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Debriefing Among Hospice Professionals During a Pandemic

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Abstract

Background: Because hospice professionals are repeatedly exposed to death, they are at a higher risk of developing compassion fatigue (Alkema et al., 2008). Over time, compassion fatigue may result in burnout, potentially causing a depletion of professionals in the hospice field (Gallagher, 2013; Haddad & Toney-Butler, 2020). While the hospice industry cannot afford to lose professionals to burnout, stress from a rapidly growing elderly population and work challenges related to the COVID-19 pandemic potentially place hospice professionals at an increased risk. Reflective debriefing has been recommended to provide emotional support to battle job dissatisfaction, compassion fatigue, and burnout (McIntosh, 2019). **Purpose:** The purpose of this study was to provide reflective debriefing sessions to hospice professionals and identify common themes reported about their professional and personal experiences during the COVID-19 pandemic. **Methods:** A qualitative descriptive design using focus groups set up as reflective debriefing sessions based on the Gibbs' Reflective Cycle was chosen. The Compassion Satisfaction-Compassion Fatigue (CS-CF) theory served as the theoretical model. Debriefing sessions were recorded and transcribed for open-coding line-by-line and incident-to-incident coding, followed by identification of themes. Participants were sent a post survey about demographics and the debriefing experience. **Results:** A total of 26 themes emerged from the data collected from the debriefing sessions. Themes that occurred more than once included, work alterations, challenges, emotion, infection control procedures, patient care, and positives from COVID-19. 96.0% ($n = 24$) of participants found the debriefing session helpful. 92.3% ($n = 24$) of participants answered that they would like to regularly debrief at their workplace. **Conclusion:** Many factors place hospice professionals at risk for compassion fatigue and burnout. During the pandemic, they are at an increased risk of compassion fatigue and burnout from changes in the

work, patient, and person environments caused by the pandemic. Findings suggested that questions asked about the pandemic in the form of a debriefing session were helpful to hospice professionals. To address the unprecedented challenges hospice professionals are facing, it is imperative that employers provide them with emotional support.

Keywords: hospice, debriefing, compassion fatigue, pandemic, COVID-19, Gibbs' Reflective Cycle, Compassion Satisfaction-Compassion Fatigue Theory, qualitative

Introduction and Background

In 2016, the CDC reported 4,300 hospice care agencies in the United States (U.S.) with 1.4 million hospice patients (Harris-Kojetin et al., 2019). Today, the hospice care team includes a range of professionals: nurses, therapists, hospice aids, spiritual and bereavement counselors or chaplains, social workers, counselors, and physicians (National Hospice and Palliative Care Organization, 2019). These hospice professionals see death on a daily basis, providing support for patients in the end-of-life stage (Alkema et al., 2008). While hospice can be rewarding work, it can also be challenging, placing hospice professionals at risk for compassion fatigue (Gallagher, 2013; Sardiwalla et al., 2007).

Compassion fatigue results from chronic stress and is the emotional withdrawal of those caring for suffering people over an extended period of time (Cocker & Joss, 2016; Merriam-Webster, n.d.). Compassion fatigue may compromise medical professionals' ability to appropriately care for their patients (Gallagher, 2013). Over time, compassion fatigue may result in burnout, potentially causing a depletion of professionals in the hospice field (Gallagher, 2013; Haddad & Toney-Butler, 2020). While the hospice industry cannot afford to lose professionals to burnout, stress from a rapidly growing elderly population and work challenges related to the COVID-19 pandemic potentially place hospice professionals at an increased risk.

Because the entire baby boomer population is not expected to reach total retirement age until 2029, the older population is suspected to increase by 73% (Haddad & Toney-Butler, 2020). In 2011, there were already 41 million people aged 65 years and older (Haddad & Toney-Butler, 2020). Since then, the number has increased by 30 million due to the baby boomer generation being the largest older adult population ever recorded in U.S. history (Haddad & Toney-Butler, 2020). Because the majority of long-term care patients 65 years and older are

hospice patients, the increased number of elderly patients has the potential to increase the stress and workload of hospice collaborative team members (Harris-Kojetin et al., 2019). Already from 1990 to 2013, the number of people receiving hospice services increased more than seven times (Green, 2015). Currently, for every 100,000 adults aged 65 years and older, the U.S. has only 13.4 hospice and palliative care experts (Parker, 2019). Hospice is even experiencing a shortage in chaplains, nurses, and social workers (Parker, 2019). Since March 2020, increasing numbers of hospice professionals are leaving their jobs due to COVID-19 (Manisero, 2020).

COVID-19, also known as the coronavirus, was declared a pandemic by the World Health Organization in March of 2020 (World Health Organization, 2020). The risk of developing severe respiratory illness and being hospitalized with COVID-19 increases with age, and therefore, older hospice patients are vulnerable (CDC, 2020a; Vitetta et al., 2001). In the U.S., eight out of 10 reported COVID-19 related deaths occur in the older adult population, aged 65 years and older, putting hospice patients at a higher risk (CDC, 2020a). Because of COVID-19 surges and an overwhelming demand for hospice care, there have been reports of delayed hospice care or lack of access to hospice care (Abbott et al., 2020)

Prior to the COVID-19 pandemic, 35-60% of U.S. nurses, physicians, medical students, and residents reported significant symptoms of burnout across all clinical disciplines and care settings (National Academy of Medicine, 2019). Now, in the face of a global public health emergency, healthcare workers are facing unprecedented challenges that are taking a toll on their well-being, accelerating burnout (National Academy of Medicine, 2020; Sinclair, 2020). Factors contributing to the acceleration of burnout include the following: emotional strain and physical exhaustion, shortages of personal protective equipment (PPE), fear of COVID-19 exposure, fear of infecting family members, and limited access to services for managing anxiety and

psychological distress (Ayanian, 2020). Hospice professionals face many challenges due to the COVID-19 pandemic, restrictive visitation policies, patient isolation, and an increase in workload (Abbott et al., 2020; Kates et al., 2020). Because of the current challenges caused by the COVID-19 pandemic, it is important for hospice professionals to be able to cope effectively to combat job stress, compassion fatigue, and burnout.

It is important to identify ways to overcome the potential effects of psychological distress that hospice professionals are experiencing as a result of the pandemic (Kates et al., 2020).

Reflective debriefing has been recommended to provide emotional support to battle job dissatisfaction, compassion fatigue, and burnout (McIntosh, 2019). Huggard (2013) argues that debriefing is vital for staff support for those in the hospice field because it provides a way to reflect on events, difficult situations, or deaths to help those involved cope more effectively. Debriefing involves hearing other professionals' perspectives to aid in peer support and communication (Huggard, 2013). Because of the potential for devastating psychological stress, evidence suggests that employers need to be proactive in providing support for stress during the pandemic (Kates et al., 2020; National Center for PTSD, 2020).

Problem Statement

During the COVID-19 pandemic, healthcare workers are facing unprecedented challenges, which may lead to mental health issues, compassion fatigue, and burnout. It is important to understand and learn from the personal and professional experiences of hospice workers during the COVID-19 pandemic because they are frontline workers providing care for vulnerable populations. Because current evidence on hospice workers' experiences is limited, information learned could lead to better understanding of ways to support these workers and their patients. Debriefing has been recommended to address mental health issues and increase staff

support during the pandemic (Nelson & Lee-Winn, 2020). Even prior to the pandemic, literature proposed that debriefing is beneficial to hospice professionals, but few studies have examined reflective debriefing in this population (Harder et al., 2020). Although it is recommended, no current studies evaluate debriefing sessions among hospice professionals during the COVID-19 pandemic, making this scholarly project timely and important.

Purpose

The purpose of this Doctor of Nursing Practice scholarly project was to provide reflective debriefing sessions to hospice professionals and identify common themes reported by hospice professionals about their professional and personal experiences during the COVID-19 pandemic.

Review of Evidence

Compassion Fatigue Among Hospice Professionals

The term compassion fatigue was first used in 1983 by Figley who defined it as a “stage of tension and preoccupation with the cumulative impact of caring” (p. 10). Pfifferling and Gilley (2000) more recently defined compassion fatigue as “a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain” (p. 39). This all-encompassing exhaustion has been known to result in biological, physical, social, spiritual, and psychological problems, which can affect individuals on a personal and professional level (Cross, 2019; Lehto et al., 2018; Melvin, 2015; Pelon, 2017). Alkema et al. (2008) explained that compassion fatigue is the ultimate result of showing compassion over a long period of time, and showing compassion was described as a fundamental element of hospice work.

Hospice professionals are repeatedly exposed to death, grieving families, patients in pain, and personal grief (Alkema et al., 2008). Continually serving patients and their families in these stressful situations has placed hospice professionals at a higher risk of developing compassion

fatigue than those from other helping professions (Alkema et al., 2008). In a study by Melvin (2012), all participants working in hospice and palliative care for over 10 years reported experiencing symptoms of compassion fatigue at some point in their careers. Participants also reported that working in hospice and palliative care involves physical and emotional costs. Another study found that a significant portion of hospice workers reported moderate-to-severe symptoms of compassion fatigue including depression and anxiety, which placed a significant portion of hospice workers at risk for burnout (Whitebird et al., 2013).

Authors recognized burnout as a possible result from compassion fatigue, and symptoms can include the following: exhaustion, job ineffectiveness, dissatisfaction with work, depersonalization, and a loss of caring about work-related issues, making it more likely for clinical errors and patient dissatisfaction (Alkema et al., 2008; Gallagher, 2013). In addition, compassion fatigue caused difficulty sleeping, intrusive thoughts and images, depression, and anxiety (Alkema et al., 2008). Compassion fatigue was identified as a cause for decreased quality of patient care and for professionals leaving the hospice field (Alkema et al., 2008; Melvin, 2012).

Hospice Challenges During COVID-19

Due to the newness of the current pandemic, the majority of information regarding hospice challenges during the COVID-19 pandemic are from expert opinions and recommendations. Very few peer-reviewed articles have been found.

The foundation of hospice care promotes closeness, comfort, and touch for those reaching the end of their lives, all of which are restricted during the COVID-19 pandemic (Birnstengel, 2020). To prevent the spread of COVID-19, hospice professionals are required to increase protective procedures, such as masks, gloves, and distance, and decrease patient visitations,

which has placed a strain on hospice personnel (Birnstengel, 2020). There has also been a shortage of the PPE required by healthcare professionals, which has caused ethical dilemmas (Brown, 2020). Without adequate PPE, healthcare workers question their moral obligation to continue to provide patient care or choose to reuse PPE for as long as they possibly can (Brown, 2020). The PPE shortage endangers the safety of hospice staff and patients (Thornberry LTD, 2020).

Before the COVID-19 pandemic, Kamal et al. (2019) found that one-third of palliative and hospice professionals experienced burnout and projected that there would not be enough physicians in the field by year 2045. Experts report that COVID-19 is accelerating burnout (Nelson & Lee-Winn, 2020; Sinclair, 2020). The hospice workforce is experiencing a strain due to increased services at an extraordinary rate because of the pandemic (Kates et al., 2020). Not only did Kates et al. (2020) find that hospice professionals are having an increase in workload, but respondents also reported reduced staffing and psychological distress due to the pandemic (Kates et al., 2020). There could potentially be devastating psychological long-term effects of the pandemic on hospice professionals (Kates et al., 2020). Current literature has limited clinical research to explain specific factors contributing to pandemic-related burnout or to suggest helpful methods for mitigating these problems.

Debriefing

Debriefing was recommended to identify stressors, provide emotional support, and increase support among workers during the pandemic (CDC, 2020b; Nelson & Lee-Winn, 2020). Given that physical distancing is required during the pandemic, debriefing can occur remotely and virtually (CDC, 2020b; National Center for PTSD, 2020).

Reflective debriefing was described as a way to talk about a situation, event, or death and may be formal or informal (Huggard, 2013). It was shown to increase communication among different types of professionals involved with patient care (Hockley, 2014). According to Keene et al. (2010) and Rushton et al. (2006), debriefing provided a way for interdisciplinary team members to hear others' perspectives and recognize that emotional responses they experience are normal.

Coping methods, such as debriefing, may be emotion-focused or problem-focused (Dietz, 2009; Huggard, 2013). While emotion-focused debriefing was used to talk about a stressful or traumatic event to reduce psychological harm, problem-focused debriefing was used to talk about an adverse event, what caused the error, and/or the need for policy changes (Huggard, 2013). Sardiwalla et al. (2007) found that problem-focused coping strategies are correlated with higher levels of emotional exhaustion and are less effective than emotion-focused coping strategies when the situation involves illness or death, which is the case for those working in hospice care. Furthermore, Strentz and Auerbach (1988) found that participants given emotion-focused coping techniques reported lower anxiety and emotional distress levels compared to participants given problem-focused techniques. Experts suggested hospice workers would benefit more from emotion-focused coping strategies versus problem-focused strategies (Sardiwalla et al., 2007). Hospice professionals care for dying patients, which may impact them emotionally, and potentially produce negative consequences if not effectively addressed (Eng et al., 2015).

Benefits

Reflective debriefing normalized sharing emotions, improved communication gaps, and increased support for professionals caring for patients in the end-of-life stage (Eng et al., 2015; Hockley, 2014; McIntosh, 2019). Prior to one study, a nurse manager had encouraged a staff

member to seek professional help for unresolved grief but was unsuccessful (Hockley, 2014). However, by participating in the study and attending reflective debriefing groups, the staff member opened up about his grief, encouraging a supportive and communicative environment among team members (Hockley, 2014).

Debriefing attendance was found to have a negative association with posttraumatic stress symptoms (Sattler et al., 2014). In a study by Eng et al. (2015), participants with the highest number of attendance in debriefing sessions had the most improvement in emotional responses. Although Duncan et al. (2018) found that approximately half of participants reported debriefing was available to them in their healthcare field, almost all of the participants reported debriefing would be beneficial. Moreover, the participants who reported debriefing was available to them had lower emotional exhaustion. Participants in another study reported that debriefing helped them cope with dying patients, provided closure, and offered emotional support (Khot et al., 2011).

Receiving emotional support in the work environment was identified as a critical component to building resilience and retaining staff (Cameron & Brownie, 2010). Cameron and Brownie (2010) found that healthcare professionals that are unable to build resilience are more likely to leave their profession. Furthermore, they suggested that validating experiences, defusing stress, and providing emotional support through debriefing promotes resilience in the work environment (Cameron & Brownie, 2010).

Barriers

Providing opportunities for professionals to cope with patients' deaths, such as group debriefing, was described as important, yet deficient in today's healthcare world (Keene et al., 2010). Although debriefing was recommended to fight job dissatisfaction, compassion fatigue,

and burnout, it was often overlooked (McIntosh, 2019; Duncan et al., 2018). Harder et al. (2020) reported there is a lack of evidence-based debriefing frameworks focused on healthcare providers' emotional issues and psychological safety (Harder et al., 2020). Some debriefing models with this focus can be found, however, they were developed in response to a specific need within an organization, making psychologically focused and evidence-based debriefing models uncommon (Harder et al., 2020). Although healthcare professionals expressed desire for debriefing, the lack of reported debriefing in the clinical setting suggested that this need remains unmet (Harder et al., 2020). There is limited literature to suggest why debriefing has not been used, or it is being used but not being reported.

Theoretical Model

The scholarly project utilized Stamm's Compassion Satisfaction-Compassion Fatigue (CS-CF) theory to examine how the three environments of work, patient, and person were affected in hospice workers during the COVID-19 pandemic. According to the CS-CF theory, these three environments promote either compassion satisfaction or compassion fatigue. The theory further explains compassion fatigue's relationship to burnout and work-related trauma (Stamm, 2010). Refer to Figure 1 for a visual depiction of the CS-CF theory.

Environments

The first environment, *work*, includes organizational aspects and work tasks (Stamm, 2010). Hospice professionals take care of dying patients and grieving families in their work environment (Alkema et al., 2008). Continually serving patients and families in these intense situations places hospice professionals at a higher risk for compassion fatigue (Alkema et al., 2008). Compassion satisfaction may be encouraged in the work environment by engaging hospice professionals in work support groups (Alkema et al., 2008).

The *patient* environment pertains to the environment of the person being provided care or assistance (Stamm, 2010). For example, hospice professionals may have to observe patients in extreme pain, a stressor which can promote compassion fatigue (Alkema et al., 2008). However, when hospice professionals recognize the positive impact they have and are able to do their work well, compassion satisfaction is enhanced (Alkema et al., 2008).

Lastly, the *person* environment is the professional's own personal environment that they bring to their work (Stamm, 2010). Hospice professionals may experience personal grief when their patients die, which can contribute to compassion fatigue (Alkema et al., 2008). To increase compassion satisfaction, experts recommend that hospice professionals focus on emotional and spiritual self-care while maintaining a personal and professional balance (Alkema et al., 2008).

Compassion Satisfaction

According to Stamm (2005), compassion satisfaction derives from pleasure felt when able to do one's work. For example, hospice professionals may feel fulfillment from helping others in the end of their lives. Other factors that increase work gratification include how professionals feel about their colleagues, their own ability to impact the work setting, and their contribution to society through their work (Stamm, 2005). When a professional feels compassion satisfaction, they are able to adhere to employer's patient care protocols (Stamm, 2010). They also have a desire to work, and they feel successful (Stamm, 2010). Compassion satisfaction increases the quality of care hospice professionals provide to patients (Alkema et al., 2008). Compassion satisfaction is encouraged when professionals feel support from their fellow colleagues (Merk, 2018). Since debriefing has been identified as a way to increase support for hospice professionals in the work environment, the three environments of the CS-CF theory were

explored through debriefing sessions (Huggard, 2013). While compassion satisfaction is the desired result, compassion fatigue is the undesired result.

Compassion Fatigue

Stamm (2010) describes compassion fatigue as being overwhelmed by work or having fear associated with work (Stamm, 2010). Individuals who become overwhelmed by work exhibit symptoms of burnout, such as exhaustion, frustration, anger, and depression (Stamm, 2010). After experiencing primary or secondary work-related trauma, individuals develop fear associated with their work (Stamm, 2010). Primary trauma occurs when an individual's work puts them directly in the path of danger (Stamm, 2005). For example, being exposed to and/or contracting COVID-19 in the work environment would be primary trauma. A person can experience secondary trauma from exposure to stressful events or trauma that happens to other people (Stamm, 2010). For example, hospice professionals being repeatedly exposed to death as part of their job is considered secondary trauma. According to the CS-CF theory, burnout and work-related trauma can coincide (Stamm, 2010).

Project Design

A qualitative descriptive design using focus groups was chosen to obtain participants' perspectives about how the COVID-19 pandemic affected them professionally and personally. Focus groups consisted of hospice workers and were set up as debriefing sessions to provide support to participants. Using a qualitative approach allowed for concepts to emerge from the data constructed by the participants. The chosen methodology of this scholarly project allowed for exploration of the inner experiences of participants within the context of the COVID-19 pandemic, an area not yet thoroughly explored. This scholarly project was approved by the Belmont University Institutional Review Board as Exempt.

Clinical Setting

Participants were employed by a nonprofit hospice organization that offers five levels of hospice care, routine care, respite care, general inpatient care, continuous care, and residential care (Alive Hospice, n.d.-b; Alive Hospice, n.d.-a). The hospice organization currently serves 12 counties across the state of Tennessee, including Davidson county, the state's county with the second highest number of COVID-19 cases (Organizational Representative, personal communication, 2020; TN Department of Health, 2021). The hospice organization currently has five outpatient units located in Nashville, Murfreesboro, Lebanon, Franklin, and Hendersonville (Organizational Representative, personal communication, 2020). In 2018, professionals working at the hospice organization provided care for approximately 4,000 patients reaching the end of their lives (Alive Hospice, 2019).

Project Population

The scholarly project's population included hospice workers with different roles, so that data would consist of a more widespread representation of those involved with direct patient care. Roles included the following: nurses, chaplains, providers, social workers, hospice aids, and directors. Participants were employed in one of the organization's five outpatient units. Other inclusion criteria for participants included English-speaking, at least 18 years of age, involved in direct patient care, and access to Zoom online. Exclusion criteria for participants included non-English speaking, younger than 18 years of age, not currently employed at the organization in the outpatient setting, not involved in direct patient care, or unable to access Zoom online. Directors were excluded from the debriefing sessions for the outpatient units but were included in a debriefing session for directors only. The incentive to participate included payment by means of the participants' employer for their time spent participating in the study.

An implied consent form was electronically sent to participants and also read aloud to them before each debriefing session. The implied consent form explained the project's purpose, risks, benefits, the voluntary nature of their participation, and that by participating they were implying their consent (See Appendix B).

Hospice professionals with direct patient care roles working in outpatient units were chosen because of their involvement with dying patients during the COVID-19 pandemic. Their perspectives offered real-time data on a topic not thoroughly explored. Participants were chosen based on their availability and accessibility, thus utilizing convenience sampling. The types of professional roles included were chosen based on their involvement in direct patient care and their ability to represent hospice professionals, thus utilizing purposive sampling.

Data Collection Instruments

During the debriefing sessions, participants were asked about the effects of the COVID-19 pandemic on their professional and personal lives. These questions were formed using the Gibbs' Reflective Cycle as a reflective debriefing framework. The Gibbs' Reflective Cycle has been used to practice and teach critical reflection skills and has been influential among health care professionals (Gibbs, 2013). The cycle includes six stages, which were used to form six categories of debriefing questions: description, feelings, evaluation, analysis, conclusion, and action plan. *Description* explains what happened during the experience (Gibbs, 2013). *Feelings* describes what the individual felt during the experience (Gibbs, 2013). *Evaluation* answers what was good and bad about the experience (Gibbs, 2013). *Analysis* depicts what sense an individual can make of the experience (Gibbs, 2013). *Conclusion* explains what can be deducted from the experience (Gibbs, 2013). Lastly, *action plan* describes what steps an individual can take moving forward (Gibbs, 2013). While answering questions, participants were permitted to bring up and

discuss patient cases as they wish. See Table 1 for the categories and questions asked during the debriefing sessions.

Data Collection Process

Participants were initially informed of the scholarly project by their unit directors, followed by an introduction to the primary researcher via email. The primary researcher then sent an email to all potential participants that included an explanation of the study and implied consent, incentive, dates of the debriefing sessions, and Zoom links. Eight debriefing sessions took place for the five outpatient units and the directors virtually via Zoom (n.d.), a communications technology platform, during the months of October and November of 2020. Debriefing sessions were recorded through Zoom and lasted approximately 15 minutes to 1 hour. During the debriefing sessions, the primary researcher asked structured questions and then allowed participants to engage in open discussion. After each debriefing session, participants were sent a link through Zoom to an online survey platform, Qualtrics (n.d.), where participants provided deidentified information on demographic characteristics and their debriefing experience (See Appendix C). Prior to the beginning of recordings, participants were given the option to turn their camera off and participate only audibly, and their Zoom display names were replaced with a coded alias to increase confidentiality. The recordings of the debriefing sessions were transcribed to typed documents and saved as encrypted files on the researcher's password protected computer. After the completion of transcriptions, recordings were deleted.

Data Analysis

Prior to data collection, a bracketing interview was completed to identify any biases of the researcher. During data collection, field notes were taken to keep a record of observations. Data analysis began with open-coding line by line to delineate concepts for interpreted data.

Next, incident-to-incident coding took place to compare and contrast pieces of data. Coding was completed by two researchers to enhance rigor. Themes were then identified and explained through their properties and dimensions. Properties are “characteristics that define and describe concepts” (Corbin & Strauss, 2015, p. 220). Dimensions are “variations within properties” (Corbin & Strauss, 2015, p. 220). To preserve rigor, memos and audit trails were kept as the coding process took place to provide written records of the analysis. Memos and audit trails are available upon request.

The post-debriefing survey consisted of nine questions, eight of which were analyzed by descriptive statistics. The remaining question asked participants why or why not they found the debriefing session helpful. The question allowed for participants to answer openly, and it was coded like the other qualitative data.

Results

Participant Demographics

A total of 29 hospice professionals ($N = 29$) participated in the debriefing sessions. Of these 29 participants, a total of 26 participants ($n = 26$) completed the post survey. Survey data showed that 96.2% ($n = 25$) of participants were women and 3.9% ($n = 1$) were male. A total of 15.4% ($n = 4$) of participants were aged 18-29 years, 15.4% ($n = 4$) were aged 30-39 years, 23.1% ($n = 6$) were aged 40-49 years, 34.6% ($n = 9$) were aged 50-59 years, and 11.5% ($n = 3$) were 60 years and older. All participants (100%, $n = 26$) were Caucasian and currently employed at the hospice organization at the time of participation. With 50% ($n = 13$) of participants having worked at the hospice organization for 2 years or less, the remaining 50% had been there 3-5 years (23.1%, $n = 6$), 6-10 years (11.5%, $n = 3$), or 11 years or more (15.4%, $n = 4$). Some participants reported working in more than one location ($n = 28$). A total of 39.3% ($n = 11$) of

participants reported working in Nashville, 10.7% ($n = 3$) reported working in Murfreesboro, 7.1% ($n = 2$) reported working in Lebanon, 17.9% ($n = 5$) reported working in Franklin, and 25.0% ($n = 7$) reported working in Hendersonville. The project's population included participants from a variety of disciplines. The population was made up of 38.5% ($n = 10$) nurses, 15.4% ($n = 4$) chaplains, 23.1% ($n = 6$) social workers, 15.4% ($n = 4$) directors, and 7.7% ($n = 2$) "other". The "other" category included a hospice consultant ($n = 1$) and a volunteer coordinator ($n = 1$). See Table 2 for participant demographics.

Debriefing Session

Out of the 26 participants who completed the post survey, 25 answered the following question, "Did you find today's debriefing session helpful?" 96.0% ($n = 24$) answered "yes," while 4.0% ($n = 1$) answered "no." The participant who answered "no" explained under the question, "Why or why not?" and stated, "It was geared toward clinical staff and not those who are not providing different services." Of the 24 participants who answered "yes," 10 did not explain why they found it helpful. Of the 14 who explained why they found the debriefing session helpful, the following properties of debriefing helpfulness were identified: talking about situation, connection, and therapeutic. The property of talking about situation were given the following dimensions: with colleagues, do not feel alone, viewpoint of others, emotions versus "the daily business," and situation versus patients. The properties of connection and therapeutic were not given dimensions. Lastly, 92.3% ($n = 24$) of participants answered "yes," they would like to regularly debrief at their hospice organization, and 7.7% ($n = 2$) answered "no."

Qualitative Results

This scholarly project produced valuable qualitative data of hospice professionals' perspectives on how the COVID-19 pandemic has affected their personal and professional lives.

The six domains of the Gibbs' Reflective Cycle were used as an outline for debriefing questions and organization of data (See Figure 2). Themes that emerged from the data according to the six domains of the Gibbs' Reflective Cycle were identified and are illustrated in a thematic diagram (See Figure 3). To maintain integrity of results and to show how themes emerged in response to structured debriefing questions, some themes may appear in more than one domain. A total of 26 themes were identified and explained through their properties and dimensions. Properties and dimensions of each theme are included in list form (See Appendix D).

Seven themes emerged from the *Description* domain and include the following: work alterations, challenges, emotion, infection control procedures, patient care, decreased interaction, and coping strategies. The *Feelings* domain revealed seven themes, including the following: emotion, challenges, patient care, positives from COVID-19, work alterations, infection control procedures, and interaction. Two themes emerged from the *Evaluation* domain, distressing factors and positives from COVID-19. The *Analysis* domain revealed three themes, self-care, patient care, and directors. Four themes emerged from the *Conclusion* domain and include the following: preparation for pandemic, learned weakness and strength, realizations, and learned needs. Two themes emerged from the *Action Plan* domain, received support and needed resources. Lastly, the *Closing Thoughts* domain revealed one theme, emotion.

Description: Theme 1: Work Alterations

Work alterations emerged from the data within the *Description* domain. First, working remotely and/or completing patient visits by telehealth was identified. Data revealed that working remotely caused decreased motivation, decreased productivity, and decreased self confidence. "Frequent policy changes" were noted along with a difference in facility protocols. These facilities are where hospice professionals routinely visit to provide patient care.

A work alteration identified for hospice nurses was a lack of support from other team members, such as social workers and chaplains, for in-person patient care. One participant revealed, "...the nurse is sort of the solo warrior on the frontline without a lot of interpersonal support from their team members..." Because of this lack of support, data suggested that hospice nurses' responsibilities have increased. However, not all work alterations were perceived as negative. Because of the pandemic, a director reported a change in perspective for her team's personal challenges they may be experiencing.

Description: Theme 2: Challenges

Data suggested participants encountered multiple challenges professionally and personally. Data suggested an internal challenge existed between caring for patients versus caring for self with one participant stating, "There's a conflict between trying to help people and save yourself."

Workplace challenges involving COVID-19 guidelines were identified in the data. It was revealed that it was difficult to enforce COVID-19 guidelines (e.g. social distancing) when families were in grief. Another challenge described in the workplace involved end-of-life care. Because of the physical barriers required by the pandemic, hospice professionals feel as though they are unable to show love and compassion in the manner they normally would to patients in the end-of-life stage. Even when they are present in the room, participants felt that patients are dying alone. Because of all the changes COVID-19 has brought in the workplace, data suggested that the emotional challenges are harder to handle than the physical challenges, specifically for nurses.

Personal challenges emerged from the data as well. When one participant's children contracted COVID-19, data revealed that being a healthcare worker caused family challenges.

She described the conflict of being a hospice professional and taking care of her children, “...because I can’t come in contact with COVID-19 positive person and do my job, I took care of them from afar versus getting to be a mom...” Another personal challenge that data revealed was relationship disturbances due to differences in COVID-19 opinions. Participants disclosed that the pandemic had been damaging to relationships “because not everybody takes it as seriously.”

Description: Theme 3: Emotion

Data revealed participants felt emotionally fragile. Participants described being easily agitated, bothersome, more tearful, and emotionally triggered by small issues. Many different types of emotions also surfaced from the data. Anxiety was felt in personal and professional aspects of participants’ lives. One participant revealed that things she once found enjoyable now provoke anxiety because of COVID-19. Another participant reported “heightened anxiety” associated with patient care and the workplace. The feeling of isolation was also reported in professional and personal aspects. Participants described feeling isolated in the workplace along with feeling isolated from family members and friends.

A fear of COVID-19 also emerged from the data. Specifically, hospice professionals feared being the one to expose patients and family members to the virus. Distress was felt by participants when patients and their family members were non-compliant with COVID-19 guidelines. Another distressing feeling identified was the uncertainty that revolves around COVID-19.

Description: Theme 4: Infection Control Procedures

A theme apparent in the data was infection control procedures due to COVID-19. Participants labeled infection control procedures as inconvenient. Specifically, PPE was noted to

change hospice professionals' self-presentation when providing patient care, and it was identified as a cause of patient confusion.

Description: Theme 5: Patient Care

Barriers to patient care were identified in the data. The first barrier was associated with facility restrictions, which created inefficiency for hospice workers who were not allowed inside, "...it's very difficult to do my job effectively, especially when I spend 45 minutes waiting outside the door of a facility, and then they turn me away. A lot of wasted time, a lot of hardship for the family members." Another barrier to patient care was recognized when a chaplain reported that the decrease in face-to-face visits has reduced the care he can provide for patients. Lastly, when family members were not allowed to see their loved ones, hospice professionals lost the ability to provide them with emotional support.

Data suggested that providing patient care during the pandemic produced secondary trauma exposure for hospice professionals. One participant stated, "...it's really difficult to see the struggle that people are physically going through and the families are mentally and emotionally going through." However, data revealed that participants were not afraid to take care of patients with COVID-19. Data revealed that participants held a responsibility to provide COVID-19 patients with care, but they described providing care for COVID-19 patients as "hard." Chaplains and social workers reported providing COVID-19 patients with indirect care, such as supporting their staff and family members. Patients with COVID-19 were reported to have unchanged comfort measures, however a barrier to closeness with these patients was identified and described, "...the hard part is going in that room and being with a patient who's dying and being disconnected, and that breaks my heart for them."

Description: Theme 6: Decreased Interaction

A decrease in interaction was described between hospice professionals and their families, patients, and families of patients. They expressed a struggle with having a decrease in interaction with coworkers, friends, family members, and patients. Data showed that this was a specific hardship for those in the nursing role.

Description: Theme 7: Coping Strategies

Hospice professionals' coping strategies during the pandemic were found in the data. These included: church, exercise, family, nature, and virtual interaction. It was also found that there were less opportunities for outdoor coping strategies during the winter. Coping strategies were also described as not being fully effective.

Feelings: Theme 8: Emotion

Within the *Feelings* domain, the theme of emotion emerged from the data. A desire for pre-COVID normalcy was strongly prevalent in the data. Participants expressed a longing to “go back to the way things were.” A fear of COVID-19 was also discovered in the data. Participants feared COVID-19 transmission to family members, COVID-19 transmission to other people in general, having personal high risk health, and living with people with high risk health. Therefore, participants felt appreciation for safety precautions put in place by employer during the pandemic.

Feelings: Theme 9: Challenges

A challenge faced by hospice professionals was their perceived increased workload compared to other professions. Hearing about what other people were doing all day while working from home when the pandemic first started was “foreign” to those who felt they were working twice as hard providing patient care. This recognition of non-healthcare workers' pandemic experience also led to an internal conflict. When approached by non-healthcare

workers expressing their fear of going back to work during the pandemic, hospice professionals described being torn between feeling empathetic and frustrated since they have been working to take care of COVID-19 patients. A third challenge hospice professionals encountered was making difficult decisions. These decisions included whether or not they should have family get-togethers or travel to see family they have not been able to see. Multiple participants voiced that they have not seen their families in a year or more.

Feelings: Theme 10: Patient Care

Hospice professionals described patient care of those with COVID-19 as inconvenient, but they were not afraid to provide patient care. Once again, data showed that participants held a responsibility to provide COVID-19 patients with care.

Disturbances in patient care were also identified. One participant felt as though the medical care provided to patients did not change, however the emotional and spiritual care was more distant because of the lack of physical touch. Providing emotional support for patients was revealed as a difficulty for social workers and chaplains, who provide most care via telehealth now, "...you cannot provide that care to the patients, I mean you can't provide emotional support over the phone..."

Another cause of disturbance in patient care was the lack of family support for patients because of facility visitation restrictions. Because families are unable to visit, staff working in facilities were described by a hospice professional as becoming "lackadaisical" and patients were reported to decline in health quickly.

Feelings: Theme 11: Positives from COVID-19

Participants identified positive or beneficial outcomes from the pandemic. One positive result from the pandemic was quality time with family. Data showed that participants felt like

they got to spend more time with family with less distractions. Time spent with family focused around doing something enjoyable versus spending money.

Another beneficial outcome for some participants was working remotely. Working remotely allowed for flexibility to be able to multitask work and home tasks. Telehealth visits also increased efficiency for those who had heavy caseloads. By not having to drive across counties, caseloads were more achievable.

Feelings: Theme 12: Work Alterations

Telehealth was identified as a work alteration. Telehealth was found to be a barrier to communication and connection. Specifically, telehealth visits using iPads were identified as causing a disconnect between hospice professional and patient. Patients were reported to struggle to “control” the iPad. Telehealth visits using the telephone were reported as a barrier because hospice professionals could not see the patient’s facial expressions or affect. One participant reported, “you’re talking to them and you can hear that they’re tearful, but are they just sad, tearful, or are they like emotionally a wreck kind of tear, and sometimes it’s very hard to tell, and they don’t come across sometimes the way that they may actually be feeling, so it’s very hard to do.”

Adjustment to a new normal in the workplace was a concept that emerged from the data. Participants expressed how they adjusted to working from home, providing patient care via telehealth, and implementing in-person patient care with precautions. One participant explained how in the beginning of the pandemic she would not hold dying patients’ hands, but now she will.

Feelings: Theme 13: Infection Control Procedures

Infection control procedures, such as donning and doffing PPE and sanitizing items, were reported as inconvenient. More specifically, PPE was described as a physical and emotional barrier to closeness with patients. One participant stated, "...there's so many barriers in getting to know people in a hospice situation because it's difficult and they're, you know, they're just going through a really difficult time, so it just creates an emotional barrier that's actually physical..."

Feelings: Theme 14: Interaction

Though data suggested a preference for face-to-face interaction versus virtual interaction, hospice professionals reported decreasing their interaction with others out of fear of potentially exposing patients. When considering options for telehealth interactions with patients, telephone visits were preferred over video visits by not only hospice professionals, but also patients and their family members.

Evaluation: Theme 15: Distressing Factors

Within the *Evaluation* domain, the theme of distressing factors emerged from the data. A distressing factor for hospice professionals found in the data was others' non-compliance with COVID-19 guidelines, which included wearing a mask, social distancing, and washing hands. Another concern was the possibility of forced vaccination, "...I've been worried that I'm going to try to be forced to take something that I don't want to take because I don't trust it this soon and quick and it worries me."

Participants also reported being upset by the media's political spin involving COVID-19, along with the media's push for fear revolving around the pandemic. Societal factors were also found to be distressing, such as "societal chaos," judgment, fear, and avoidance, "I just thought we're all being horrible to each other because of this... The thing that's so frightening... the

stress is that people just avoid you all the time as opposed to say hello and good morning kind of stuff...”

Evaluation: Theme 16: Positives from COVID-19

Although there were many distressing factors that emerged from the data, benefits from COVID-19 were also found. Decreased traffic during the pandemic was a prevalent benefit identified in the data. Hospice professionals also recognized that infection control procedures have improved, and they voiced that they feel more prepared for Joint Commission evaluations. Hospice professionals also felt like the public is more aware of cleanliness and illness prevention because of the pandemic.

Analysis: Theme 17: Self-Care

The theme of self-care emerged from the data within the *Analysis* domain. Self-care was found to be difficult to provide or ineffective. Factors that contributed to this were the following: inability to travel, cancelled vacation, increased workload, limited staffing, lack of community, no time, exhaustion, and being an extrovert. Burnout and compassion fatigue were also identified as barriers to self-care, “My compassion fatigue and burnout are increasing every week, and self-care I know is the greatest antidote to that, but it almost seems more difficult to provide it whenever you’re feeling that way.” Although self-care was found to be difficult to provide, multiple methods for providing self-care were identified and included the following: going to church, exercising, gardening, completing housework, spending time in nature, watching Netflix, going on vacation, remodeling the house, and spending quality time with family.

Analysis: Theme 18: Patient Care

Some participants believed they were able to effectively provide patient care. They explained that although patient care has significantly changed, it is still effective. One participant

stated, "...it feels like we're doing the best we can under the circumstances with what we've got," while another one said, "...I always feel like I'm not doing enough..."

Other participants felt that they were not able to provide effective patient care during the pandemic. Contributing factors to ineffective patient care included differences in facility protocols and family revocation of necessary hospice care. Challenges of providing patient care were also identified and revolved around decreased face to face interaction. More specifically, patient care via telehealth posed as a challenge, especially with elderly patients.

Analysis: Theme 19: Directors

Directors reported increased stress related to management responsibilities, which was not expressed by other participants. Because of this management stress, directors reported increased anxiety, increased anger, and decreased sleep. One director reported that whenever her phone rings, she feels immediate anxiety, which triggers anger, "...if my phone rings or vibrates or a text comes through, like it's immediate anxiety, and I like immediately bite off whoever's head is closest to me in my house because I'm like oh gosh what's coming..." Management-related stress was attributed to increased COVID-19 exposures among staff members, which prevents them from working and contributes to staffing shortages.

Conclusion: Theme 20: Preparation for Pandemic

Within the *Conclusion* domain, participants voiced that mentally and emotionally preparing for the pandemic was not possible. One participant described her inability to prepare for the fear caused by the societal chaos that occurred at the beginning of the pandemic. She gave the examples of being unable to find toilet paper and meat at the grocery store. Another participant argued that it was not possible to prepare for the pandemic because experiences and challenges from the pandemic are individualistic and comparable to the personal experiences of

grief. Preparation for the pandemic was compared to preparation for death, something hospice professionals experience everyday. A participant explained how people can know death is coming and try to prepare themselves, but until it actually happens people do not know how it feels. This phenomenon was compared to the pandemic, and how people knew COVID-19 was in other parts of the world and spreading, “but until it actually happens, all of a sudden then you know it’s like oh my gosh, that’s what that feels like...”

Conclusion: Theme 21: Learned Weakness and Strength

Participants expressed that they learned a weakness and strength about themselves through the pandemic. Emotional fragility was evident throughout the data. One participant stated, “I would like to say that I’ve learned that I’m tougher than I thought I was, but I’m not sure that’s the case. I thought that I could handle something like this and not break, but I think my anger proves that I just break in different ways.” Others expressed that a strength they learned about themselves was resilience, “I can do what I need to do, whether I want to or not, whether it’s hard or not.”

Conclusion: Theme 22: Realizations

Participants acknowledged newfound realizations, one being the importance of their role as a hospice professional. One participant said that the public respect towards healthcare workers during the pandemic made her realize that her work as a hospice professional is impactful, and she should be proud. Another one verbalized the new realization that although at times her job seems thankless, she is valued as a hospice professional.

Conclusion: Theme 23: Learned Needs

Participants acknowledged their need for togetherness, community, and connection with people in general and specifically with coworkers. Data revealed that participants preferred face-

to-face interaction over virtual. A need for self-care was also acknowledged, including mental and physical self-care.

Action Plan: Theme 24: Received Support

Throughout the *Action Plan* domain, data revealed that participants felt their employer provided sufficient resources and emotional support. Participants expressed they had adequate PPE and support through frequent team huddles. One participant stated, "... I feel they have done everything they can to put the staff first, and that has allowed me to put the patients first..."

Action Plan: Theme 25: Resource Needs

Data revealed that adequate staffing was a resource need for hospice professionals. Others voiced a need for a plan for togetherness, and a desire for debriefing, "A chance for debriefing, you know, for someone to ask us how we're coping with things..."

Closing Thoughts: Theme 26: Emotion

In the *Closing Thoughts* domain, data revealed further expression of emotions. Participants voiced they felt vulnerable because of the societal mixing of science and politics. One participant described feeling a lack of control during the pandemic, which led to feelings of anger. Lastly, a participant explained that patients' families feel isolated because of facility restrictions, which has placed a strain on hospice professionals to try and provide support for those family members.

Discussion

The primary aim of this scholarly project was to identify common themes reported by hospice professionals about their professional and personal experiences during the COVID-19 pandemic through reflective debriefing sessions. The three environments of work, patient, and person from the CS-CF theory were applied to discuss how each were affected in hospice

workers during the COVID-19 pandemic. Findings about the debriefing session were also discussed. Since current evidence has suggested that hospice professionals are already at an increased risk of developing compassion fatigue, it is important to understand how these three environments were influenced by a new pandemic that has yet to be thoroughly researched (Alkema et al., 2008).

Work Environment

During the COVID-19 pandemic, working remotely and/or providing patient care via telehealth was an important finding among participants. When individuals worked remotely, their work environment imposed on their personal environment. Remote work/telehealth was portrayed in both negative and positive lights. Participants wrestled with enjoying the flexibility and sustainability of an increased workload, which would promote compassion satisfaction. According to Stamm (2005), compassion satisfaction derives from pleasure felt when able to do one's work. On the other hand, participants expressed the struggle of having a "decreased role" due to the inability to provide certain aspects of patient care virtually, such as emotional support. Because providing emotional support is a part of hospice patient care, the inability to do so resulted in compassion fatigue. To echo these findings, Vossel (2020a) reported social workers felt challenged in their role when attempting to understand the emotional, social, psychological, and nonmedical physical needs of patients and their families through telehealth.

Staff working remotely also affected nurses providing in-person patient care. Because chaplains and social workers were encouraged to work remotely, nurses felt as though they lacked support and had an increased workload along with limited staffing. According to the CS-CF theory, a high workload or a non-supportive workload is often associated with burnout (Stamm, 2010). Nurse participants reported both an increase in workload and a decrease in

support from other team members, placing them at risk for burnout. Kates et al. (2020) also reported an increase in workload and reduced staffing among hospice professionals during the pandemic.

Emotional support from coworkers in the workplace was also found to be lacking, which placed participants at risk for burnout. Due to social distancing restrictions, staff were unable to get together in person and provide face-to-face emotional support. Regardless of the pandemic, hospice workers reported that hospice care often feels isolating due to the autonomy the job requires. Hospice staff frequently met together socially to feel more connected to one another. Because they no longer had those opportunities for fellowship, they felt even more isolated from each other while facing new stress from a pandemic, which placed them at an even higher risk for burnout. Vossel (2020b) reported that the pandemic amplified hospice workers' anxiety, and staff are in need of additional support.

The pandemic also contributed to inefficiency in the workplace. Rigorous infection control procedures became an essential staff responsibility. There were many procedures they had to remember to complete, i.e., donning, doffing, sanitizing, etc. Increased time spent performing infection control procedures led to decreased efficiency in providing patient care. Despite these time constraints, hospice personnel expressed an appreciation for safety precautions put in place by the employer. However, another cause of inefficiency was facility restrictions. Facilities have different protocols for visitations, making it difficult for hospice nurses to provide care for patients living in facilities. Kates et al. (2020) reported that the most common barrier to providing hospice care was facilities' restrictive visitation policies during the pandemic. Because compassion satisfaction results from the ability to do one's work, inefficiency placed participants at risk for compassion fatigue (Stamm, 2005).

Patient Environment

Because of the physical restrictions required to prevent transmission of COVID-19, barriers were found between hospice professionals and patients. Barriers found included the following: connection, communication, closeness, physical, and emotional. Under normal circumstances, the patient environment would be filled with physical touch and closeness (Birnstengel, 2020). However, during the pandemic, hospice professionals have the added stressor of feeling as though patients are dying alone with them in the room. This finding coincides with Birstengel's (2020) assertion that the PPE required during the pandemic created a barrier of intimacy and closeness for those dying. Being exposed to this trauma experienced by patients placed participants at risk for secondary traumatic stress.

Another barrier was between hospice professionals and the patients' family members. According to Abbott et al. (2020), providing support to not only patients but also their family members is a fundamental of healthcare. However, because of COVID-19 visitation restrictions, hospice professionals were unable to provide support to the family members of patients, which created another stressor. Also due to visitation restrictions, family members were unable to provide support for the patients, affecting patients' health. Abbott et al. (2020) reported that because of COVID-19 restrictive visitations, family members have been unable to interact with clinical teams. This limits goals of care conversations, which may impact the health of the patient (Abbott et al., 2020). Once again, this barrier placed participants at risk for compassion fatigue due to the ability of one's work being hindered (Stamm, 2005).

Hospice professionals were found to be exposed to secondary trauma from watching the physical, mental, and emotional difficulties of patients and their families during the pandemic. Kates et al. (2020) found psychological distress among hospice workers during the pandemic and

reported that the long-term psychological impact on hospice workers providing care during the pandemic is unknown.

Participants described feeling the burden of making difficult decisions for patients and family members who were looking to them for answers. Patients asked participants about whether or not to have family members visit them in their homes. Family members asked for their help in deciding whether or not to go into the hospital to be with their dying loved ones who were COVID-19 positive. Family members also consulted hospice professionals to help make decisions about funerals. According to Pignatiello et al. (2020), repeatedly making decisions can cause the negative behavioral ramifications and decreased quality of future decisions that come from decision fatigue.

Person Environment

Practicing self-care is a way to boost compassion satisfaction (Alkema et al., 2008). An important finding of the person environment was hospice professionals' difficulty to provide self-care, which promoted compassion fatigue. This finding confirmed Vossel's (2020b) identification of concerns around self-care in the hospice workforce during the pandemic. This population is facing an increase in stressors while having to limit the ways they provide self-care. Most causes of difficulty to provide self-care revolved around the pandemic's social distancing guidelines and travel restrictions, along with an increased workload and limited staffing. Another important finding was that compassion fatigue and burnout made it difficult to provide self-care, continuing a vicious cycle of compassion fatigue and burnout. Although participants reported feeling isolated in their personal lives, multiple methods for providing self-care were identified and included exercise, church, vacation, house tasks, family time, and outdoor activities.

Participants felt emotionally fragile. Similarly, Kates et al. (2020) reported psychological distress among the hospice workforce during the pandemic. Being emotionally fragile manifested in different ways, including: crying, anger, stress, and agitation. These emotions correlate with the CS-CF theory's signs of burnout, exhaustion, frustration, anger, depression, and distress (Stamm, 2010). However, being resilient was also evident and reported by participants. Having a fear of COVID-19 was also made apparent by participants. Likewise, Vossel (2020b) reported hospice workers are experiencing fear of becoming ill with COVID-19 and spreading it to their families. Stamm (2010) reported secondary traumatic stress is propelled by fear and work-related trauma. Reasons for participants' fear included the risk of exposing family members to COVID-19, living with roommates or family members who have high-risk health conditions, or having a personal high-risk health condition. However, taking care of COVID-19 positive patients was more associated with fearlessness and a sense of responsibility to provide quality patient care.

It was found that having children at home added a layer of complexity and stress to participants, especially if children were in virtual school. Participants in this position were trying to help their children in school while either working from home or providing patient care out in the field. This situation caused the work environment and the personal environment to interfere with each other. Comparably, Vossel (2020b) reported issues concerning hospice professionals' work-life balance during the pandemic. Once again, hospice professionals were challenged with making difficult decisions, placing them at risk for decision fatigue. Several participants acknowledged that they had not seen their families in a year or more, so it was difficult to decide whether or not to have family get-togethers or travel to see family.

Debriefing Session

Findings suggested that questions asked about the pandemic in the form of a debriefing session were helpful to hospice professionals. Participants found the debriefing session to be therapeutic, and they valued talking about their experiences with colleagues. This finding is consistent with Hockley's (2014) finding that reflective debriefing groups encouraged communication among team members. The debriefing session was also found to increase connection. Participants reported that the debriefing session helped them not feel alone, and they appreciated hearing the viewpoints of others. Prior studies reported that debriefing allowed for team members to hear each other's perspective and recognize that their emotional experiences were normal (Keene et al., 2010; Rushton et al., 2006). Participants appreciated that the focus of the debriefing session was reflective and not situation or patient specific, which coincides with the suggestion that hospice workers would benefit more from emotion-focused coping strategies versus problem-focused strategies (Sardiwalla et al., 2007). Debriefing sessions were found to promote compassion satisfaction. Alkema et al. (2008) reported that managing work stress and addressing emotional needs are ways to promote compassion satisfaction. Most participants (92.3%) reported that they would like to regularly debrief at their hospice organization.

Implications for Practice

As of March 2021, little to no studies used debriefing sessions to examine the experiences of hospice professionals during the COVID-19 pandemic. Findings suggested that the pandemic has placed hospice professionals at an increased risk of compassion fatigue and burnout. Participants expressed feeling isolated in their work and personal lives. This project highlights the value placed on in-person interaction between hospice professionals as a means for emotional support and connection. Because hospice workers emphasized the value of in-person

connection with other coworkers, the option for safe, socially-distanced in-person debriefing sessions should be explored.

Because of the pandemic, this population has made difficult decisions within the work, patient, and person environments. Decision fatigue is the compromised capability to make decisions and control behavior because of repeated decision-making (Pignatiello et al., 2020). Making frequent and difficult decisions could potentially lead to poor decision-making (Pignatiello et al., 2020). Further research is needed towards gaining a better understanding about the concept of decision fatigue and its relationship with compassion fatigue in hospice professionals. Further research could test for and provide educational tools to overcome decision fatigue.

Hospice professionals reported having trouble providing patient care to those in facilities during the pandemic. Because of the inconsistent facility visitation restrictions, future research could examine different facility policies. Understanding the differences and reasons behind the policies, facilities could be better prepared and educated on the best universal policy. Having a universal policy could allow easier access for hospice professionals to provide needed patient care for those residing in facilities.

By understanding the professional and personal experiences of hospice workers, employers gain the ability to provide needed resources to employees. This project suggests that debriefing is beneficial for combating compassion fatigue and increasing compassion satisfaction. By utilizing regular reflective debriefing sessions, hospice organizations may provide emotional support for hospice professionals in the workplace. Further research should be done on the professional and personal experiences of hospice professionals during the pandemic for comparison. More research should also be completed using the debriefing questionnaire

based on the Gibbs' Reflective Cycle. Future studies might consider using the tool to examine how the pandemic has affected other healthcare populations to increase knowledge and better prepare healthcare professionals for future disasters. This study echoes Kates et al. (2020) finding of psychological distress among hospice workers during the pandemic. Future research should study the long-term psychological impacts on hospice workers providing care during the pandemic.

Strengths and Limitations

A strength of this DNP scholarly project is the collection of qualitative data. Qualitative study designs allow for the exploration of an area poorly understood, which was an appropriate design choice for a project exploring the unique experiences of hospice professionals' during an unprecedented pandemic. This project also increases the knowledge of debriefing sessions and their usefulness in providing emotional support for frontline workers during a pandemic. Another strength of this study is data collection in the form of a debriefing session. This strategy allowed the researcher to provide a service to the project stakeholder by offering an opportunity for participants to come together and feel supported.

However, there are limitations to this project as well. Because data were collected using structured debriefing, participants may have only responded to questions asked, which could have caused qualitative data to be missed. Since this study is qualitative, sampling should occur until data saturation has been reached, which is when no new concepts emerge from the data (Corbin & Strauss, 2015). Due to time constraints and the use of convenience sampling, the researcher cannot guarantee that data saturation was attained. Also due to time constraints, data were collected prior to data analysis. Ideally, collection and analysis of qualitative data occurs concurrently before moving on to the next focus group. Additionally, not all hospice

professionals invited to participate joined a debriefing session, therefore data may not be reflective of all hospice professionals' experiences and thoughts. Another limitation may be the debriefing facilitator's lack of hospice experience. The participants' comfort level of sharing may be low with a facilitator who does not have a background in hospice. However, knowing that the debriefing facilitator did not work with them may have encouraged participants to share more honestly, thus also being a strength of the project.

Conclusion

The findings from this scholarly project provide valuable information about the unique experiences of hospice professionals during the COVID-19 pandemic. While adding to existing literature on reflective debriefing in healthcare professionals, this project also offers new evidence to support debriefing as a tool to combat compassion fatigue and burnout during the COVID-19 pandemic. Before COVID-19, many factors placed hospice professionals at risk for compassion fatigue and burnout. Because of the pandemic, they are at a significant increased risk of compassion fatigue and burnout from changes in the work, patient, and person environments. To address the unprecedented challenges hospice professionals are facing, it is imperative that employers provide them with emotional support. Without knowledge of the professional and personal experiences of hospice workers, employers' ability to provide needed resources to employees is limited. Reflective debriefing sessions are a resource for employers to understand the professional and personal experiences of hospice professionals, as well as an emotional resource to participants.

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Appendix A

Table 1

Debriefing Questions

Category	Questions
Description:	-What changes have you noticed in the workplace and patient care due to COVID-19? -What changes have you noticed in your personal/home lives due to COVID-19. -Have you taken care of COVID-19 patients? -How often do you take care of patients with COVID-19? -Describe what it is like to take care of COVID-19 patients.
Feelings:	-How do you feel about the above named changes in the workplace and patient care? -How do you feel about the above named changes in your personal/home lives? -How do you feel about taking care of COVID-19 patients?
Evaluation:	-What has been the most distressing factor for you related to COVID-19? -Have there been any good changes that have occurred due to COVID-19?
Analysis:	-Do you feel as though you are able to effectively provide patient care in light of the above named changes? -Why or why not? -Do you feel as though you are able to effectively provide self-care in light of the above named changes? -Why or why not?
Conclusion:	-What have you learned about yourself since the COVID pandemic began? -If you could go back in time, how might you have prepared yourself mentally and emotionally?
Action Plan:	-What resources or support would help you in or outside of your workplace moving forward?

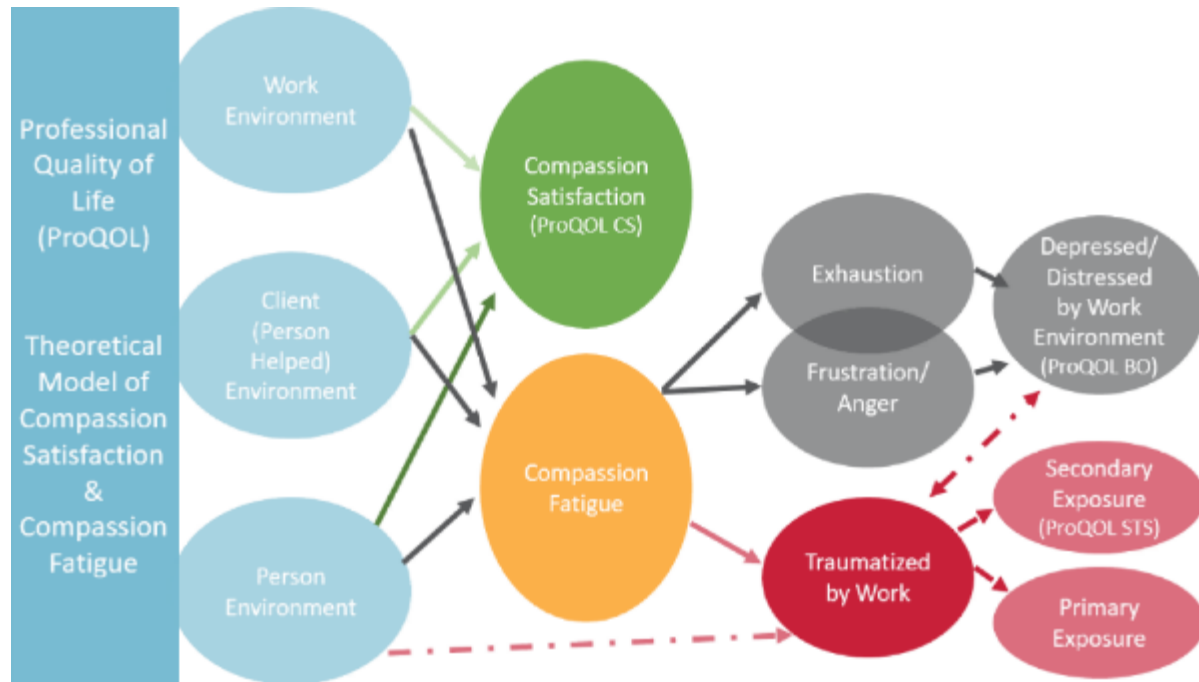
Table 2*Demographic Data*

Demographic Variable	Number of Respondents (N)	Percent (%)
Total Respondents	26	100%
Gender		
Male	1	3.9
Female	25	96.2
Age		
18-29	4	15.4
30-39	4	15.4
40-49	6	23.1
50-59	9	34.6
60+	3	11.5
Race		
Caucasian	26	100
Current employee of the Hospice Organization		
Yes	26	100
Length of employment		
2 years or less	13	50
3-5 years	6	23.1
6-10 years	3	11.5
11+ years	4	15.4

Employment Location	28	
Nashville	11	39.3
Murfreesboro	3	10.7
Lebanon	2	7.1
Franklin	5	17.9
Hendersonville	7	25.0
Professional Role		
Nurse	10	38.5
Chaplain	4	15.4
Social Worker	6	23.1
Director	4	15.4
Other	2	7.7

Figure 1

The Compassion Satisfaction-Compassion Fatigue Theory



Note. “The Concise ProQOL Manual,” B. H. Stamm, 2010, <https://proqol.org/uploads/ProQoLManual.pdf>.

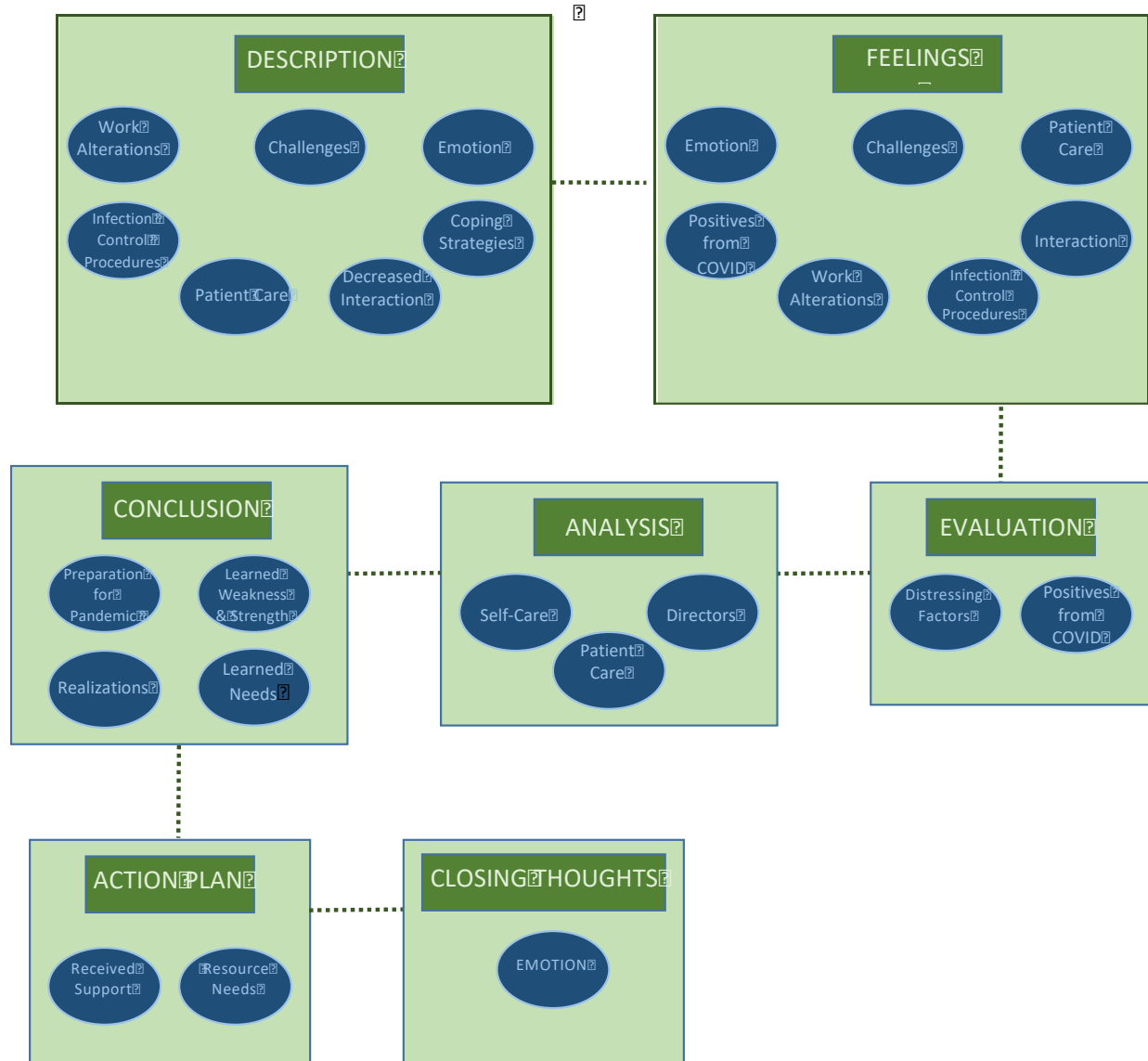
Figure 2

Gibbs' (2013) Reflective Cycle



Figure 3

Debriefing Session Themes



Note. Information in the dark green boxes represent each of the six domains, including a seventh for “Closing Thoughts.” Themes that were depicted from qualitative data are represented in dark blue boxes.

Appendix B

BELMONT UNIVERSITY RESEARCH PROJECT INFORMATION SHEET

DEBRIEFING AMONG HOSPICE PROFESSIONALS DURING A PANDEMIC

Principal Investigator: **Holly Robinson**

Co-investigator:

Faculty Advisor: **Dr. Kathryn Dambrino, DNP, APRN, FNP-BC**

You are invited to participate in a research study about reflective debriefing.

If you agree to be part of this project, you will be asked to participate in debriefing over your experiences taking care of patients during the COVID-19 pandemic. During the debriefing, you will be asked questions about how COVID-19 has impacted your personal and professional lives, and you are encouraged to discuss answers openly and honestly as a group. Discussions may include, but are not limited to, death, grief, and emotional experiences.

Benefits of the research are increased peer support, communication, and grief management. Debriefing has also been shown to help people cope more effectively. You will also be paid for your time spent participating in this study by means of your employer.

There is a possible risk of emotional discomfort when talking about previous patient deaths. Participation in this study is completely voluntary and poses no threat to employment or wages.

It is your choice whether or not to participate in this study. Even if you decide to participate now, you may change your mind and stop at any time.

Debriefing sessions on Zoom will be recorded, but your Zoom display names will be changed prior to the recording to deidentify participants. Recordings will be saved as encrypted files and only the researcher will have access to them. Please do not state any identifying information (your name, address, date of birth, etc.) during the debriefing. Please also avoid sharing patient identifying information. Participants will be asked to complete a short, anonymous post debriefing survey at the end of the debriefing session.

Recordings collected will only be accessed by the researchers involved in this project. We will not collect or share any identifying information with anyone outside of the research team. Due to the qualitative nature of this study, certain statements may be included in written publications or presentations. However, statements will not be linked to any identifying information.

By participating in this study you are confirming that you are at least 18 years of age, currently employed at the hospice organization, involved in direct patient care, and have access to Zoom online.

By clicking on the Zoom link and participating in the debriefing session, you are implying your consent to participate in the study.

If you have questions about this research study, please contact Holly Robinson at (940)597-7519 or hollyrhearobinson@gmail.com or Dr. Kathryn Dambrino at (615)460-6027 or kathryn.dambrino@belmont.edu.

Appendix C

Post Debriefing Survey

Q1 What gender do you identify as?

- Male (1)
- Female (2)
- Other (3)

Q2 What is your age?

- Under 18 (1)
- 18 - 29 (2)
- 30-39 (3)
- 40-49 (4)
- 50-59 (5)
- 60+ (6)

Q3 What is your race?

- Caucasian (1)
 - African American (2)
 - Hispanic or Latino (3)
 - American Indian or Alaska Native (4)
 - Asian/Pacific Islander (5)
 - Other (please specify below): (6)
- _____

Q4 Are you currently employed at the hospice organization?

- Yes (1)
- No (2)

Q5 How long have you been employed at the hospice organization?

- 2 years and under (1)
- 3-5 years (2)
- 5-10 years (3)
- 10+ years (4)

Q6 In what location(s) are you currently working? (Select all that apply)

- Nashville (1)
- Murfreesboro (2)
- Lebanon (3)
- Franklin (4)
- Hendersonville (5)

Q7 What is your professional role at the hospice organization?

- Nurse (1)
- Chaplain (2)
- Provider (MD, NP, PA) (3)
- Social worker (4)
- Hospice aid (5)
- Director (6)
- Other (please specify below): (7)

Q8 a. Did you find today's debriefing session helpful?

- Yes (1)
- No (2)

b. Why or why not? _____

Q9 Would you like to regularly debrief at your hospice organization?

- Yes (1)
- No (2)

Appendix D

Properties and Dimensions of Themes within Domains

**KEY:*

P: = Property

D: = Dimension

(D#, P#, pg. #, L #) = (Debriefing Session #, Participant #, page #, Line #)

DESCRIPTION

Theme: Work Alterations

P: Adjustment to a new normal

D: Nurses

P: Difference in facility protocols

P: Lack of support

D: Social workers & chaplains

D: "...the nurse is sort of the solo warrior on the frontline without a lot of interpersonal you know support from their team members..." (D8, P4, pg. 2, L 33-35)

D: Volunteers

P: Virtual interaction

D: Decreased camaraderie

D: Preference for face to face interaction

D: "... they can't, as you say, debrief, they lost all ability to do that except by Zoom, and it sucks..." (D8, P1, pg. 5, L 81-83)

P: Working remote

D: Decreased motivation

D: Decreased productivity

D: Decreased self-confidence

P: Increased responsibilities

D: Nurses

P: Telehealth

D: "It's very hard because you can't see them in person..." (D2, P4, pg. 8)

P: "Frequent policy changes" (D5, P1, pg. 1, L 5)

P: Workers' personal challenges

D: Director's change in perspective

Theme: Challenges

P: Caring for patients versus caring for self

P: Children with COVID

D: "...because I can't come in contact with COVID positive person and do my job, I took care of them from afar versus getting to be a mom..." (D6, P1, pg. 4, L 69-73)

P: COVID guidelines

D: Grieving families

D: Patient education

P: School

- D: Family with COVID
- D: Virtual
- P: End of life care
- P: Grief
 - D: Families
- P: Emotional versus physical
- P: Making difficult decisions
 - D: Families of patients
- P: Limited staffing
- P: Relationship disturbance
 - D: Difference in COVID opinions
- P: Discrimination of frontline worker
- P: Decision fatigue

Theme: Emotion

- P: Distressed
 - D: Non-compliance with COVID guidelines
 - D: Caring versus confrontation
 - D: Uncertainty
- P: Anger
 - D: Director
 - D: Families of patients
- P: Anxiety
 - D: Personal
 - D: Professional
- P: Depression
 - D: Professional
- P: Frustration
 - D: Politics
- P: Stress
 - D: Telehealth
 - D: Politics
 - D: Professional
 - D: Family
 - D: COVID positive children
 - D: Single mom
- P: Negative
 - D: Observed by director
- P: Sadness
- P: Support
 - D: Lacking from workplace peers
- P: Fragile
- P: Exhaustion
 - D: Mental
- P: Fear of COVID
 - D: Transmission to family

- D: Transmission to patients
- P: Feeling isolated
 - D: Family
 - D: Elderly family members
 - D: Friends
 - D: Workplace
- P: Decreased anxiety
 - D: Previously COVID positive
- P: Unfulfillment
 - D: Professional
- P: Worried
 - D: Pandemic effects on special needs children
 - D: Patient COVID exposure
 - D: Self-blame

Theme: Infection Control Procedures

- P: Inconvenient
- P: PPE
 - D: Inconvenient
 - D: Change in self presentation
 - D: Currently adequate
 - D: Inadequate in the beginning
 - D: Patient confusion

Theme: Patient Care

- P: Barriers
 - D: Facility restrictions
 - D: Inefficiency
 - D: COVID exposure
 - D: Emotional & spiritual
 - D: Lack of technology resource
 - D: Inability to provide family support
 - D: Reduced role
- P: Telehealth
- P: COVID
 - D: Not afraid
 - D: Responsibility
 - D: Barrier to closeness
 - D: PPE
 - D: Comfort measures unchanged
 - D: Hard
 - D: Indirect care
 - D: Chaplains & social workers
- P: Secondary trauma exposure
- P: "...it's painful to not be able to take care of our patients the way that we feel like we would like to." (D8, P4, pg. 3, L 45-46)

Theme: Decreased Interaction

- P: Family
 - D: COVID exposure at work
 - D: Children
- P: Patient
 - D: Face to face
 - D: Family visitations
 - D: Physical touch
- P: Families of patients
 - D: Physical touch
 - D: Negative effects
- P: Difficulty
 - D: Coworkers
 - D: Friends
 - D: Physical touch
 - D: Family
 - D: Nursing role
 - D: Patients
 - D: Extrovert

Theme: Coping Strategies

- P: Church
- P: Exercise
- P: Family
- P: Less opportunities during winter
- P: Nature
- P: Not fully effective
- P: Virtual interaction
- P: Decreased access
 - D: Family

FEELINGS***Theme: Emotion***

- P: Anticipation
 - D: Increased workload due to COVID
 - D: Decreased for the future
- P: Fear of COVID
 - D: COVID patients' home visits
 - D: Transmission to family
 - D: High risk health
 - D: Personal
 - D: Roommates
 - D: Transmission to others
- P: Stress

- D: COVID patient care
- D: Telehealth
- P: Desire
 - D: Pre-COVID normalcy
 - D: Having the option to go out
 - D: Togetherness with coworkers
- P: Anxiety
 - D: Risk of COVID exposure
- P: Disappointment
 - D: Cancelled vacations
 - D: Traveling
 - D: Concerts
- P: Jealousy & bitterness
 - D: Comparing family time to others'
- P: Support
 - D: Lacking from workplace peers
 - D: "...we could debrief together on our regular lives. And now we just absolutely don't have anything." (D5, P1, pg. 5, L 92-93)
- P: Appreciation
 - D: Workplace safety precautions
- P: Feeling isolated
 - D: Workplace

Theme: Challenges

- P: Perceived increased workload compared to other professions
- P: COVID guidelines
 - D: Community peer pressure
- P: Increased staff burden
 - D: Decreased family support
- P: Difficulty explaining to children
 - D: Pandemic
- P: Discrimination
 - D: Frontline worker
- P: Internal conflict
 - D: Recognition of non-healthcare workers' pandemic experience
 - D: "...it's like okay so you know Lord forbid I give it to my mom you know or somebody like that. I mean like I said I've already had one family member pass, but it's like then again I'm tired of walking on egg shells." (D7, P3, pg. 28, L 539-542)
- P: Making difficult decisions
 - D: Family get-togethers
 - D: Traveling to see family
- P: Relationship disturbance
 - D: Difference in COVID opinions
- P: Missing family members at special events
 - D: Holidays

Theme: Patient Care

- P: In person versus virtual
 - D: Choice
- P: COVID
 - D: Inconvenient
 - D: Not afraid
 - D: Responsibility
- P: Disturbance
 - D: Emotional support
 - D: Family support
 - D: Physical versus spiritual & psychological
 - D: Reduced role
- P: Secondary trauma exposure

Theme: Positives from COVID

- P: Change in perspective
 - D: Grateful & humble
- P: Learning opportunity
- P: Family quality time
- P: Support
 - D: From coworkers
 - D: From employer
 - D: Comfortable voicing concern
- P: Working remote
 - D: Flexibility
 - D: Multitask work tasks and home tasks
- P: Telehealth
 - D: Efficient

Theme: Work Alterations

- P: Adjustment to a new normal
 - D: Patient care
 - D: More laxed
 - D: Workplace
- P: Social workers coordinating care remotely
 - D: Inefficiency
- P: Lack of support
 - D: Social workers & chaplains
- P: Telehealth
 - D: Barrier to communication
 - D: Barrier to connection

Theme: Infection Control Procedures

- P: Inconvenient
- P: Affects task performance

P: PPE

D: Barrier to closeness

D: Physical & emotional

D: "...there's so many barriers in getting to know people in a hospice situation because it's difficult, and they're just going through a really difficult time, so it just creates an emotional barrier that's actually physical..." (D3, P2, pg. 4, L 67-70)

D: Change in self presentation

D: Concern about waste

D: Discomfort

D: Currently adequate

Theme: Interaction

P: Preference for telephone versus video

D: Patient & family

D: Staff

P: Preference for face to face versus virtual

D: "...technology is one resource, and it can never replace being in person with people you care about." (D2, P6, pg. 10)

P: Decreased

D: Fear of exposing patients

D: Patient decline

D: Difficulty

D: Family

D: Aware of COVID risk

EVALUATION

Theme: Distressing Factors

P: Concern of forced vaccination

P: Blamed for COVID exposure

D: Facility

P: Enforcing patient isolation

P: Decreased interaction

D: Physical touch

D: Patients & families

P: Media insight

D: Fear factor

D: Political spin

P: Non-compliance with COVID guidelines

P: Politics

D: Political fear factor

P: Questioning transmission to others

P: Societal factors

D: Chaos

D: Judgment

D: Fear

- D: Avoidance
- P: Uncertainty
 - D: Politics
 - D: Unknowns of COVID
- P: Disturbances in patient care
 - D: Family opinion
 - D: COVID restrictions
 - D: Limited staffing
- P: Fear of COVID
 - D: High risk health of family member
 - D: Unknown COVID effects
- P: Fear of judgment
 - D: Cough in public
- P: Pandemic effect on children
- P: Personal grief
 - D: COVID restrictions
- P: Missing family members at special events
 - D: Wedding
- P: Family stress
 - D: Children in virtual school

Theme: Positives from COVID

- P: Decreased focus on appearance
 - D: Make-up
 - D: Clothing
- P: Decreased traffic
- P: Decreased viral illnesses
- P: Family quality time
- P: Infection control procedures
 - D: Improvement
 - D: JCO prepared
- P: Public awareness
 - D: Cleanliness
 - D: Illness prevention
- P: Support from community
- P: Public respect
- P: Realization of importance of relationships
- P: Telehealth
 - D: Efficiency
 - D: Productivity
- P: Working remote
 - D: Non-clinical staff
- P: Appreciation
 - D: Virtual interaction
 - D: Workplace safety precautions

ANALYSIS***Theme: Self-Care***

P: Difficult to provide

D: Cancelled vacation

D: Limited staffing

D: Burnout

D: Compassion fatigue

D: Extrovert

D: “My compassion fatigue and burnout are increasing every week, and, self-care I know is the greatest antidote to that, but it almost seems more difficult to provide it whenever you’re feeling that way.” (D5, P1, pg. 9, L 167-170)

P: Ineffective

D: Inability to travel

D: Increased workload

D: Lack of community

D: No time

D: Exhaustion

P: Challenges

D: Motivation

D: Gym avoidance because of healthcare field

D: Decreased interaction with friends

P: Church

P: Exercise

P: Gardening

P: Housework

P: Nature

P: Netflix

P: Vacation

P: Remodeling house

P: Family quality time

P: Introvert

D: Not much has changed

Theme: Patient Care

P: Different but effective

D: Overcoming challenges

P: Disturbance

D: COVID procedures hinder ability to care

D: Emotional support

P: Effective

D: Home setting

D: Hospice facility nurse

D: Unchanged role

D: Adequate medical supplies

P: Ineffective due to COVID

- D: Difference in facility protocols
- D: Family revocation of needed hospice care
- P: Challenges:
 - D: Telehealth
 - D: Telehealth with elderly patients
 - D: Decreased face to face interaction
- P: "...it feels like we're doing the best we can under the circumstances with what we've got." (D2, P5, pg. 16)
- P: "...I always feel like I'm not doing enough..." (D7, P4, pg. 40, L 770-771)

Theme: Directors

- P: Management stress
 - D: Anxiety
 - D: Decreased sleep
 - D: Anger- easily triggered

CONCLUSION

Theme: Preparation for Pandemic

- P: Virtual work format
- P: More hobbies
- P: More quality time with elderly relatives
- P: No change
- P: Not possible
 - D: Mentally & emotionally
 - D: Societal chaos
 - D: Individualized challenges
 - D: Compared to dying process
 - D: Unfulfillment
- P: Change in perspective

Theme: Learned Weakness and Strength

- P: Emotionally fragile
 - D: "I would like to say that I've learned that I'm tougher than I thought I was, but I'm not sure that's the case. I thought that I could handle something like this and not break, but I think my anger proves that I just break in different ways." (D8, P2, pg. 23, L 447-450)
- P: Resilience

Theme: Realizations

- P: Importance of relationships
- P: Importance of role
- P: Self-reliance

Theme: Learned Needs

- P: Togetherness
 - D: Preference for face to face interaction versus virtual interaction

- P: Self-care
 - D: Mental & physical
- P: Community
- P: Connection

ACTION PLAN

Theme: Received Support

- P: Community
 - D: PPE
- P: Employer
 - D: Deciding comfort level
 - D: Emotional
 - D: Frequent team huddles
 - D: Resources
 - D: PPE
 - D: Virtual meetings
 - D: More in person interaction
 - D: Appreciation of employee recognition

Theme: Resource Needs

- P: Adequate staffing
 - D: Inefficiency due to COVID
- P: Plan for togetherness
- P: Debriefing

CLOSING THOUGHTS

Theme: Emotion

- P: Anger
 - D: Lack of control
- P: Vulnerable
 - D: Science versus politics
- P: Feeling isolated
 - D: Families of patients
 - D: Difficulty to provide support