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Stress and Coping in Hospice Care

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Abstract

Accommodating current hospice care needs and anticipated industry expansion requires protection and optimization of human resources serving as frontline care providers. Coping responses employed by individuals serve as important determinants of their overall personal and occupational well-being. There is limited research focusing on the coping responses of hospice professionals, specifically, how they perceive and manage their own work stress and work-related quality of life. The purpose of this study was to examine how coping responses are related to work-related quality of life among individual professionals working together on outpatient interdisciplinary hospice care teams. A cross-sectional survey-based design was utilized to explore the association between coping responses and work-related quality of life in a sample of 35 outpatient hospice care professionals at a non-profit hospice organization in the southeastern United States. There was a statistically significant, moderate positive association between use of emotional support and work-related quality of life (r_s =.480, p =.004). There was also a statistically significant, weak negative association between behavioral disengagement and work-related quality of life (r_s = -.380, p =.024). Investing in resources designed to enhance and leverage protective coping responses and team emotional support are necessary to promote professional sustainability by optimizing work-related quality of life.

Keywords: hospice professionals, end-of-life care, coping, work-related quality of life

Introduction and Background

Since its inception in 1974, hospice care has emerged as an established and growing care model in the United States (Casarett, Spence, Haskins, & Teno, 2011). The National Hospice and Palliative Care Organization (2017) notes the number of patients served by hospice has grown from 25,000 in 1982 to two million in 2014. This increase is largely attributed to the Medicare Hospice Benefit of 1982, which guaranteed access to quality end-of-life care for patients expected to live six months or less (Casarett et al., 2011; Halabi, 2014). Over the next 25 years, the impact of population aging is expected to substantially increase the demand for hospice care, especially in-home services (Bone et al., 2017). This persistent demand for end-of-life care along with a cultural shift toward greater acceptance and early utilization of hospice services will sustain the need for hospice care and prompt steady expansion of the hospice industry (Bone et al., 2017). Likewise, the Bureau of Labor Statistics (2015) projects the hospice industry will experience the fastest employment growth among all health care and social assistance sectors.

Accommodating current hospice care needs and anticipated industry expansion requires protection and optimization of human resources serving as frontline care providers (Bone et al., 2017). The interdisciplinary team of hospice care professionals including physicians, nurse practitioners, nurses, hospice aids, chaplains, and social workers serves as the foundation of a unique integrated care model that anticipates and responds to the complex or co-occurring emotional, social, physical, and spiritual needs of patients and families as they approach and move through the end of life (Kobayashi & McAllister, 2014).

Hospice care professionals describe end-of-life care as challenging and rewarding, but the stress associated with caring for patients and families during death and dying carries the potential

to take a negative toll on these highly dedicated professionals (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013).

The average daily census and subsequent individual staff caseloads vary according to the specific hospice organization and individual disciplines (National Hospice and Palliative Care Organization, 2017). In 2016, most hospices had an average daily census of less than 50 patients (mean of 63 and median of 31) and 94% of all hospice patients were receiving end-of life-care wherever they call home (National Hospice and Palliative Care Organization, 2017).

Problem Statement

Understanding how the unique nature of end-of-life care impacts staff wellness, turnover and retention is essential as hospice organizations seek to enhance and retain their human resources (Whitebird et al., 2013). And yet, there is limited research focusing on how the coping responses of hospice professionals influence their work-related quality of life, e.g., how they perceive and manage their own general well-being, home-work balance, job satisfaction, control and stress at work, and working conditions.

Purpose

The purpose of this study was to examine how coping responses are related to work-related quality of life among individual professionals working together on outpatient interdisciplinary hospice care teams. This project will explore both adaptive and maladaptive coping responses among interdisciplinary outpatient hospice professionals in order to identify and appropriately target future staff wellness initiatives.

Hypotheses

The authors predicted a positive association between adaptive coping and work-related quality of life in a cohort of outpatient interdisciplinary hospice care professionals. Likewise, the

authors predicted an inverse association between maladaptive coping and work-related quality of life.

Review of Evidence

Outpatient interdisciplinary hospice care professionals play a pivotal role in caring for patients and families during death and dying (Martens, 2009). Hospice research suggests many hospice professionals experience a calling toward hospice service (McGrath, 1997; Vachon, 1986; Yoon, Hunt, Ravella, Jun, & Curlin, 2017). Pioneering research supporting the notion of hospice work as a calling first emerged in Vachon's (1986) qualitative study of 100 hospice professionals which identified the calling to hospice service as aligning with one's religious or spiritual beliefs. Vachon's (1986) research also found this religious and/or spiritual calling serves as a practice philosophy guiding an individual's care and enabling hospice professionals to find meaning in death. A survey of 215 interdisciplinary hospice care professionals conducted by Clark et al. (2007) found 98% of respondents reported their practice was motivated and guided by a high degree of spirituality. Subsequent hospice research supports these findings and identifies hospice work as rewarding and a privilege, further calling individuals to the profession (Desbiens & Fillion, 2007; Harris, 2013; Kulbe, 2001). For instance, Harris' 2013 qualitative focus group of 19 hospice nurses addressed the rewarding nature of hospice work, specifically attributing this to the work of helping patients transition to death and witnessing the sacred moment of death. Respondents in Kulbe's (2001) survey of 97 hospice nurses described hospice work as a privilege and classified the practice of finding meaning in death as a rewarding experience. The ability to find meaning in death and the call to hospice work have been associated with inherent protective coping abilities that promote professional sustainability (Yoon et al., 2017).

Coping Responses

Coping as a concept was first described in the literature by Lazarus in 1966 and defined as the process of executing a response to stress (Carver, Scheier, & Weintraub, 1989). The concept has evolved over the years to include coping responses, or ways of thinking and behaving employed to minimize the internal and/or external difficulties surrounding a certain situation (Martins, Chavez, & Campos, 2014). In his seminal 1997 paper, Carver used coping theory and previous coping research to approach the exploration of coping and identified 14 distinct coping responses (Carver, 1997). The 14 coping responses include: Self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame (Carver, 1997; Monzani et al., 2015). Self-distraction entails engaging in work or other activities to minimize thinking regarding the stressor (Carver, 1997). Active coping is the process of reorganizing the effects of a stressor or actively engaging in steps to remove the stressor (Yusoff, Low, & Yip, 2010). Denial includes diminishing or failing to acknowledge the stressor (Yusoff et al., 2010). Substance use entails using one or more substances in response to stress (Carver, 1997). Use of emotional support includes seeking sympathy, compassion or moral support while use of instrumental support involves searching for information, help or advice (Yusoff et al., 2010). Behavioral disengagement occurs when individuals stop trying to cope or deal with the stressor (Carver, 1997). Venting is the expression of negative/unpleasant feelings (Carver, 1997). Positive reframing occurs when individuals attempt to see the stressor from a different, more positive perspective and try to find the good in the situation (Carver, 1997). Planning is actively thinking about what steps or strategies to use in response to the stressor (Carver, 1997). Humor occurs when individuals utilize jokes or make fun of the

situation (Carver, 1997). Acceptance includes learning to live with the stressor and accepting it is happening (Carver, 1997). Religion entails meditating, praying or finding comfort in one's spiritual or religious beliefs (Carver, 1997). Self-blame occurs when individuals blame or criticize themselves for what is happening (Carver, 1997). Carver (1997) noted an individual can utilize one or multiple coping responses at any given time. The coping responses employed by individuals serve as important determinants in their overall personal and occupational well-being (Monzani et al., 2015). The 14 coping responses identified by Carver have been classified as either adaptive (protective) coping or maladaptive (detrimental) coping (Gellis, 2002; Holton, Barry, & Chaney, 2016; Kasi et al., 2012).

Adaptive Coping.

The eight adaptive coping responses include: Active coping, instrumental support, planning, acceptance, emotional support, humor, positive reframing, and religion (Holton et al., 2016; Kasi et al., 2012). There is evidence to support that individuals who rely on adaptive coping are also likely to engage in health promoting behaviors and actively avoid risky health behaviors. A survey of 12 hospital nurses found individuals employing adaptive coping (seeking social support, listening to music, praying/meditating) had a higher likelihood of positive general well-being to include engagement in physical activity, healthy diet, avoidance of tobacco, and adequate sleep (Jordan, Khubchandani, & Wiblishauser, 2016). Hospice specific research regarding coping responses is limited to the hospice nurse rather than all hospice professionals serving as frontline providers. Additionally, most of the research is qualitative with small cohorts (Harris, 2013; Kulbe, 2001, Vachon, 1987). A survey conducted by Kulbe (2001) identified seven adaptive coping responses specific to 97 hospice nurses across 25 non-profit and for-profit agencies. These coping responses (in ranked order) were: Discussing concerns with

other hospice colleagues, exercise/recreation, taking time off, humor, discussing concerns with nonhospice personnel, meditation, and religious/spiritual practices (Kulbe, 2001). The use of coping responses such as seeking social support, humor, and prayer/meditation among hospice nurses is further supported by Harris' 2013 qualitative research which analyzed focus groups of 19 hospice nurses. These three adaptive coping responses were reported by respondents to be the most effective coping responses when confronted with hospice work stress (Harris, 2013). This study also confirmed previous research linking adequate social support and belonging to an effective team to success, staff retention, and well-being of hospice care professionals (Harris, 2013; Vachon, 1987). Specifically, nurses within the focus group cited support from and ability to vent to fellow nurses, management, and/or chaplains and social workers as key to their personal decompression and work sustainability (Harris, 2013). As previously discussed, the hospice professional's ability to find meaning in death has been classified in the hospice research as an adaptive coping response utilizing religious/spiritual coping and/or positive reframing coping (Desbiens & Fillion, 2007; Harris, 2013; Kulbe, 2001). A 2007 survey of 117 palliative care nurses completed by Desbiens and Fillion found the ability of palliative care nurses to give meaning to death is an adaptive stress response positively associated with better quality of life. The focus groups conducted by Harris (2013) expanded on the impact of meaning-making as a religious/spiritual coping response. For instance, respondents noted their own spirituality was reaffirmed while helping patients in the dying process and subsequently facilitated personal appreciation and reflection regarding their own lives (Harris, 2013).

Maladaptive Coping.

Conversely, the six maladaptive coping responses include: Behavioral disengagement, denial, self-distraction, self-blame, substance use, and venting (Holton et al., 2016; Kasi et al.,

2012). A survey of 120 hospital nurses found individuals utilizing maladaptive coping responses (consuming more than five alcoholic drinks on one occasion, unhealthy eating habits, lack of exercise, using tobacco or other drugs) when confronted with work stress reported statistically significant increased days of feeling tense, anxious, worried, suffering from pain, inadequate sleep, sadness, and depression (Jordan et al., 2016). In addition to poor general well-being, these coping responses are also linked to organizational consequences such as decreased work productivity, increased absenteeism, and diminished quality of care (Martens, 2009; Melvin, 2012).

Following identification of the 14 distinct coping responses, Carver developed the Brief COPE to measure the coping responses employed by individuals experiencing stress (Carver, 1997). This valid and reliable tool has been used to measure coping responses across multiple populations. This includes populations coping with cancer, depression, drug addiction, heart failure, aging, caregiving, and work stress (Alosaimi, Alghamdi, Aladwani, Kazim, & Almufleh, 2016; Monzani et al., 2015; Muller and Spitz, 2003). Research utilizing the Brief COPE has suggested the coping responses assessed by the measurement tool are significant in the coping process and predictive of possible physiological effects (Carver, 1997). For instance, in a study of 60 breast cancer patients, acceptance as a coping response was associated with lower distress while denial and behavioral disengagement were subsequently associated with distress (Carver, 1997). The coping responses employed by individuals may also impact their work-related quality of life (Ablett & Jones, 2006).

Work-Related Quality of Life

There have been a wide range of evolving definitions for the construct of work quality of life (Van Laar, Edwards, & Easton, 2007). The two dominant theoretical definitions of this

concept emphasize different factors impacting work quality of life (Van Laar et al., 2007). The first definition emphasizes job satisfaction and work commitment while the second definition emphasizes work life and non-work life (Van Laar et al., 2007). In their 2007 seminal paper, Van Laar et al. utilized previous research and theory to identify the factors associated with work quality of life for healthcare workers (Van Laar et al., 2007). These six identified domains include: General well-being, home-work interface, job and career satisfaction, control at work, working conditions, and stress at work (Van Laar et al., 2007). General well-being consists of both general physical health and psychological well-being (Van Laar et al., 2007). General well-being is often linked to an individual's overall work quality of life and therefore both influences and is influenced by work (Van Laar et al., 2007). Home-work interface measures work-life balance and an individual's perception regarding organizational understanding and assistance with demands outside of work (Van Laar et al., 2007). Job and career satisfaction assess the degree to which an individual is content with their work/working prospects and is influenced by role appraisal, ambiguity, reward, recognition, career benefits, and training needs (Van Laar et al., 2007). Control at work reflects an individual's perceived degree of involvement in decisions that impact their work, such as the ability to contribute to decision making processes affecting the individual (Van Laar et al., 2007). Working conditions reflects the degree of satisfaction related to the working environment, security, and fundamental resources necessary to effectively complete one's job (Van Laar et al., 2007). The stress at work subscale assesses an individual's perception of work demands as acceptable, rather than stressful or excessive (Van Laar et al., 2007). Occupational demands can be positive factors in work experience allowing for stimulation and challenge, or these demands can be perceived as excessive beyond an individual's ability to cope and subsequently result in stress and overload (Van Laar et al., 2007).

These elements shape an individual's work-related quality of life (WRQoL), a construct that has been used to predict overall staff wellness and retention (Mosadeghrad, 2013).

Hospice Specific Stressors

Prior research has identified job satisfaction among hospice professionals as a strong predictor of staff retention (Qaseem, Shea, Connor, & Casarett, 2007; Whitebird et al., 2013). In a study completed by Qaseem et al. in 2007, a statistically significant association was found between high job satisfaction scores and low annual staff turnover rates among a survey of 599 hospice professionals from 10 separate hospices. Conversely, research has also linked poor job satisfaction and subsequent staff turnover to work stress (Peters et al., 2012). For instance, a survey of 209 palliative care nurses in 2007 by Fillion et al. found an inverse association between work stress and job satisfaction. Work stress among hospice/palliative care nurses have been linked to poor health outcomes for the nurses themselves, compromised quality of care for their patients, and direct cost to the healthcare system through absenteeism and decreased staff retention (Lachman, 2016; Martens, 2009; Melvin, 2012).

The perceived work stress reported by hospice professionals aligns with research regarding work stress reported by other health care professionals (Ablett & Jones, 2007; Newton & Waters, 2001; Vachon, 1998). For example, Newton and Waters (2001) conducted qualitative semi-structured interviews among 21 community palliative care nurses and reported high workloads, largely due to staff shortages, as the leading contributor of work stress. A 2007 qualitative study of 10 palliative care nurses by Ablett and Jones supported the findings of Newton and Waters (2001) and noted unmanageable workloads, staff shortages, and subsequent extra demands on existing staff served as major work stressors. Subsequently, Fillion et al. (2007) noted the need to understand the perceived work stress specific to hospice professionals

in order to promote job satisfaction and retention of these frontline care providers. A survey of 33 hospice nurses conducted by Dean in 1998 identified four hospice work stressors including: Managing intractable symptoms, interdisciplinary team communication challenges, impact of death and loss, and isolation related to working alone. According to Martens' (2009) survey research of 146 home and inpatient hospice nurses among 14 hospice organizations, additional stressors include: Death of patients with whom a close relationship was developed, lack of opportunities to talk openly with other staff members to process emotional stress of work, communicating with patients and families about death, and caring for the spiritual and emotional needs of dying patients and their families. While the hospice work stressors identified by Martens (2009) were consistent among both inpatient and home hospice nurses, specific stressors regarding rural hospice care emerge in the research. For instance, providing 24-hour hospice care services over varying distances, lack of financial resources, and absence of team support were found to be significant stressors in Wilkes and Beale's 2001 qualitative study of 20 palliative home care nurses. The stressors specifically noted by rural home hospice nurses are important to note as expansion of hospice care includes increased coverage outside of urban areas (Bone et al., 2017). However, perceived work stress is not synonymous with negative personal and organizational manifestations as various adaptive coping responses are associated with mitigating work stress and subsequently protecting personal and organizational well-being (Ablett & Jones, 2006).

Theoretical Model

DiTullio and MacDonald's (1999) Hospice-Specific Stress Model served as the theoretical framework for this project, and the model's core concepts anchored the examination of occupational demands, coping, and work-related quality of life among interdisciplinary

outpatient hospice professionals. This model expands upon Vachon's Life Model (1987) and Lazarus and Folkman's Transactional Model of Stress and Coping (1984) and provided a coherent framework of stress and coping specific to hospice work (DiTullio & MacDonald, 1999). This study utilized the model to examine the associations between the concepts of hospice work stress, personal and organizational coping responses/resources, and work-related quality of life. See Figure 1 for a visual depiction of the adapted model.

Concepts and Assumptions

According to the model, several environmental and personal demands impact the hospice professional (DiTullio & MacDonald, 1999). Environmental stressors consist of organizational demands and situational factors (Harris, 2012). Organizational demands specific to this study include simultaneously managing intakes and death, patient load, travel, multiple bereavements, interpersonal team dynamics, and other hospice specific work stressors. Situational factors consist of complex family dynamics, emotional strain, grief, professional discipline, and outpatient hospice setting (Harris, 2012). These environmental demands interact with personal demands such as demographic variables, social support, personality factors, and current stressful life events (DiTullio & MacDonald, 1999). While this study does not measure personal demands, the authors acknowledge the existence and impact of such stressors on the hospice professional.

The presence of these demands prompts appraisal of available organizational and personal resources and coping responses by the hospice professional (Harris, 2012). Organizational resources include effective leadership, team support, control at work, and staff education (DiTullio & MacDonald, 1999). These resources are provided through organizational coping strategies such as interdisciplinary team meetings, team communication/debriefing,

employee assistance programs, and formal/informal staff support groups (DiTullio & MacDonald, 1999). Personal resources and coping responses include professional training, rewards of hospice work, spirituality, and supportive relationships (DiTullio & MacDonald, 1999).

Following evaluation of available resources and coping responses, the hospice professional will perceive personal and organizational demands as either stressful or not stressful (Harris, 2012). If resources and coping responses are deemed inadequate, individual manifestations of stress (poor work-related quality of life, decreased general well-being) and organizational manifestations (decreased staff retention, poor team collaboration) may occur (DiTullio & MacDonald, 1999; Harris, 2012). In comparison, if resources and coping responses are perceived as adequate, personal balance (positive work-related quality of life) and organizational balance (staff retention, team collaboration) will likely be achieved (DiTullio & MacDonald, 1999; Harris, 2012).

This model makes several assumptions. The central assumption focuses on the interaction between the individual and environment, assuming that 1) the hospice professional is impacted by both personal and organizational demands and that 2) individuals experiencing stress will engage in cognitive appraisal of existing resources and then actively reach out to those resources that he or she identifies (DiTullio & MacDonald, 1999). The model also assumes that to create balance, an individual must leverage both the personally and organizationally derived resources and coping responses and that such balance is determined by the individual's perception and cognitive appraisal of resources and coping responses (DiTullio & MacDonald, 1999).

Application

Based on this model, outpatient interdisciplinary hospice care professionals can achieve and maintain positive work-related quality of life if personal and organizational resources and coping responses are present and adequate. Conversely, absent and inadequate personal and organizational resources and coping responses may subject these individuals to poor work-related quality of life.

Project Design

This scholarly project utilized a cross-sectional survey-based design to assess baseline work-related quality of life and coping in a cohort of outpatient hospice care professionals as well as the relationship between each individual's coping responses and their work-related quality of life. The project also included questions specifically designed to gather information regarding the partnering agency's employee stressors and employee's perception of team support to inform staff wellness policies and direct the use of organizational resources. The project was verified as exempt by the Belmont University Institutional Review Board and approved by the partnering agency's ethics committee.

Clinical Setting

A non-profit hospice organization located in southeastern United States served as the setting for project implementation. The hospice organization was recently voted by its employees as one of the best places to work, specifically related to trust in senior leadership and team effectiveness (Organizational Representative, personal communication, August 31, 2018). Organizational services cover 12 metropolitan and rural counties and serve more than 3,600 patients and their families annually, more than 70% of whom are served at home by one of the five outpatient interdisciplinary hospice care teams.

Project Population

A purposive sampling method was utilized to recruit physicians, nurse practitioners, nurse, hospice aids, social workers, and chaplains from each of the five outpatient interdisciplinary hospice care teams employed and working full time between October and December 2018. There were roughly 60 full-time hospice care professionals (physicians, nurse practitioners, nurses, hospice aids, social workers or chaplains) employed on the outpatient end-of-life care teams at the time of data collection; all were eligible to complete a one-time electronic survey. The specific breakdown of each interdisciplinary professional within the sample is unknown, but an estimated 3 physicians, 2 nurse practitioners, 20 nurses, 20 hospice aids, 9 social workers, and 6 chaplains were employed on the outpatient hospice care teams at the time of data collection. Additionally, while the average patient load of each interdisciplinary professional is unknown, patient loads across the professional disciplines are variable due the nature of each professional's engagement with patients. However, known information regarding this sample includes: Each physician covers the entire patient load for the team they are assigned, and social workers and chaplains tend to have higher average patient loads than nurses and hospice aids. Inpatient hospice professionals, volunteers, and staff not practicing in one of the outpatient interdisciplinary team roles were not eligible for participation.

Sources of Data/Data Collection Instruments

The survey included demographic questions including gender, age, race/ethnicity, professional discipline, current patient load, years worked for the organization, and team assignment followed by the 28-item Brief COPE questionnaire and the Work-Related Quality of Life Scale (WRQoL). The Brief COPE is a self-report questionnaire that captures the frequency of respondents' engagement in each of the 14 specific coping behaviors: self-distraction, active

coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame (Carver, 1997; Monzani et al., 2015). The Brief COPE was adapted from a full version scale, the COPE questionnaire, to minimize participant response burden and quickly measure coping responses in hurricane trauma survivors (Carver, 1997). This study adapted the tool to measure coping responses specific to the stress of hospice work among outpatient interdisciplinary care professionals. Responses are entered on a four-point Likert scale where 1 equals "not at all" and 4 "a lot" (Carver, 1997). The 14 subscales consist of two items each and individual subscale scores range from two to eight, with higher scores indicating greater use of the coping response (Carver, 1997). The Brief COPE has undergone exploratory factor analysis demonstrating a factor structure consistent with the full version scale (Carver, 1997). Empirical evidence has determined the validity and reliability of the scale in assessing 14 coping responses associated with stress (Monzani et al., 2015). Subscale reliabilities have all met or exceeded the minimally acceptable values necessary to support internal reliabilities (Carver, 1997; Monzani et al., 2015).

The instructions preceding the 28-item questionnaire were modified and directed participants to "please answer the following questions with your greatest work stressor in mind." The adaptation of the survey was intended to improve the specificity of responses and survey brevity. The four-point Likert scale response language was modified ranging from "not at all" to "a lot" to improve content validity and survey brevity. Verb tenses of the 28-items were also changed and various forms of the phrase "hospice work stress" were added to items 1-3, 6-8, 11, 12, 14, 16, 18-21, 23-26, and 28 for further item clarity and content validity.

The WRQoL is the most commonly used instrument to measure employee work experiences, assess employee adaptability to organizational changes, and evaluate employee work capabilities (Zubair et al., 2017). It has been used in various occupational groups including social work, nursing, education, and medicine (Van Laar et al., 2007). Exploratory and confirmatory factor analysis demonstrate a good fit and subsequently deem the scale a psychometrically valid and reliable measurement of work-related quality of life (Van Laar et al., 2007). The project leader modified the instructions preceding the tool to promote survey brevity.

The 23-item tool has a five-point Likert scale response ranging from "strongly disagree" (1) to "strongly agree" (5) measuring six research identified psychosocial domains impacting an individual's perceived WRQoL (Van Laar et al., 2007). These subscales include: General well-being, home-work interface, job and career satisfaction, control at work, working conditions, and stress at work (Van Laar et al., 2007). General well-being and job and career satisfaction each contain six items. Home-work interface, control at work, and working conditions contain three items while stress at work contains two items (Van Laar et al., 2007). The WRQoL scale has a 24th item that serves as a reliability and validity indicator for the scale and subscales and is subsequently treated as a stand-alone item for scoring (Zubair, Hussain, Williams, & Grannan, 2017). Three items in the scale, one item (question 9) in the general well-being scale and two items (questions 7 and 19), are negatively scored and reverse scoring was completed per the WRQoL user manuel (Van Laar et al., 2007). Individual subscale scores are calculated by determining the average of the items contributing to that subscale (Van Laar et al., 2007). The possible scoring range for each subscale is as follows: General well-being (6-30), home-work interface (3-15), job and career satisfaction (6-30), control at work (3-15), working conditions (3-15), and stress at work (2-10). The individual subscale scores can be totaled to calculate the full

scale WRQoL score (Van Laar et al., 2007). Higher scores for the subscales and full scale WRQoL indicate greater perceived work quality of life (Van Laar et al., 2007).

Additionally, eight quantitative questions were derived from the literature and the Hospice-Specific Stress Model's assertion that individuals appraise and utilize personal and organizational coping responses and resources in the presence of work stress. Therefore, these questions solicited information regarding greatest work stressor, perceived extent of individual and team support in processing emotional work stress, and primary mode and frequency of team communication surrounding work stress. One qualitative survey question asked participants to "please share any details you can offer about the specific nature of your work stress."

The adapted survey was pretested, reviewed, and revised with an outpatient interdisciplinary hospice expert and a Doctor of Nursing Practice (DNP) serving as the project advisor. This was completed to improve content validity and item clarity. All revisions were reviewed with the project advisor prior to survey distribution. See Appendix A for the complete project survey and permission statements regarding the use of the Brief COPE and the WRQoL scale.

Data Collection Process/Procedures

Prior to participant recruitment, a meeting was held with the hospice organization's leadership to discuss the project premise and identify the target population. Data was collected electronically via Qualtrics survey software between October 2018 and December 2018. Recruitment occurred through the hospice organization's administration. An invitation to a one-time electronic survey was sent to eligible employee emails by a designated individual within the organization. This individual also sent weekly email reminders to potential participants to optimize response rate. Informed consent was not required as participant completion of the

survey indicated implied consent. To optimize response rate, the project leader attended one interdisciplinary team meeting per team to share the purpose of the study and encourage participation. All outpatient team members present at the team meetings were given a gift bag containing a $5 coffee gift card and candy. Survey responses were both confidential and anonymous.

The data was downloaded into Excel and exported to SPSS for analysis. The statistical analysis was performed using IBM Statistical Packages for Social Sciences (SPSS) software, version 25, with an alpha level of 0.05. The independent variables in the study included the 14 coping responses. The dependent variable was work-related quality of life. To determine associations between the variables, Spearman's correlation was conducted. According to Plichta Keller and Kelvin (2013), Spearman's correlation assesses the direction and strength of the association between two ordinal variables. Descriptive statistics were used for the remaining data. Data analysis occurred from December 2018 through January 2019. Survey results were shared with hospice leadership in aggregate form only.

Results

Sample Characteristics

A total of 35 individuals completed the survey, making the overall response rate 58%. Sample characteristics including age, gender, race/ethnicity, professional discipline, years worked for the hospice, and outpatient team are provided in Table 1. The study population was predominantly female (80%) and 94.3% of respondents identified as Caucasian. The mean age of respondents was 47 (SD = 13.07) years. There were 2 missing values for professional discipline (n = 33), however, the majority of respondents were nurses (40%, n = 14). Of the remaining respondents, 22.9% (n = 8) were social workers, 17.1% (n = 6) were chaplains, 11.4%

(n = 4) were hospice aids, 2.9% (n = 1) were physicians, and eligible nurse practitioners did not participate. Most respondents (37.1%) reported working for the hospice for 3-5 years. There were 4 missing values for patient load, however, the mean patient load was 29.9 patients (n = 31, SD = 28.8). Nurses reported a mean patient load of 13.4 (n = 13, SD = 3), hospice aids reported a mean patient load of 7.3 (n = 3, SD = 1.2), social workers reported a mean patient load of 32 (n = 8, SD = 3), and chaplains reported a mean patient load of 56.6 (n = 6, SD = 12.7). One physician reported a patient load of 150 patients.

Work-Related Quality of Life

The mean score for the full scale WRQoL was 85.89 (score 23-115). The majority of respondents (71.1%) reported high quality of working life (score 83-115) and 17.3% of respondents reported low quality of working life (score 23-71). The means and standard deviations of the full scale WRQoL and the individual subscales are provided in Table 4.

General Well-Being.

The mean score for general well-being was 22.97 (score 6-30). The majority of respondents (57.1%) reported positive general well-being (score 24-30) and 28.7% of respondents reported negative general well-being (score 6-20).

Home-Work Interface.

The mean score for home-work interface was 11.83 (score 3-15). The majority of respondents (57%) reported positive home-work interface (score 12-15) and 20% of respondents reported negative home-work interface (score 3-9).

Job-Career Satisfaction.

The mean score for job-career satisfaction was 23.40 (score 6-30). The majority of respondents (68.6%) reported positive job-career satisfaction (score 23-30) and 17.2% of respondents reported negative job-career satisfaction (score 6-19).

Control at Work.

The mean score for control at work was 10 (score 3-15). The majority of respondents (45.8%) reported positive control at work and 25.8% of respondents reported negative control at work (score 3-8).

Working Conditions.

The mean score for working conditions was 12.06 (score 3-15). The majority of respondents (68.5%) reported positive working conditions (score 12-15) and 5.8% of respondents reported negative working conditions (score 3-9).

Stress at Work.

The mean score for stress at work was 5.63 (score 2-10). The majority of respondents (54.4%) perceived work stress as acceptable (score 6-10) and 37.1% of respondents perceived work stress as excessive (score 2-4).

Primary Work Stressors

Table 2 contains a summary of work stressors. Of the 35 respondents, 42.9% identified simultaneously managing intakes and deaths as their greatest work stressor. Followed by 34.3% of respondents reporting patient load as the greatest work stressor, 11.4% reporting travel, 5.7% reporting multiple bereavements, and 5.7% reporting interpersonal dynamics with team.

Coping Responses

Among the 14 coping responses studied, adaptive coping responses were used 67% of the time and maladaptive coping responses were used 33% of the time. The most frequently used responses were acceptance (M = 6.23), followed by religion (M = 6.06), positive reframing (M = 5.94), use of emotional support (M = 5.94), humor (M = 5.57), planning (M = 5.54), use of instrumental support (M = 5.26), and active coping (M = 5.20). Coping responses less frequently used were self-distraction (M = 4.94), self-blame (M = 4.69), venting (M = 4.63), denial (M = 3.63), behavioral disengagement (M = 2.77), and substance use (M = 2.60). The means and standard deviations of coping responses are presented in Table 3.

Team Support and Communication

Table 2 contains a summary of team support, communication methods, and frequency. Most respondents (88.6%) reported that they "sometimes or always" rely on their team to process the emotional stress of their work, while 91.4% of respondents reported their team members "sometimes or always" rely on them to process the emotional stress of work. The majority of respondents (97.2%) reported team members "sometimes or always" rely on one another to process the emotional stress of their work. Of the 35 respondents, 71.4% reported their personal habits of processing work stress are "somewhat or very healthy" and 80% of respondents reported their team's habits of processing work stress are "somewhat or very healthy." The majority of respondents (45.7%) identified the telephone as their primary mode of communication with team members. Most respondents (34.3%) reported communicating with other team members 3-5 times a week to process work stress.

Associations

Spearman's correlation was conducted to assess whether there is an association between coping responses and work-related quality of life. Preliminary analysis included visual inspection of scatterplots demonstrating non-monotonic relationships, but further analysis was completed to determine if there was a monotonic component to the association (Laerd Statistics, 2018). There was a statistically significant, moderate positive association between use of emotional support and work-related quality of life (r_s =.480, p =.004). There was also a statistically significant, weak negative association between behavioral disengagement and work-related quality of life (r_s = -.380, p =.024). There was no statistically significant association between the following coping responses and work-related quality of life: Acceptance (r_s = -.188, p =.278), religion (r_s = -.096, p =.585), positive reframing (r_s = .050, p =.777), humor (r_s = -.183, p =.293), planning (r_s = -.132, p =.449), use of instrumental support (r_s = .134, p =.442), active coping (r_s = -.166, p =.341), self-distraction (r_s = -.104, p =.551), self-blame (r_s = -.322, p =.059), venting (r_s = -.301, p =.079), denial (r_s = -.151, p =.386), substance use (r_s = -.137, p =.433).

Discussion

Work-Related Quality of Life

Most of the respondents in the study reported high perceived work-related quality of life. Additionally, the majority of respondents reported positive scores across all six domains (general well-being, home-work interface, job-career satisfaction, control at work, working conditions, stress at work) of the WRQoL. Similar results were found in a study done by DeLoach (2003) which noted high work satisfaction among 76 hospice interdisciplinary team members. DeLoach (2003) also found overall work satisfaction increased as an individual's general well-being, job-career satisfaction, and control at work increased. However, it is important to note that 17.3% of

respondents in this study reported low work-related quality of life. A study of 740 hospital professionals done by Mosadeghrad (2013), found an inverse relationship between work-related quality of life and turnover intention. The study results highlight the risks of declining work-related quality of life and reinforce the need to support and promote hospice professionals' naturally adaptive coping responses as a way to promote their role sustainability. According to DiTullio and MacDonald's (1999) Hospice-Specific Stress Model, outpatient interdisciplinary hospice professionals can achieve and maintain positive work-quality of life if coping responses are present and adequate (Figure 1).

Coping

The results of this study showed that respondents utilized adaptive coping responses more frequently than maladaptive coping responses. This is consistent with previous research, which has found palliative and hospice nurses mainly utilize adaptive coping techniques such as problem-focused (planning, seeking instrumental support, active coping) and emotion-focused (acceptance, positive reframing, religion, emotional support) approaches when caring for the dying (Desbiens & Fillion, 2007; Hawkins, Howard, & Oyebode, 2007; Whitebird et al., 2013). The six most commonly employed coping responses (acceptance, religion, positive reframing, use of emotional support, humor, planning) in this study were a mix of problem-focused and emotion-focused approaches. Similar results were found in a study of 84 hospice nurses done by Hawkins et al. (2007), which noted switching between problem-focused and emotion-focused coping may serve as a healthy response to end-of-life care and subsequently promote staff well-being. Conversely, a shift toward maladaptive coping (self-blame, venting, denial, behavioral disengagement) occurs once an individual's emotional quality of life is impacted (Farcas & Nastasa, 2011). Hospice research suggests an individual's religious and/or spiritual calling

toward hospice service enables hospice professionals to find meaning in death, a protective coping response associated with positive emotional quality of life (McGrath, 1997; Vachon, 1986; Yoon et al., 2017). This study found meaning-making coping responses (religion, positive reframing) were two of the top three most frequently employed coping approaches. Comparable results were found in a study of 117 palliative care nurses done by Desbiens and Fillion (2007), which found positive reinterpretation to be the most frequently utilized coping response and the principle predictor of positive well-being.

Associations

Emotional Support.

This study found a positive association between use of emotional support and work-related quality of life, consistent with prior research regarding the association between emotional support and staff coping and well-being (Hospice Friendly Hospitals Programme, 2013; Huggard & Nichols, 2011; Hulbert & Morrison, 2006). A study of 36 palliative care professionals done by Hulbert and Morrison (2006) found a professional's ability to cope was directly associated with the availability of emotional support. This study illuminated the perceived extent of individual and team emotional support to process work stress among the cohort of outpatient interdisciplinary hospice professionals. The majority of respondents reported reliance on team emotional support (e.g., they rely on team, team members rely on them, team members rely on one another) to process work stress. While this demonstrates utilization of emotional support, it also prompts the need to further consider the dynamics surrounding an individual seeking emotional support. For instance, the action of acknowledging the need for emotional support and subsequently reaching out for that support lies with the individual who is struggling. Organizations can mitigate this burden on staff through preventative approaches designed to

build support into daily practice, teach and orient new staff to the available support resources and by doing so, create a culture of emotional support and connection. Prior research has identified the following mechanisms to foster emotional support among end-of-life care providers: Building and maintaining a supportive interdisciplinary team, weekly interdisciplinary team meetings, debriefing when requested or required, team designated rituals (regular memorial services), and mentoring from more experienced peers (Huggard & Nichols, 2011; Rokach, 2005; Van Staa et al., 2000). Additionally, a 2013 literature review suggested the utilization of off-site staff retreats focusing on topics such as cultivating team support and effectiveness, staff well-being, developing/sustaining coping techniques, and managing losses to promote emotional support and staff sustainability (Hospice Friendly Hospitals Programme, 2013). These intentional organizational interventions allow for the creation of spaces and protected time to foster support and connection among staff. However, while research supports the positive impact of these interventions on hospice staff, further evaluation is needed to evaluate long-term effectiveness (Hospice Friendly Hospitals Programme, 2013).

Behavioral Disengagement.

This study found a negative association between behavioral disengagement and work-related quality of life. This finding aligns with prior research regarding the association between behavioral disengagement and poor well-being and subsequent staff turnover (Desbiens & Fillion, 2007; Whitebird et al., 2013). In a study of 117 palliative care nurse done by Desbiens and Fillion (2007), behavioral disengagement was associated with poor staff well-being. A survey of 547 hospice workers by Whitebird et al. (2013) found poor well-being increased the risk of staff turnover. Prior research has suggested interventions to foster emotional support (as previously discussed) may decrease the prevalence of behavioral disengagement and promote

hospice staff wellness and retention (Huggard & Nichols, 2011; Rokach, 2005; Van Staa et al., 2000). The study findings align with DiTullio and MacDonald's (1999) Hospice-Specific Stress Model which asserts positive work-related quality of life is achieved in the presence of adequate coping responses and poor work-related quality of life occurs in the presence of inadequate coping responses (Figure 1). This study adds that behavioral disengagement could be an early sign of declining work-related quality of life and that strategies to support staff who are struggling should focus on reconnecting them to the emotional support structure of their team.

Implications for Practice

Accommodating current hospice care needs and anticipated industry expansion requires the protection and optimization of hospice professionals (Bone et al., 2017). This study aligns with previous research regarding the positive association between emotional support, connection, adaptive coping and work-related quality of life and staff well-being (DeLoach, 2013; Hawkins et al., 2007; Mosadeghrad, 2013; Whitebird et al., 2013). The inverse association between behavioral disengagement and work-related quality of life supports the need for organizational resources to identify and respond quickly to behavioral disengagement by increasing access to emotional support. Intentional organizational resources to prevent behavioral disengagement center on building and maintaining a culture of emotional support and connection. Embedding emotional support into the organizational culture allows organizations to leverage the team environment and connection to mitigate behavioral disengagement. However, preventing behavioral disengagement should also be coupled with early identification of this coping response, followed by targeted interventions to direct individuals back into emotional support and team connection.

To retain and recruit hospice professionals, efforts should also be made to leverage the call to hospice work and the subsequent inherent protective coping abilities that promote professional sustainability (Yoon et al., 2017). The authors suspect the connection between behavioral disengagement and decreased work-quality of life may exist in those individuals who answer the spiritual/religious calling to hospice work and subsequently utilize disengagement coping to continue their work despite the negative impact on their well-being. As previously discussed, an organizational culture of support, early identification of behavioral disengagement, and targeted interventions could serve to help these individuals lean into not only emotional support, but also adaptive coping responses that reinforce their calling to the work.

Organizations may consider conducting staff wellness surveys to assess baseline coping responses, work quality of life, and perceived team support among all members of the interdisciplinary team. Organizations may also consider evaluating team debriefing to ensure hospice professionals have access to scheduled/as needed debriefing opportunities (Huggard & Nichols, 2011; Van Staa et al., 2000). These debriefing sessions should target both problem-focused and emotion-focused coping responses. Two debriefing prompts addressing both coping aspects include: (1) what can we do better/differently to make this team/experience/system better and (2) how was this experience for you, how are you feeling/doing/coping? Additionally, off-site staff retreats focusing on: Cultivating team support and effectiveness, staff well-being, developing/sustaining coping techniques, and mentoring from more experienced peers could be implemented to promote emotional support and staff sustainability (Hospice Friendly Hospitals Programme, 2013; Rokach, 2005).

Strengths, Limitations, and Future Directions

The purpose of this study was to illuminate the experience of professionals at the partnering hospice organization. The value of this study was not in its capacity to be generalizable, but rather translated to inform improvements in organizational practices and policies directly impacting the study population. Additionally, the study utilized self-report surveys, which could have contributed to social desirability bias. Healthcare professionals may be more likely to report with a social desirability bias when being asked questions by a researcher associated with their employer. Although efforts were made to minimize this bias, respondents were ensured their responses were anonymous, this type of bias may still have persisted in a small sample. While study findings demonstrated an association between emotional support and work-related quality of life, the authors cannot assume emotional support was solely representative of emotional support encountered at work. Also, the authors must acknowledge the interpersonal dynamics inherent in any team-based collaborative practice environment and the possibility that relationships between team members may be more challenging along the power differentials associated with the clinical hierarchy. For instance, a physician may not feel equally able to lean into a team they are directing. Also, while everyone may feel comfortable seeking emotional support from the chaplain, it is important to acknowledge who the chaplain feels comfortable confiding in.

While the study authors acknowledge various limitations, the study provided a baseline assessment of coping responses and work-related quality of life in a cohort of outpatient interdisciplinary hospice professionals. The partnering hospice organization can use this data to implement organizational resources and interventions to mitigate behavioral disengagement through early identification and a culture of emotional support. Additionally, this study also

adds to the limited research regarding the association between coping responses and work-related quality of life, specifically in this population.

This study identified the associations between emotional support and behavioral disengagement and work-related quality of life. Subsequently, the authors recommend the partnering agency create and sustain a culture of emotional support and connection coupled with early identification and intervention for individuals exhibiting behavioral disengagement. Organizational interventions should also implement protected time and space to address problem-focused and emotion-focused debriefing as the study results demonstrate this population needs and benefits from both coping responses. Future studies may consider employing larger sample populations and longitudinal design in order to identify coping and staff well-being patterns over a longer period and evaluate long-term effectiveness of resources designed to prevent behavioral disengagement and promote emotional support.

Conclusion

The persistent demand for hospice care and the anticipated industry expansion highlight the need to ensure professionals who respond to a vocational calling to support individuals and their families through the transition of death and dying are offered the same level of support and care they offer others. Their experience of stress compromises their capacity to make meaning of their work and threatens their sustainability in the role. This study highlights the importance of social support as a critical adaptive coping response to the stress of end-of-life care giving. Interventions that formalize connection among team members for both problem-focused and emotion-focused coping stand to optimize their work-related quality of life.

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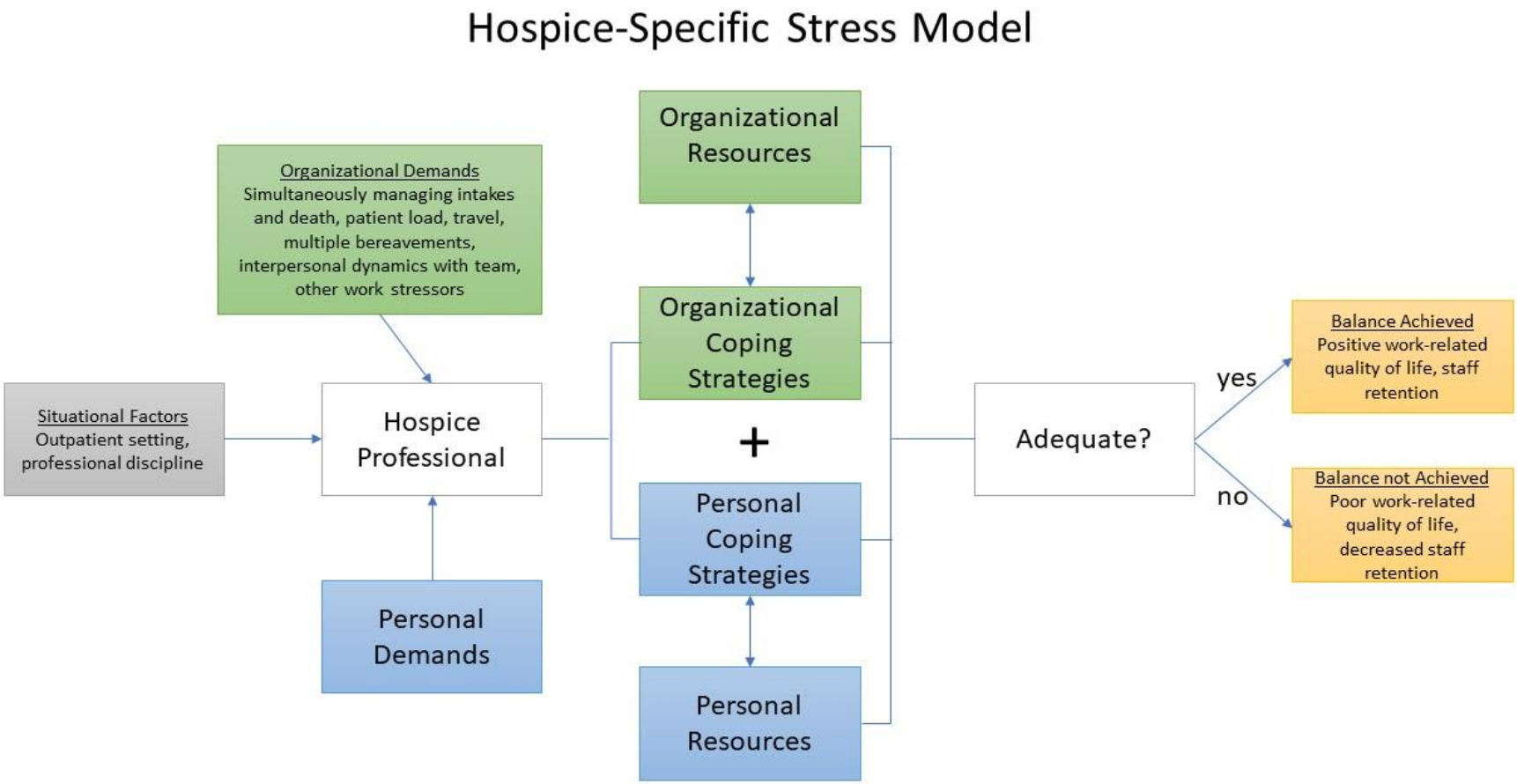

Figure 1: Graphic Depiction of the Hospice-Specific Stress Model. Adapted from Harris, L.J. (2012). Ways of coping, understanding workplace stress and coping mechanisms for hospice nurses (Doctoral dissertation). Retrieved from http://d-scholarship.pitt.edu/17134/1/LHarrisDissertation_011613_FINAL.pdf. Adapted from original work, DiTullio, M., & MacDonald, D. (1999). The struggle for the soul of hospice: Stress, coping, and change among hospice workers. *American Journal of Hospice and Palliative Care, 16*(5), 641-655.

Tables

Table 1

Sample Characteristics

N = 35	**N (%)**
Age (N = 35)	
25-28	1 (2.9%)
29-32	6 (17.2)
33-36	1 (2.9%)
37-40	7 (20%)
41-44	3 (8.6%)
45-48	1 (2.9%)
49-52	4 (11.5%)
53-56	1 (2.9%)
57-60	3 (8.6%)
61-64	3 (8.6%)
65-68	5 (14.3%)
Gender (N = 35)	
Female	28 (80%)
Male	6 (17.1%)
Other	1 (2.9%)
Race/Ethnicity (N = 35)	
African American	1 (2.9%)
Caucasian	33 (94.3%)
Hispanic/Latino	1 (2.9%)
Professional Discipline (n = 33)	
Chaplain	6 (17.1%)
Hospice Aid	4 (11.4%)
Nurse	14 (40%)
Physician	1 (2.9%)
Social Worker	8 (22.9%)
Years Worked for the Hospice (N = 35)	
< 1	6 (17.1%)
1-2	6 (17.1%)
3-5	13 (37.1%)
6-10	7 (20%)
11-20	3 (8.6%)
Outpatient Team (n = 32)	

Team A	8 (22.9%)
Team B	5 (14.3%)
Team C	7 (20%)
Team D	4 (11.4%)
Team E	8 (22.9%)

Table 2

Stressors/Team Support/Communication

N = 35	**n (%)**
Primary Work Stressors	
Simultaneously Managing Intakes and Deaths	15 (42.9%)
Patient Load	12 (34.3%)
Travel	4 (11.4%)
Multiple Bereavements	2 (5.7%)
Interpersonal Dynamics with Team	2 (5.7%)
You rely on team to process emotional stress of your work	
Always or Sometimes	31 (88.6%)
Never	4 (11.4%)
Team members rely on you to process emotional stress of their work	
Always or Sometimes	32 (91.4%)
Never	3 (8.6%)
Team members rely on one another to process emotional stress of their work	
Always or Sometimes	34 (97.2%)
Never	1 (2.9%)
Do you believe your habits of processing the emotional stress of your work are healthy?	
Somewhat or Very Healthy	25 (71.4%)
Unhealthy or Toxic	10 (28.6%)
Do you believe your team's habits of processing the emotional stress of work are healthy?	
Somewhat or Very Healthy	28 (80%)
Unhealthy or Toxic	7 (20%)
Primary mode of communication with team members to process work stress	
In person conversations	11 (31.4%)
Phone	16 (45.7%)
Text	5 (14.3%)
Email	3 (8.6%)

How often over the course of a week do you communicate with other team members to process work stress?	
Less than 1 time	5 (14.3%)
1-2 times	10 (28.6%)
3-5 times	12 (34.3%)
6-10 times	6 (17.1%)
Greater than 10 times	2 (5.7%)

Table 3

Adaptive Coping Reponses								
	Acceptance	Religion	Positive Reframing	Use of Emotional Support	Humor	Planning	Use of Instrumental Support	Active Coping
N	35	35	35	35	35	35	35	35
Mean	6.23	6.06	5.94	5.94	5.57	5.54	5.26	5.20
Std. Error of Mean	.217	.323	.221	.287	.313	.260	.288	.249
Mode	6	8	6	8	8	6	6	5
Std. Deviation	1.285	1.909	1.305	1.697	1.852	1.540	1.704	1.471
Variance	1.652	3.644	1.703	2.879	3.429	2.373	2.903	2.165
Skewness	-.983	-.759	-.141	-.365	.057	-.341	-.087	-.073
Std. Error of Skewness	.398	.398	.398	.398	.398	.398	.398	.398
Kurtosis	2.341	-.418	-.444	-.799	-1.274	-.317	-.619	-.384
Std. Error of Kurtosis	.778	.778	.778	.778	.778	.778	.778	.778
Minimum	2	2	2	2	2	2	2	2
Maximum	8	8	8	8	8	8	8	8

Maladaptive Coping Responses						
	Self-Distraction	Self-Blame	Venting	Denial	Behavioral Disengagement	Substance Use
N	35	35	35	35	35	35
Mean	4.94	4.69	4.63	3.63	2.77	2.60
Std. Error of Mean	.278	.277	.232	.197	.184	.184
Mode	5	5	4	3	2	2
Std. Deviation	1.644	1.641	1.374	1.165	1.087	1.090
Variance	2.703	2.692	1.887	1.358	1.182	1.188
Skewness	-.156	.539	.798	.320	1.359	1.607
Std. Error of Skewness	.398	.398	.398	.398	.398	.398
Kurtosis	-.223	-.300	-.154	-.767	1.152	1.614
Std. Error of Kurtosis	.778	.778	.778	.778	.778	.778
Minimum	2	2	2	2	2	2
Maximum	8	8	8	8	8	8

Table 4

WRQoL Scores

	GWB	HWI	JCS	CAW	WCS	SAW	Full Scale WRQoL
N	35	35	35	35	35	35	35
Mean	22.97	11.83	23.40	10	12.06	5.63	85.89
Std. Error of Mean	.690	.435	.657	.420	.281	.336	2.206
Mode	24	12a	26	11	12	4	87
Std. Deviation	4.084	2.572	3.890	2.485	1.662	1.987	13.054
Variance	16.676	6.617	15.129	6.176	2.761	3.946	170.398
Skewness	-.660	-.458	-.629	-.402	-.218	.073	-.742
Std. Error of Skewness	.398	.398	.398	.398	.398	.398	.398
Kurtosis	.819	-.579	-.227	.607	-.120	-.890	.734
Std. Error of Kurtosis	.778	.778	.778	.778	.778	.778	.778
Range	19	9	15	12	8	7	60
Minimum	11	6	15	3	8	2	49
Maximum	30	15	30	15	15	9	109

a. Multiple modes exist. The smallest value is shown.

Appendix A

Email Invitation:

Dear Hospice Team,

My name is Elyse Collier and I'm writing to invite you to participate in a project that is part of my research in the Doctor of Nursing Practice program at Belmont University.

My project explores how the stress of providing hospice care influences coping behaviors and your work-life balance as hospice care professionals. You are eligible to complete this survey if you are a physician, nurse practitioner, nurse, hospice aid, chaplain or social worker on one of the hospice's five outpatient hospice care teams. You can access my survey through the link below. It should take no more than 15 minutes of your time.

Your participation is voluntary, and all your responses will be anonymous. Feel free to contact me at elyse.collier@pop.belmont.edu or 615-337-9604 if you have questions. My faculty advisor is Dr. Elizabeth Morse, DNP, MPH.

Thank you for your time!

Elyse Collier

Impact of Coping Responses on Work-Related Quality of Life of Outpatient Interdisciplinary Hospice Care Professionals: A Survey

Thank you for participating in this study. The more we understand coping strategies among hospice staff, the better we can support staff wellness and a healthy work environment.

Your participation is voluntary, and all your responses will be anonymous. Results of the study will be shared with the Hospice's leadership team in aggregate format only and cannot be traced to you. Please respond to all items in the survey. Your consent to participate is implied by your completion of the online survey.

Thank you for your participation!
Elyse Collier

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1. Gender

- ○ Male
- ○ Female
- ○ Other

---

2. What is your age in years?

_____

---

3. Race/Ethnicity

- ○ African American
- ○ American Indian/Alaska Native
- ○ Asian
- ○ Caucasian
- ○ Hispanic/Latino
- ○ Non-Hispanic/Latino
- ○ Native Hawaiian/Pacific Islander
- ○ Other (please specify) _____

Page Break

4. Professional Discipline

- ○ Chaplain
- ○ Hospice Aid
- ○ Nurse
- ○ Nurse Practitioner
- ○ Physician
- ○ Social Worker

What is your current patient load?

_____

---

5. Years worked for the hospice

- ○ < 1
- ○ 1-2
- ○ 3-5
- ○ 6-10
- ○ 11-20
- ○ > 20

---

6. Outpatient Team

- 1
- 2
- 3
- 4
- 5

Page Break

The following items are an assessment of the quality of your work life. Please select the response that best fits with your current work life.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have a clear set of goals and aims to enable me to do my job.	○	○	○	○	○
I feel able to voice opinions and influence changes in my area of work.	○	○	○	○	○
I have the opportunity to use my abilities at work.	○	○	○	○	○
I feel well at the moment.	○	○	○	○	○
My employer provides adequate facilities and flexibility for me to fit work in around my personal life.	○	○	○	○	○
My current working hours/patterns suit my personal circumstances.	○	○	○	○	○
I often feel under pressure at work.	○	○	○	○	○
When I have done a good job it is acknowledged by my supervisor.	○	○	○	○	○

Recently, I have been feeling unhappy and depressed.	○	○	○	○	○
I am satisfied with my life.	○	○	○	○	○
I am encouraged to develop new skills.	○	○	○	○	○
I am involved in decisions that affect me in my own area of work.	○	○	○	○	○
My employer provides me with what I need to do my job effectively.	○	○	○	○	○
My employer actively promotes flexible working hours/patterns.	○	○	○	○	○
In most ways my life is close to ideal.	○	○	○	○	○
I work in a safe environment.	○	○	○	○	○
Generally things work out well for me.	○	○	○	○	○
I am satisfied with the career opportunities available for me here.	○	○	○	○	○

I often feel excessive levels of stress at work.	○	○	○	○	○
I am satisfied with the training I receive in order to perform my present job.	○	○	○	○	○
Recently, I have been feeling reasonably happy all things considered.	○	○	○	○	○
The working conditions are satisfactory.	○	○	○	○	○
I am involved in decisions that affect members of the public in my own area of work.	○	○	○	○	○
I am satisfied with the overall quality of my working life.	○	○	○	○	○

Page Break

We recognize there are multiple stressors in your role as a hospice professional. Which of the following is your greatest work stressor?

- ○ Simultaneously managing intakes and deaths
- ○ Patient Load
- ○ Travel
- ○ Multiple Bereavements
- ○ Interpersonal dynamics with team

Please share any details you can offer about the specific nature of your work stress.

_____

_____

_____

_____

_____

Page Break

Please answer the following questions with your greatest work stressor in mind.

	Not at all	A little bit	A medium amount	A lot
I've turned to other activities to take my mind off hospice work.	○	○	○	○
I've concentrated on doing something about the amount of stress related to hospice work.	○	○	○	○
I've denied the amount of stress in hospice work.	○	○	○	○
I've used alcohol or other drugs to make myself feel better.	○	○	○	○
I've received emotional support from others.	○	○	○	○
I've given up trying to deal with the stress I feel from hospice work.	○	○	○	○
I've taken action to try to improve my work stress.	○	○	○	○
I've refused to accept the stress of hospice work.	○	○	○	○
I've said things to let my unpleasant feelings escape.	○	○	○	○
I've received help and advice from other people.	○	○	○	○

I've used alcohol or other drugs to help me get through the stress of hospice work.	○	○	○	○
I've tried to see the stress of hospice work in a different light, to make the stress seem more positive.	○	○	○	○
I've criticized myself.	○	○	○	○
I've tried to come up with a strategy about how to cope with the stress of hospice work.	○	○	○	○
I've received comfort and understanding from someone.	○	○	○	○
I've given up the attempt to cope with the stress of hospice work.	○	○	○	○
I've looked for something good in what is happening.	○	○	○	○
I've joked about the stress of hospice work.	○	○	○	○
I go to movies, watch TV, read, daydream, sleep, or shop to avoid thinking about the stress of hospice work.	○	○	○	○
I've accepted the reality that hospice work is stressful.	○	○	○	○

I've expressed my negative feelings about the stress of hospice work.	○	○	○	○
I've tried to find comfort in my religion or spiritual beliefs.	○	○	○	○
I've tried to get advice or help from other people about how to manage my stress.	○	○	○	○
I've learned to live with work stress.	○	○	○	○
I've thought hard about what steps to take to change my work stress.	○	○	○	○
I've blamed myself for the work stress.	○	○	○	○
I've prayed or meditated.	○	○	○	○
I've made fun of the stress of hospice work.	○	○	○	○

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To what extent do you rely on your team to process the emotional stress of your work?

- ○ Always
- ○ Sometimes
- ○ Never

Do you believe your habits of processing the emotional stress of your work are healthy?

- Very healthy
- Somewhat healthy
- Neutral
- Somewhat unhealthy
- Toxic

Page Break

To what extent do you feel members of your team rely on you to process the emotional stress of their work?

- Always
- Sometimes
- Never

To what extent do you feel members of your team rely on one another to process the emotional stress of their work?

- Always
- Sometimes
- Never

Do you believe your team's habits of processing the emotional stress of work are healthy?

- ○ Very healthy
- ○ Somewhat healthy
- ○ Neutral
- ○ Somewhat unhealthy
- ○ Toxic

Page Break

What is your primary mode of communication with other team members to process work stress?

- ○ In person conversations
- ○ Phone
- ○ Text
- ○ Email
- ○ Other (please specify) _____

How often over the course of a week do you communicate with other team members to process work stress?

- ○ Less than 1 time
- ○ 1-2 times
- ○ 3-5 times
- ○ 6-10 times
- ○ Greater than 10 times

Page Break

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We have hundreds of researchers who use our WRQoL scale each year. The WRQoL scale is free to use provided you agree to the following two conditions.

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2. You agree to **email** any WRQoL data (**in this format**) to us. We will add these data to our International database and use them only for the purpose of further validating the WRQoL scale (e.g. updating norms, creating benchmark datasets).

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