-of-life care experienced in intensive care units (Poncet et al., 2007). An alternate interpretation of our findings may be that nurses in surgical services incorporate the tenets of Swanson's (1993) theory of caring in their daily interactions with each other to a greater degree and in doing so have less burnout than nurses in intensive care units. Additional research is needed to more specifically identify individual, unit-level, and system-level factors contributing to differential levels of burnout on various nursing units.

Another interesting finding in this study was the significantly higher levels of CS noted by those reporting their race as "Other." Those indicating their race as "Other" also had lower burnout and STS scores; however, these findings were not statistically significant. Although the number of respondents in this category was small ($n = 9$), the difference in CS was striking. Other studies of nurses using the ProQOL did not compare findings by race/ethnicity. In the ProQOL manual, Stamm (2010) reports

lower CS and higher burnout and STS scores for the non-White cases in their data bank. Additional research is needed exploring differences in ProQOL components for RNs based on racial and ethnic identity.

Overall, findings regarding CS, burnout, and STS in RNs were similar to those in studies across professions in which approximately one fourth of participants had low CS, high burnout, and high STS (Stamm, 2010). A higher percentage of RNs in our study had low CS compared to the RNs surveyed by Hooper et al. (2010) and Young et al. (2011). With regard to burnout and STS, a greater percentage of participants in our study had high burnout but fewer had high STS than those in the Abendroth and Flannery (2006) and Hooper et al. (2010) studies. Stamm (2010) identified five categories that combined scores on the three subscales. Categories range from the most positive category—having high CS and moderate to low burnout and STS—to the most distressing category—having high STS and burnout and low CS. In our sample, 18.4% ($n = 29$) were in the most positive category suggesting that these nurses "Maintain Belief" in their commitment to the caring relationship and are "Enabled" by the positive reinforcement they receive from colleagues and patients (Stamm, 2010; Swanson, 1993). An additional 38% ($n = 59$) of participants were identified as having either high burnout or high STS with low to moderate CS, placing at risk the nurses' commitment to the healing and caring relationship between themselves and their patients (Swanson, 1993). Nurses with high burnout/STS and low/moderate CS may no longer be emotionally present with their patients and have difficulty "Being With" and "Doing For" their patients. These nurses may need time out from the current work situation and possibly professional intervention to "Enable" them to achieve their own well-being. While these categories were originally identified to assist in interpreting individual respondent scales and their usefulness in formulating focused aggregate interventions is yet unclear, the importance of determining the prevalence of high burnout/STS and low CF in nursing is critical in assuring a viable, healthy workforce that provides compassionate, nurturing care.

Participants in our study identified a number of holistic and stress-reducing strategies to address CF and burnout, including exercise, gardening, relaxation, and talking with coworkers, friends, and family. The implementation of these strategies by

nurses is consistent with the “Maintaining Belief” and “Enabling” components of Swanson’s (1993) Theory of Caring. By employing holistic and stress reducing strategies, nurses maintain belief in their own ability to meaningfully make it through difficult events and assure their personal well-being (Swanson, 1993).

While massage was mentioned by a few participants as a strategy, none indicated attending S&R to address CF or burnout. This omission highlights the need to expand efforts to inform nurses about additional holistic modalities and other programs within the health care system that can be accessed to help address any CF or burnout experienced. Maytum, Heiman, and Garwick (2004) highlight the importance of nurses knowing their personal CF triggers and to develop a planned approach for managing CF. Personal coping strategies; living a “well-rounded life” including physical, spiritual, and emotional phases of life; and activities providing relaxation or distraction are useful (Yoder, 2010).

Health-promoting strategies have been reported to be helpful in maintaining resiliency in the midst of overwhelming and challenging work situations (Neville & Cole, 2013; Stamm, 2014). Strategies that can be applied, such as getting enough sleep, doing something pleasurable, doing light exercise, praying, meditating, or relaxing are reported to be beneficial in improving ProQOL. Holistic modalities such as those employed in S&R, which are consistent with the five components of Swanson’s (1993) theory of caring, could be a part of worksite health promotion programs. Thornton (2005) stated that “the healthcare team must first learn to care for themselves” (p. 112) before increases in patient and employee satisfaction are demonstrated. The Standards of Practice of the American Holistic Nurses Association (Mariano, 2013) identify the need for nurses to integrate self-care, self-responsibility, reflection, and spirituality in their own lives. Also, the promotion of health and self-care in nurses can provide the personal energy and enthusiasm needed to improve the care of patients, families, and communities (McElligott et al., 2009).

Challenges and Nursing Implications

The S&R program was well received by participants with comments such as “awesome event,” “made me feel special,” and “shows value of staff.”

Since the completion of this study, expansion of S&R system-wide and implementation of a Healing Cart program are being explored. The development of a viable holistic staff support/wellness program for the health care system has been recognized as a priority initiative. Members of the HCC continue to offer educational programs on holistic nursing and modalities within the health care system and the community. Future evaluation efforts will focus on the impact of these efforts on nurses’ job satisfaction and ProQOL, as well as staff retention, and patient satisfaction scores.

Limitations

Findings from this study cannot be generalized beyond the study participants. With regard to the S&R evaluation, data were collected without identifiers, and therefore we were unable to track the number of times an individual attended different S&R sessions. Stress was measured not using a validated tool but with a self-report measure of 0 (no stress) to 10 (high stress). While this provided an easily administered cursory indication of stress, each individual could have differentially interpreted the anchors. Future evaluation efforts need to address these limitations with a more specific tracking mechanism and the use of a validated measure of stress.

Limitations of the ProQOL survey include the use of convenience sampling; only about one fifth of the potential RN respondents completed the survey. While we did use several mechanisms to inform nurses about the study, assured that the responses did not include any identifiers, and provided an incentive to the unit with the highest percentage of RN participants, our response rate was relatively low. Nurses may have been concerned about the anonymity of their responses if they completed the survey at their worksite, and staffing shortages on specific units may have resulted in limited available work time to complete the survey. By allowing nurses to complete the survey either via hard copy or online, we were able to increase the participation rate. However, it is possible that a participant completed more than one survey. It is also possible that non-RNs completed the survey, given that surveys were not handed out to RNs and were available in areas where other health care workers (e.g., aides) congregate. However, we had no indication from the responses or from anecdotal information that

respondents completed more than one survey or that non-RNs completed the survey. While 90 RNs participated in an S&R session, only 44 (48%) completed the survey. It is possible that our results would differ had a larger percentage of these nurses completed the survey.

Conclusions

This is the first study that attempted to assess differences in ProQOL measures based on participation in a holistic intervention for hospital staff. While our results did not show differences in CS, burnout, or STS based on S&R participation, nurses provided a number of examples of situations that contributed to feelings of CF and burnout. Providing holistic interventions for nurses in the workplace has the potential to alleviate the immediate felt stress generated from patient care and provide a moment of peace. Burkhardt (2014) identified the need to show up, step in, and reach out to advance holistic nursing, stating “Holistic nursing is promoted when we take action to create, expand and share resources and support for holistic nurses and nursing within the healthcare system” (p. 5). The S&R program is an example of this caring commitment of nurses who actively support one another in compassionate care and holism.

References

- Abendroth, M., & Flannery, J. (2006). Predicting the risk of compassion fatigue: A study of hospice nurses. *Journal of Hospice & Palliative Nursing*, 8, 346-356.
- Anderson, J. G., & Taylor, A. G. (2011). Effects of healing touch in clinical practice: A systematic review of randomized clinical trials. *Journal of Holistic Nursing*, 29, 221-228. doi:10.1177/0898010110393353
- Bost, N., & Wallis, M. (2006). The effectiveness of a 15 minute weekly massage in reducing physical and psychological stress in nurses. *Australian Journal of Advanced Nursing*, 23(4), 28-33.
- Burkhardt, P. (2014). Advancing holistic nursing & transforming healthcare: Showing up, stepping in, reaching out. *AHNA Beginnings*, 34(2), 5.
- Cuneo, C. L., Drew, C. S., Naoum-Heffernan, C., Sherman, T., Walz, K., & Weinberg, J. (2011). The effect of Reiki on work-related stress of the registered nurse. *Journal of Holistic Nursing*, 29, 33-43. doi:10.1177/0898010110377294
- Diaz-Rodriguez, L., Arroyo-Morales, M., Cantarero-Villanueva, I., Fernandez-Lao, C., Polley, M., & Fernandez-de-las-Penas, C. (2011). The application of Reiki in nurses diagnosed with burnout syndrome has beneficial effects on concentration of salivary IgA and blood pressure. *Revista latino-americana de enfermagem*, 19, 1132-1138.
- Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing*, 36, 420-427.
- KPMG Healthcare & Pharmaceutical Institute. (2011). *KPMG's 2011 U.S. hospital nursing labor costs study*. Retrieved from http://natho.org/pdfs/KPMG_2011_Nursing_LaborCostStudy.pdf
- Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *Online Journal of Issues in Nursing*, 16(1), 1-1. doi:10.3912/OJIN.Vol16No01Man03
- Mariano, C. (2013). *Holistic nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: American Holistic Nurses Association.
- Maytum, J. C., Heiman, M. B., & Garwick, A. W. (2004). Compassion fatigue and burnout in nurses who work with children with chronic conditions and their families. *Journal of Pediatric Health Care*, 18, 171-179.
- McElligott, D., Siemers, S., Thomas, L., & Kohn, N. (2009). Health promotion in nurses: Is there a healthy nurse in the house? *Applied Nursing Research*, 22, 211-215.
- Medina, M. E. G., González, O. P., & Westerlund, S. (2012). Effect of human electromagnetic fields in relief of minor pain by using a Native American method. *Integrative Medicine*, 11, 39-44.
- Neville, K., & Cole, D. A. (2013). The relationships among health promotion behaviors, compassion fatigue, burnout, and compassion satisfaction in nurses practicing in a community medical center. *Journal of Nursing Administration*, 43, 348-354.
- Poncet, M. C., Toullic, P., Papazian, L., Kentish-Barnes, N., Timsit, J., Pochard, F., . . . Azoulay, E. (2007). Burnout syndrome in critical care nursing staff. *American Journal of Respiratory and Critical Care Medicine*, 175, 698-704.
- Stamm, B. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf
- Stamm, B. (2014). *Promote resiliency and prevent compassion fatigue: The helper pocket card*. Retrieved from http://www.proqol.org/Helper_Pocket_Card.html
- Swanson, K. (1993). Nursing as informed caring for the well-being of others. *Image: Journal of Nursing Scholarship*, 25, 352-357.
- Tang, R., Tegeler, C., Larrimore, D., Cowgill, S., & Kemper, K. J. (2010). Improving the well-being of nursing leaders

through healing touch training. *Journal of Alternative and Complementary Medicine*, 16, 837-841. doi:10.1089/acm.2009.0558

Thornton, L. (2005). The model of whole-person caring: Creating and sustaining a healing environment. *Holistic Nursing Practice*, 19, 106-115.

Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research*, 23, 191-197. doi:10.1016/j.apnr.2008.09.003

Young, J. L., Derr, D. M., Cicchillo, V. J., & Bressler, S. (2011). Compassion satisfaction, burnout, and secondary traumatic stress in heart and vascular nurses. *Critical Care Nursing Quarterly*, 34, 227-234.

Youngson, R. A. (2012). *Time to care: How to love your patients and your job*. Raglan, New Zealand: Rebelheart.

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