

EXPRESSIONS OF COMPASSION FATIGUE BY EMERGENCY DEPARTMENT NURSES CARING FOR PATIENTS WITH OPIOID AND SUBSTANCE USE DISORDERS

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Contribution to Emergency Nursing Practice

- The misuse of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids, are a national public health crisis. As a result, emergency nurses in 1 Philadelphia, PA, hospital are experiencing work stress and higher levels of compassion fatigue related to care delivery issues.
- Findings support that emergency nurses working and providing care to patients with opioid and substance use disorder in this level I trauma center are experiencing compassion fatigue with related levels of frustration, negative emotional responses, and decreasing levels of job satisfaction. Managing compassion fatigue requires proactive assessment, education, and support.
- Areas identified by these emergency nurses to improve compassion levels included opportunities for debriefing, education, increased formal support systems, and management encouragement across all work shifts.

Abstract

Introduction: The misuse of and addiction to opioids are a national public health crisis. The complexity of delivering patient care in emergency departments exposes nurses to stressful work situations with complex patient loads and increasing levels of compassion fatigue. Emergency nurses were asked about their feelings of compassion fatigue while caring for patients with opioid use and/or substance use disorders.

Methods: Twenty-four focus groups with emergency nurses ($N = 53$) at a level I trauma center were conducted in late 2019 and early 2020 are used in this qualitative study using thematic analysis that identified 1 main theme of compassion fatigue with 3 subthemes (nurse frustration with addicted patients, emotional responses, and job satisfaction).

Results: Findings highlight that emergency nurses working with patients with opioid use and/or substance use disorders are dealing with a number of negative emotional stressors and frustrations, which in turn has increased their levels of compassion fatigue. These nurses repeatedly expressed feelings of increasing frustration with addicted patients, negative emotional responses, and decreasing levels of job satisfaction as components of their compassion fatigue.

Discussion: These emergency nurses identified 3 areas to improve their compassion: improved management support with encouragement across all work shifts, debriefing opportunities, and more education. Fostering a high level of self-awareness and understanding of how the work environment influences personal well-being are necessary strategies to avoid the frustrations and negative emotional responses associated with compassion fatigue.

Key words: Nurses; Opioids; Substance use; Compassion fatigue; Qualitative

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Introduction

The misuse of opioids affects thousands of people crossing all ages, genders, races, religions, economic groups, and geographic locations. In 2019, the Centers for Disease Control and Prevention (CDC) reported that in the United States opioids were involved in 49,860 overdose deaths accounting for 70.6% of all drug overdose deaths.¹ The abuse of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids such as fentaNYL, have been identified as a national public health crisis. There is a growing body of evidence that nurses working with complex patient loads and long shifts in a fast-paced environment that can be emotionally and physically challenging are reporting increasing levels of compassion fatigue.²⁻⁵

COMPASSION FATIGUE

Often referred to as the “Cost of Caring,” the term compassion fatigue was first introduced in 1992 by Carla Joinson,⁶ a nurse educator, to explain the “loss of the ability to nurture” in emergency nurses. Compassion fatigue is often defined as a gradual worsening of feelings of frustration with career responsibilities associated with high patient acuity, overcrowding, witnessing tragedy, and problems with administration.^{7,8} Compassion fatigue results from the continuing stress of meeting or not meeting the frequently overwhelming needs of patients and their families.⁹ Hunsaker et al² describe it as a state of exhaustion, including feelings of isolation, confusion, and helplessness encompassing one’s physical, emotional, and spiritual states. Compassion fatigue often occurs in conjunction with or as a result of a loss of empathy, which is the inability to relate to what other people are feeling. Declining empathetic ability is also found from repeated exposure to others’ suffering. Professionals who have low empathy may excessively criticize others or, in the case of addiction, blame the person for the addictive behaviors and actions.¹⁰

Health care professionals are generally considered to be in one of the highest-risk groups for experience of compassion fatigue and loss of empathy, which is directly related to emotional strain and the stressful work environment.⁵ The impact of compassion fatigue on nurses can be profound, leading to decreased productivity, job dissatisfaction, job turnover, and high levels of frustration.^{5,9} All nurses are at risk of compassion fatigue; however, emergency nurses are often found to have 25% higher levels than other groups.¹¹ Many emergency nurses are exposed to extremely stressful work situations involving high volume and acuity patients along with higher rates of violence and aggression.^{4,11-13} Specific ED issues identified in the literature include a

lack of resources, workload, no debriefing following challenging patient situations, inability to take breaks or rest periods, abusive patients, abusive families, violent patient situations, psychiatric presentations, and patients affected by alcohol and/or drugs.^{3,10,11}

Emergency nurses who work with patients with opioid use disorder (OUD) frequently report high levels of compassion fatigue and low levels of compassion satisfaction such as happiness or professional fulfillment.¹⁴ The notion of offering care to patients who may not be willing or able to fully recover and who have high recidivism rates with poor follow-up often contributes to nurses’ negative feelings.¹⁴ In this opioid misuse crisis, emergency nurses across the country have been reporting intense and stressful work environments such as those currently being experienced in Philadelphia, PA.¹⁵ In 2019, 1150 people died in Philadelphia from drug overdoses and more than 80% of those deaths involved opioids, a number nearly 4 times the city’s homicide rate.¹⁶ To gain insight and understanding about the perceptions and feelings of emergency nurses caring for patients with OUD and/or substance use disorder (SUD), a study was undertaken at 1 urban emergency department in Philadelphia. Most of the emergency nurses expressed feelings of compassion fatigue specific to working with this challenging patient population. The purpose of this paper is to report on the descriptive qualitative findings specific to the theme of compassion fatigue and its 3 sub-themes of nurse frustration with addicted patients, emotional response, and job satisfaction.

Methods

DESIGN

This study used focus groups with emergency nurses at a level I trauma center located in Philadelphia. Before the beginning of data collection, permission from the first author’s institutional review board was obtained to conduct this expedited study (IRB-FY2019-147). The use of focus groups with this emergency nurse population was to gather their opinions, ideas, and feelings specific to experiences of working with patients with OUD and/or SUD. Focus groups were used because they can provide an atmosphere where ideas are generated in a nonthreatening way with the facilitator who emphasized that all ideas were valuable and respected.¹⁷

Recruitment of emergency nurses for the focus groups was done by word of mouth, email blasts, posting of flyers, and reminders from the emergency nurse manager during shift change. Hospital administration provided access for

4 months to recruit and conduct the focus groups, which were all conducted on site at the hospital. Focus group sessions were confidential and held in a private room. Nurses were asked to protect any personal information discussed in the focus groups by not sharing with others after the group to protect confidentiality; additionally, all participating emergency nurse badges were replaced with a color badge so that no names were used. No nurse participated in more than 1 group and each group was led by an advance practice psychiatric nurse who had the expertise and skill set to manage group dynamics. The size of the focus groups was influenced by time, with those following a day shift (7 AM to 7 PM) having the most participants, followed by the night shift (7 PM to 7 AM) and the middle shift (11 AM to 11 PM). Inclusion criteria were being a registered nurse (RN) currently licensed in Pennsylvania and a full-time employee working 90% or more of their time in the emergency department and at least 1 year of ED experience. Exclusion criteria were working part-time or as needed (temporary, per diem, or pool) in the emergency department and/or a member of the administration team (supervisor, management, or education). This study endeavored to maintain subject confidentiality and anonymity. Participation did not affect the nurses' work situations or involve any benefits or incentives.

DATA ANALYSIS

Focus group data were analyzed using the Braun and Clarke¹⁸ qualitative methodology of thematic analysis. Reflexive thematic analysis is an approach to analyzing qualitative data (eg, focus group transcripts), to answer questions about people's experiences, views, perceptions, and representations of events.¹⁸ This data analysis method involves 7 steps: transcription, reading and familiarization, coding, searching for themes, reviewing themes, defining, and naming themes and finalizing the analysis.¹⁸ In our study, all focus groups were audio recorded and asked the same questions (Box 1). The focus groups lasted between 45 to 120 minutes, and following step 1, all of the recordings were transcribed verbatim using a professional service. Step 2, transcripts were then read in their entirety by the first 4 authors (EBD, SEA, NF, EH) to gain an overall impression with familiarization of the text. Step 3, data were then coded in a meaningful pattern in relation to the research question specific to compassion fatigue. For this, all transcripts were entered into the ATLAS.ti8 qualitative software package (Scientific Software Development GmbH), and the code function was used on each transcript to identify words that related to compassion fatigue, which were then pulled into a grid and highlighted. Step 4 involved

BOX 1

Focus group questions

- 1) Do you get satisfaction from being able to help people?
- 2) How do you feel about working with opioid addicted patients?
- 3) Do you feel like you receive adequate support from colleagues and supervisors regarding working with opioid addicted patients?
- 4) Do you ever feel like you are taking your work home?
- 5) What do you do to soothe or calm yourself when your anxiety level is high as a function of working with opioid addicted patients?
 - a. What has worked for you?
 - b. What has not worked for you?
- 6) How do you view drug addiction—is it an acute or chronic disease?
- 7) Are there any other areas that we have not covered that you would like to discuss?

searching for themes, reviewing themes, defining, and naming themes.¹⁸ A theme was recognized when saturation or a redundancy in the data was found with more than 70% of the sample saying the word or combination of words (eg, "lack of compassion" or "frustration"). The same 4 authors followed recommended steps to ensure trustworthiness in the analysis process, including the preparation, organization, and reporting of results. These same individuals worked in pairs and evaluated the Atlas.ti8 coding for each theme and identified subthemes. Any differences were reconciled by consensus following discussion.

Trustworthiness was addressed by all authors through discussions about data credibility and confirmability to identify any biases that might have influenced the analysis process. Dependability and confirmability were supported by the maintenance of an audit trail through Outlines and Excel tables (Microsoft Office 365) using accessible Google Docs (Google) to assist in systematic comparisons of data.¹⁸ During analysis and discussion, it became clear that there were a number of codes described by the emergency nurses that defined certain feelings or perceptions of compassion fatigue. The theme of compassion fatigue had more than 14 subcodes within this category and was reduced by clustering quotes into subthemes (Table). The 3 subthemes of frustration with addicted patients, emotional responses, and job satisfaction (Figure) were identified.

In this paper, we have chosen to focus on the expressions and perceptions of emergency nurses specific to the theme of compassion fatigue and its 3 subthemes. Expressions and feelings of compassion fatigue by these emergency

TABLE
Numbers of quotes that comprise compassion fatigue and each of the subthemes

Main themes No. of quotes	Subcodes No. of quotes	Subthemes No. of quotes
Compassion fatigue (148)	• Compassion fatigue and frustration with patients (88)	• Emotional responses (36) • Frustration with patients (24)
Frustration (96)	• Frustration with work stress or job (59)	• Job satisfaction (37)

nurses cannot be fully understood without considering the role of emotion, often overwhelmingly negative in this sample, associated with caring for patients with OUD/SUD. Direct quotes are used to support thematic findings, illustrate emergency nurse emotions, and demonstrate the findings of the analysis.

Results

SAMPLE

The level I trauma urban hospital used in this study is a large, more than 500 bed, teaching hospital that routinely sees and provides care to individuals who have health problems related to substance and drug abuse. For this study, there was a total of 24 focus groups that yielded 55 emergency nurses; however, 1 nurse did not talk in the focus group and 1 nurse left at the start of the group, leaving a final sample of 53 RNs. The response rate for this emergency department was found to be 54.6% (53/97). Of the emergency nurse sample, the majority (85%) identified as female ($n = 45$) with 8 males. The racial composition of nurses found that most were Caucasian (74%, $n = 40$), followed by African American (17%, $n = 9$), Asian, Biracial, or Latino (9%, $n = 5$). The emergency department used for data collection is a designated Magnet (American Nurses Credentialing Center) recognized hospital where most nurses reported having a BSN (73.5%, $n = 39$), a master's degree (13.2%, $n = 7$), or an associate degree (9.3%, $n = 5$).

Theme: Compassion Fatigue

Subtheme 1: Frustration with addicted patients. All focus groups were asked "During the past 2 weeks, have you taken care of patients who have addiction or substance problems?"

and 100% of this emergency nurse sample answered "yes." They all perceived and felt that they had taken care of at least 1 patient with a substance problem. Negative feelings of frustration related to anger, annoyance, being upset, and disappointment in the patients with OUD and/or SUD were voiced by the majority of nurses.

RN #1: "I am frustrated with the whole [drug] ordeal. I feel frustrated. I feel aggravated. I feel disrespected and lied to."

RN #25: "When they come in and they just want drugs, then it's exhausting."

Frustrations about the time spent, resources, and energy devoted to patients with OUD and/or SUD were frequently shared as contributing to the nurses' growing feelings of compassion fatigue. They perceived a high recidivism rate of patients, which when coupled with the needs of patients with OUD and/or SUD seemed to be significant factors that increased nurse feelings of physical and emotional exhaustion. Access to hospital records or statistics on recidivism of patients was unavailable; however, these emergency nurses felt that they were seeing the same individuals repeatedly whether it was true or not. Patients with OUD/SUD entering the emergency department must be treated for their priority problem(s), trauma, medical complication or disease process, opioid relapse, or impending death owing to overdose. Adding to nurse frustration is the feeling of exhaustion, physical and emotional, related to nurse perception that these patients are constantly in and out and returning repeatedly to the emergency department, sometimes multiple times per day.

RN #24: "I think the opioid stuff probably gets me more than the traumas for the simple fact that it's exhausting. It's just exhausting. They come back and they come back and they come back."

RN #42: "It's one thing for you to have someone that, like, overdosed, okay, but when you get the same

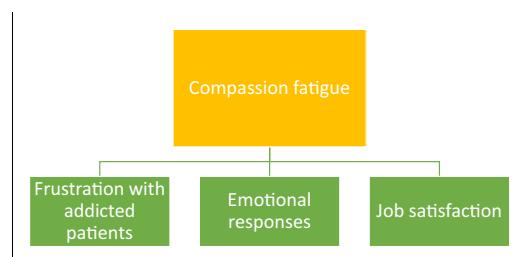


FIGURE
Theme of compassion fatigue and subthemes.

person in day after day – I mean, literally there are people who come, it's like, morning, noon, and night, and they're here. It's a revolving door..."

RN #4: "The first thought is, here we go again... So, you know, I hate to say it like this, but like it is a waste of our time and resources..."

Nurses also talked about feelings of frustration, a lack of empathy, and the resulting conflict when they have to choose between patients with OUD/SUD who are "high" and those with other emergencies.

RN #45: "It's very frustrating when you have people with true cardiac emergencies, or any type of emergency and you have no time, because you are dealing with someone who is high."

RN #39: "I have real sick patients out in the waiting room, and now I have to give a bed or a spot to somebody who chose to get high."

RN #46: "And it's like you're babysitting them when there's other sick people who really need your attention."

Frustrations about drug-using behaviors also were found regarding treatment of patients with OUD with the administration of Narcan (naloxone), which is used to counter the effects of opioid overdose. The resulting withdrawal symptoms can lead patients to leave the hospital before discharge in search of opioids to alleviate their acute distress. Nurses shared experiences of patients with OUD who were no longer "high" fleeing the hospital and the anger or concerns this caused.

RN #44: "You know, heroin high, give the Narcan, save them and the next thing we know, they're eloping with two IV accesses, and they're gone. Then we have to call the police to get them, and you know where they're going to go. Go right outside to get high and then they come back, if they're not dead, you know?"

RN #2: "I had a girl who was overdosing [gave treatment] and we discharged her. She was leaving, and I went to give her the nasal Narcan [part of discharge]...She said, 'What do I need that for? I have a whole purse of it.'...That was a slap in the face."

Subtheme 2: Emotional Response. Emergency nurses in the focus groups identified caring for the patient population with OUD and/or SUD as heavily emotional and not always positive.

RN #26: "We can always relate it [feeling angry] back to the opioid patient and they need my emotion, they need my compassion, they need me to make those phone calls [to rehab, social work] and I just can't do it."

RN #27: "I don't have any sympathy. You know I have no empathy at all for these people, now, none."

Negative or intentional emotional responses are viewed as a component of compassion fatigue.^{7,19} Nurses in the focus groups who talked about their emotional response of feeling drained, overloaded, and angry from working with patients with OUD and/or SUD shared that these emotions increased their feelings of compassion fatigue. They shared how their growing levels of negative emotions were adding to a lack of feeling compassion. The need to feel and be seen as human also was identified as an important feeling in terms of how nurses deliver care and are treated by patients with OUD/SUD.

RN #26: "I just want to be careful that it [having no compassion] doesn't, you know, change me in ways that I don't feel or know or want to see."

RN #16: "I think we've all said fuck it at some point or thought it or like hear it or heard someone say it, because you're just frustrated at the time and we're human beings as well as nurses."

RN #15: "If someone's like coding [and dies], whether it's an overdose or whatever drug, sometimes we're so numb to it, we're like laughing and joking over the body. And I get it. They put a needle in their arm. They did it to themselves. But then some days I'm driving home and am like damn, I should have been a little bit more compassionate... And I think sometimes we forget, like when we're standing there, like, this is still a human being."

These nurses acknowledged the emotional toll and were fearful of how these negative emotional responses, especially after a major case involving drugs, such as a complex trauma or overdose case, made them feel. These feelings were caused for concern in terms of bringing work into their home by having displaced or projected their work feelings onto family members.

RN #8: "I'm taking care of a mom and her baby's brains were all over her hair [gunshot victim from a drug deal gone bad] and I just walked out of the room and I wanted to cry, and I had two new patients where I was and the doctor was like, that person needs

to be seen right now. And I went home and I fought with my boyfriend and my 16-year-old son and I was like, I can't control my anger right now...then I realized it was all about that baby.

RN #35: "The opioid stuff is exhausting. You go home and you're like, what is wrong with these people? It's just exhausting."

Subtheme 3: Job satisfaction. Job satisfaction was frequently discussed in terms of negative and positive feelings by these emergency nurses. Negative job satisfaction was the more common subtheme and related to the ED environment, dealing with nonemergency nurses, and a lack of recognition or support from management/administration.

RN #26: "So no one makes emergency room nursing easy. Not the patients, not the hospital... We have to get these patients out [of the ED]. We have to move them [up to the floor or unit]. There are such fights on the phone from other nurses, who can't take that patient."

RN #28: "It's money, it's volume, push them through... I don't know what happened to the compassion in medicine."

RN #8: "I used to get a lot of satisfaction from being a nurse, but as of now I have zero."

The lack of staff, time, and space for emergency nurses were tangible factors contributing to their compassion fatigue.

RN #1:

But no one ever checks on the nurse to see if they're okay. The physicians can go on with their physician lounge and just take five minutes. We don't have a lounge. The physicians have a lounge. Our old walk-in clinic waiting room is their lounge. I'm talking carpet, computers, a couch for them to crash on weekends...there is no place for the nurses to go. We go in a dirty stairwell by the kitchen to talk or cry....

Nurses shared that the lack of space or a breakroom for nursing in this emergency department contributed to their feeling underappreciated by management and administration. In particular, they did not have a clean and dedicated space or room in or near the emergency department. Their previous breakroom was remodeled and given to the physicians, leaving nursing staff with no place or room, other than a dirty stairwell located off the emergency department, to gather to talk, debrief, or feel relaxed. Doing a job when

they were understaffed or not recognized or appreciated by nursing management or hospital administration lowered levels of job satisfaction.

Discussion

The emergency department is a fast-paced clinical site that requires nurses to demonstrate communication, critical thinking skills, and leadership. Patients and families who come to the emergency department desire compassionate care from all the nurses and health care providers with expectations that the delivery of care will be consistent and of high quality. Emergency nurses in this study repeatedly expressed increasing frustration with addicted patients, negative emotional responses, and decreasing levels of job satisfaction. Intensifying these feelings were stressors such as being understaffed, having few available professional supports, and absence of recognition from management/administration. Although most of the feelings and perceptions shared by the emergency nurses in this study were negative, it is important to note that some nurses did share positive feelings. Most talked about having hope that change would happen in the emergency department, with staffing, management, and workload. This sense of hope for the future led emergency nurses in our study to identify 3 areas that would increase feelings of compassion and decrease their fatigue: improved management support with encouragement across all work shifts, debriefing opportunities, and more education.

Implications for Emergency Nurses

MANAGEMENT SUPPORT WITH ENCOURAGEMENT

In the emergency department, there are demanding workloads and aspects of the work environment, such as poor staffing ratios, lack of communication between physicians and nurses, and lack of management or administrative leadership with support, that are associated with compassion fatigue and burnout in nurses.⁵ Employees who feel valued and supported perform better at work. Support at work can be critical during stressful times, such as when short staffed or extremely busy, and although stress is a normal and unavoidable part of life, especially at work, too much stress can affect an individual's emotional and physical well-being.²⁰ Managerial support in the workplace is a critical component of creating safe and healthy workplace environments. In the United States, federal law provides that

each individual is entitled to a safe workplace that is free from hazards.²⁰ Safety involves effective communication between employees and managers that can help increase an employee's feelings of competence and productivity, which meets management goals of having a team full of exceptional employees.²⁰

Research on compassion fatigue suggests that it is best managed by prevention through proactive assessment, education, and support both formal and informal.^{7,9,21-23} For any ED or clinical setting, an essential component of a supportive, productive, and healthy work environment is having a nurse manager who is visible on the unit, promotes communication, validates employee concerns, and has strong leadership skills.^{9,22} An essential component of inclusive leadership involves nurse managers and administrators who are able to develop positive relationships with open lines of communication.⁵ Although nurses themselves need to identify their personal stressors, it is imperative that ED management and hospital administration also acknowledge these concerns and act on the workplace issues. The emergency nurses in this study felt that there was little support given from hospital administration.

In our study, emergency nurses shared that short staffing was a problem across all nursing specialties within their own hospital, but they felt it could be helped, if not solved, through realistic planning with hiring of additional staff and opportunities to debrief after major cases (overdose, trauma). The increases in the number of patients with OUD and SUD are not expected to stop any time soon, especially in Philadelphia.¹⁶ Staffing in the emergency department needs to reflect this reality. Overstressed nurses often react by leaving a position when they believe they will not get relief. It is expensive to recruit, orient, and train new nurses to take the place of experienced nurses. Administrators and management need to balance the cost of doing this against providing debriefing, psychological or formal support, and education.

Management and administration also can use formal supports to help nurses with the negative feelings associated with compassion fatigue and work stress through a benefit program, often called an employee assistance program (EAP). An EAP is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems. Many individuals use EAPs to cope with workplace violence, trauma, and other emergency response or disaster situations. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as stress, grief, family problems, alcohol, other substance abuse issues, and psychological disorders.²⁴ In our study, we

were surprised that there were nurses who stated that they were unaware that EAP services existed at their hospital. Nurses who were aware of or had used EAP for a work-related incident shared that they found the EAP response to be of no help, occurring too late after a crisis or trauma case happened. Not surprisingly, many of the nurses in our study turned to their peers for informal support. Peer support during the shift and often after work may provide the benefit of informal support based on an understanding that their peers have gone through similar situations with associated feelings. Social support and talking with colleagues have been found to be significant moderators between aggression/conflict situations and emotional exhaustion in addition to a useful self-care strategy supporting balancing work with a personal life.^{13,22,25}

OPPORTUNITIES FOR DEBRIEFING

A successful evidence-based action to decrease compassion fatigue is the purpose of debriefing, which is defined as a session that involves sharing and examining information after a critical event to improve communication and review team performance, as well as provide emotional support.²⁶ Debriefing is not counseling, because it is a structured voluntary discussion aimed at putting an abnormal event into perspective.^{21,26} Reviewing the positives and negatives of a difficult experience encourages communication with reflection on specific actions to incorporate improvement into future performance. Allen and Palk²¹ reported that debriefing was the most common action found to be beneficial to resilience and coping. The process of debriefing involves structured voluntary discussion aimed at putting an atypical, complex, challenging, or traumatic event into perspective.^{26,27} In a perfect and well-staffed work environment, debriefing after a traumatic case or event should be provided immediately after the case or as soon as possible; some recommend no longer than the first 24 to 72 hours after the initial impact of the event.²⁶ Others have found that debriefing is effective when conducted within the first week after a difficult or traumatic case.^{21,27} Further research on what timeline for debriefing works best for nurses, staff, and providers and how to implement in an ED setting is recommended.

EDUCATION

Debriefing also can include an educational component that focuses on learning about compassion fatigue, OUD/SUD knowledge, and self-care techniques to promote individual well-being. Specialty education programs can increase both

knowledge and skill in the ED environment with a spotlight on how to identify, manage, and reduce stress in addition to the latest innovations in combating and preventing compassion fatigue. Trauma informed care, workplace violence identification, and reporting to enhance ED safety are other educational ways to prevent compassion fatigue. Understanding how to manage frustration with patients, negative emotional responses, and job dissatisfaction also can help nurses' professional and personal growth while providing better patient care. Education for nurses can be accomplished through modules, standard continuing education contact hours, courses, simulations, virtual conferences, or speakers. In our study, emergency nurses expressed a desire to receive education about providing care to individuals with OUD and SUD. Areas identified for education included the neurobiology of addiction to improve attitudes of working with patients with OUDs and SUDs, which may increase nurse knowledge to help separate the person from their addiction.

THE WARM HANDOFF PROGRAM

In the Commonwealth of Pennsylvania and across the city of Philadelphia, there is a state-supported program called the Warm Handoff Program that was developed and implemented to better meet the needs of individuals with OUD/SUD diagnosis and their recidivism rates.²⁸ The program was designed to provide recognition and response to the need for improved OUD/SUD treatment access. The goal of the program is to directly transfer overdose survivors from the hospital emergency department to a drug treatment provider and recovery services.²⁸ The program provides support for the individual and staff given that patients with OUD/SUD entering the emergency department must be treated for their priority problem, trauma, medical complication or disease process, opioid relapse, or impending death owing to overdose. The emergency nurses in this study voiced frustration that these "high," "high care," and "needy" patients with OUD and SUD limited their capacity to care for other sick patients. Emergency nurses were frustrated and resentful when expected to provide care to someone with OUD/SUD over someone without it, especially if they perceived that the patient was someone they frequently saw in the emergency department. At the time of this study, the emergency department had not had a Warm Handoff drug/rehabilitation contact or a full-time social worker or psychiatric/mental health liaison for a number of months. This lack of a program designed to help ED staff by taking patients with OUD/SUD directly into rehabilitation or recovery may have been a factor in nurses' feelings of exhaustion and frustration surrounding perceptions of patient recidivism.

Limitations

Although this study provides strong support for emergency nurses having high levels of compassion fatigue related to their providing care to patients with OUD/SUD, limitations should be considered. First, the emergency nurses in this study were from a single, level I trauma center in Philadelphia and there was no comparison group, and all participants were from the same clinical unit, which limits generalizability and provides the greater threat to external validity, meaning application of these findings to other settings may be limited. The sample size was small and included a range of ages, years of nursing and emergency nursing experience, in addition to the study occurring in late 2019 and early 2020, before the coronavirus pandemic. Because this study consisted of focus groups with emergency nurses who chose to participate (self-selection), their personal feelings and perceptions of experiences working with patients with OUD/SUD suggest that the transferability of the findings also may be limited. Although more than half of the full-time emergency nurses participated in this study, the small sample size may not be representative of other larger or smaller emergency or other nurse groups. There is also the possibility that some of the emergency nurses may have felt peer pressure to participate in the focus groups or to give similar answers as others in the group when faced with the moderator's questions. In addition, our sample was biased toward education with more than 73% being prepared at the baccalaureate level and all were working in a Magnet recognized hospital. Future research could focus on the impact of compassion fatigue interventions (management supports, education, consistent and timely debriefing, and/or huddles) in a more diverse range of emergency departments and with nurses such as those who are younger. Inclusion of more ethnically diverse and male nurses to determine the effectiveness of interventions designed to reduce compassion fatigue also must be included in the future.

Conclusion

Across the nation and in the city of Philadelphia, emergency nurses, providers, and staff witness devastating illness, suffering, and trauma on a daily basis. Adding to this workload are patients with drug and addiction issues that nurses in our focus groups shared were increasing their feelings of frustration, negative emotions, and job dissatisfaction. These feelings were found to interfere with nurses' well-being, job satisfaction, and ability to provide patient-centered quality care. Emergency nurses, providers, nurse managers, and hospital administrators must begin to understand the effects of compassion fatigue and recognize the signs and symptoms. Fostering a high level of

management support with encouragement, self-awareness, and understanding of how the work environment influences personal well-being are suggested strategies to avoid the negative frustrations and emotional responses associated with compassion fatigue. Using formal support systems, debriefing, education, and recognition to prevent and address nurses' compassion fatigue must be prioritized.

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Author Disclosures

Conflicts of interest: none to report.

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