# Measuring Pastoral Care Performance

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The *Ethical and Religious Directives for Catholic Health Care Services* calls pastoral care — that is, the full range of spiritual services — "an integral part of Catholic health care"[1] but doesn't specify how to fulfill it. As a result, there is a wide variation of ways that pastoral care is provided across the country, often at the expense of both staff and patients.

Because organizations tend to be subjective, decisions about staffing pastoral care departments suffer from lack of research that documents chaplains' effectiveness. The need for chaplains currently is assessed by productivity metrics that depend upon the number of patients in the hospital, their acuity and factors connected to the hospital's mission and values. Although chaplains also provide spiritual support to staff, most productivity statistics don't measure that.

KentuckyOne Health's Jewish Hospital in Louisville, Kentucky, proposed to study the effect chaplains might have in the emergency department setting, where chaplains rarely were integrated into daily operations. This made the emergency department a perfect "pre-test" environment in which to measure the impact of chaplaincy not only on patient care but also on staff care, which further impacts patient care. The emergency department staff had a poor understanding of the role of chaplains, and frequently they paged a chaplain only after a death had occurred — if they paged one at all.

When the study was first proposed, the chaplains worried that the impact of their work and presence might not translate into statistical significance. This lack of confidence, along with a lack of research knowledge, may present the biggest obstacles to self-advocacy by chaplains.

But if the profession is to survive, chaplaincy needs to embrace evidence-based spirituality as its primary language. As the research illustrates, if something is true on one level — the spiritual level, for example — then it can be translated into another level, like statistics. Such translation is vitally important, because decisions about health care are determined by data and the people who are grounded in that "language." When chaplains can speak the same language as their colleagues, then they will be able to more fully integrate into patient care and serve effectively and confidently.

## BACKGROUND OF THE PROBLEM

There is a profusion of research in the literature on health care professionals such as nurses, who experience burnout and stress from their work. However, the canon is much smaller regarding secondary traumatic stress that nurses can experience from working with trauma patients in hospital emergency departments.[2] In a 2013 paper, researchers Kathleen Flarity, J. Eric Gentry and Nathan Mesnikoff emphasized the gap in the lit-

erature when they declared, "Compassion fatigue is an important and often unrecognized problem that has not been thoroughly explored or quantified in a large group of emergency nurses."[3] The impact that staff burnout can have upon patient experience is even less studied.

The phrase "compassion fatigue," which includes secondary traumatic stress, is a common reference in the literature and describes several challenging contributing social factors. It can be defined as "a secondary traumatic stress reaction that results from helping a person suffering from a traumatic event."[4] And researchers Crystal Hooper et al. wrote, "A nurse experiencing compassion fatigue may have a change in job performance, an increase in mistakes, a noticeable change in personality, and a decline in health, and may feel he or she needs to leave the profession."[5]

In 2018, the Joint Commission issued a safety alert related to the importance of attending to "second victims," the health care providers who are most directly involved in attending to a patient's adverse event. The emotional trauma associated with the event can have a lasting effect on the provider, including post-traumatic stress disorder resulting from an experience with medical errors.[6] This dynamic contributes to compassion fatigue, which in turn can lead to further safety errors, as well as affecting job performance, staff retention and patient experience. Nursing researchers pointed out that "understanding the linkages between caring, patient satisfaction with nursing care, and patient satisfaction with the hospital experience is now more important than ever,"[7] and "nurse caring is the most influential dimension of patient advocation and is predictive of patient satisfaction."[8]

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Consequently, there is burgeoning interest among hospital administrators and staff to mitigate the negative effects of compassion fatigue, secondary traumatic stress and burnout,[9] because the prevalence of these elements in their cultures and employees ultimately presents a threat to the overall health and financial viability of these institutions.[10]

A leading researcher on the quality of professional life succinctly summarizes the abstractions of the strengths and challenges of providing care under two categories: compassion fatigue and compassion satisfaction. She defines compassion fatigue as a combination of both burnout and secondary traumatic stress.[11] Distilling these ideas down further, burnout "describes . . . the physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations."[12]

Secondary traumatic stress or "vicarious traumatization" refers to the transmission of traumatic stress through observation and/or hearing others' stories of traumatic events and the resultant shift/distortions that occur in the caregiver's perceptual and meaning systems.[13]

Beth Hudnall Stamm, whose work has focused on a person's strengths as a remedy for compassion fatigue, pioneered the idea of compassion satisfaction, a positive outcome for caregivers of persons with trauma. She elaborated on her concept when she likened compassion satisfaction to "the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society."[14]

Placing compassion satisfaction in the context of hospital emergency departments, Flarity, Gentry and Mesnikoff contended that it was "the joy, purpose, and meaning emergency nurses derive from their work..."[15] For example, compassion satisfaction can result when emergency department nurses bear witness to observable improvements in patient suffering, such as the reduction of pain following the administration of medication.[16] However, inherent to the brevity of nurse-patient relationships and levels of acuity in emergency departments of hospitals, this source of positive reinforcement often is lacking. Thus, when compassion satisfaction was absent in those situations, researchers have named resiliency as a rem-

edy, and they defined it as "individuals' strengths and resources, both internal and external protective factors, that help a person bounce back from or thrive despite adverse circumstances.[17]

More than 30 years of research literature has supported the effectiveness of programmatic staff support systems.

"It is important to collaborate with human resource staff to identify psychosocial resources to support staff in constructive debriefing after especially traumatic events, as well as to anticipate the need for and provide assistance to individual staff experiencing unusually high levels of stress," wrote Hooper et al.[18] And Burtson and Stichler pointed out that "there is an opportunity for nurse managers to change direction away from educational interventions and toward interventions that focus on reawakening the source of satisfaction that nurses derive from caring, while improving their sense of social belonging."[19] Thus, there is an emphasis in the literature on staff education and evidence-based interventions for compassion fatigue, burnout and secondary traumatic stress being combined into one modality.[20]

## HOW A RESEARCH PROJECT ANALYZES DATA

Due to the project's small sample size, lack of statistical power and a moderate skew on two of the key variables of interest, nonparametric statistical analyses were conducted with the data. In order to preserve anonymity of the study participants, demographic information was not collected. A series of Wilcoxon Signed Ranks Tests were performed on the pre-test/post-test subscales contained within the Professional Quality of Life Scale. The table below details the median and range for each of the subscales.

*Medians and ranges of ProQol Subscales*

| Item | Median | Minimum | Maximum | Range |
|---|---|---|---|---|
| Compassion Satisfaction (Pre) | 31.00 | 14.00 | 48.00 | 34.00 |
| Compassion Satisfaction (Post) | 46.50 | 33.00 | 50.00 | 17.00 |
| Burnout (Pre) | 28.00 | 15.00 | 44.00 | 29.00 |
| Burnout (Post) | 15.50 | 11.00 | 29.00 | 18.00 |
| Trauma (Pre) | 24.00 | 14.00 | 47.00 | 33.00 |
| Trauma (Post) | 15.00 | 10.00 | 31.00 | 21.00 |

**Pre-test and post-test ranks of compassion satisfaction.** A Wilcoxon Signed Ranks Test indicated that the post-test ranks of the compassion satisfaction of study participants ($mdn = 47$) was much higher after the intervention than their pre-test ranks ($mdn = 31.00$), $Z = 2.80$, $p < .005$, $r = .72$, for a statistically significant finding.

**Pre-test and post-test ranks of levels of burnout.** A Wilcoxon Signed Ranks Test indicated that the post-test ranks of the level of burnout experienced ($mdn = 15.50$) was also significantly lower after the intervention than the pre-test ranks ($mdn = 28.00$) burnout levels of participants, $Z = -2.56$, $p < .01$, $r = -.66$.

**Pre-test and post-test ranks of secondary trauma.** A Wilcoxon Signed Ranks Test indicated that the post-test ranks of the secondary trauma ($mdn = 15.00$) participants experienced was much lower after the intervention than the pre-test ranks ($mdn = 24.00$) and were statistically significant, $Z = -2.073$, $p < .05$, $r = -.054$.

**Pre-test and post-test scores of HCAHPS** (Hospital Consumer Assessment of Healthcare Providers and Systems), as measured by HealthStream, increased over the same three-month time frame by 83 percent, going from the 17th percentile to the 31st percentile.

More specifically, the efficacy of staff psychosocial support interventions provided by chaplains also has been noted for decades. Because of their integration with staff, chaplains are uniquely positioned to build relationships and foster trust. Chaplains are skilled in crisis intervention and are oriented toward whole-person care. Indeed, chaplains attend to the human and spiritual needs of employees and organizations that long to find in their work the merits of a calling, more so than simply a profession. Using chaplaincy services for staff is efficient because the funding of these positions usually already is part of hospital budgets, and if any cost is incurred, it is minimal when compared with other professionals who have provided such support.

## METHODS FOR THE PILOT PROJECT

The research project examined the impact of having a chaplain present in the emergency department, rounding on patients and staff for four hours a day over the course of three months. Prior to this project, chaplains primarily provided pastoral care to inpatient units and intensive care units within the hospital and had minimal interactions with the emergency department.

In order to access emergency department nurses for the pilot project, KentuckyOne Health's vice president of mission worked with the chief nursing officer, along with the performance excellence coach stationed in Jewish Hospital's emergency department, to determine parameters.

Participants were required to be full-time emergency department staff (nurses and nurses' aides both participated), and they had to have a reading comprehension above the eighth grade level. There were no personal incentives offered for completing the survey. Procedures of informed consent were observed, and respondents' anonymity was maintained.

Participants completed a pre-test to measure levels of burnout and compassion fatigue and collaborated with a chaplain for three months. During that time, both staff and patients received pastoral counseling interventions and then took a post-test after the intervention. The study used the Professional Quality of Life Scale, a reliable and valid barometer of levels of compassion satisfaction, burnout and compassion fatigue in employees.

The study was approved by the Institutional Review Board of KentuckyOne Health as a quality improvement project.

## DISCUSSION AND IMPLICATIONS

In short, the study results showed that compassion satisfaction (the opposite of compassion fatigue) went up, levels of burnout went down and symptoms of secondary trauma went down after participants talked with a chaplain.

Note that there were several limitations to the study, and preliminary findings suggest that ongoing research is essential. The project involved a very small sample of nurses and nurses' aides. Although findings were replicated at other hospitals within the organization, their processes varied and therefore are not reportable. Furthermore, no demographic data was collected, which would have provided additional information for some of the findings.

**Chaplains are skilled in crisis intervention and are oriented toward whole-person care. Indeed, chaplains attend to the human and spiritual needs of employees and organizations that long to find in their work the merits of a calling, more so than simply a profession.**

Still, a decrease in compassion fatigue among a sample of emergency room nurses resulting from a brief pastoral intervention represents a new way of understanding the impact of a cost-effective measure on the lives of those who make their living caring for others. The research supports the need for nurse managers to move away from reliance mainly on educational interventions to use of interventions that highlight caring as the source of satisfaction among nursing professionals.

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