RISK FOR COMPASSION FATIGUE AMONG DOCTOR OF NURSING PRACTICE
STUDENTS

by
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GRADUATE COLLEGE

As members of the Practice Inquiry Project Committee, we certify that we have read the practice inquiry project prepared by Kathleen Cecilia Kulesa entitled “Risk for Compassion Fatigue Among Doctor of Nursing Practice Students” and recommend that it be accepted as fulfilling the practice inquiry project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this practice inquiry project is contingent upon the candidate’s submission of the final copies of the practice inquiry project to the Graduate College.

I hereby certify that I have read this practice inquiry project prepared under my direction and recommend that it be accepted as fulfilling the practice inquiry project requirement.

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SIGNED: _____________________
Kathleen Cecilia Kulesa
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DEDICATION

This manuscript is dedicated to my sister, Lisa Healey. She was a thinker, a gifted artist, and a woman ahead of her time. Lisa inspires me to follow my passion and bravely face the unknown.
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ABSTRACT

Background/Objectives: Compassion fatigue (CF) is severe emotional and physical exhaustion resulting from unresolved burnout and/or secondary traumatic stress. Prevalent in registered nurses and physicians, CF negatively impacts both the caregiver and the care provided and is associated with job attrition. There is no direct measure for CF. Risk is assigned according to the intensity of each constituent part and the relationships between these parts. The purpose of this practice inquiry was to describe the risk for CF among doctor of nursing practice (DNP) students seeking nurse practitioner certification, a previously unstudied and potentially at-risk population.

Design: A descriptive study was performed to describe: 1) the prevalence of compassion satisfaction; 2) the prevalence of burnout; 3) the prevalence of secondary traumatic stress; 4) the prevalence of risk profiles developed by Stamm (2010); and 5) the relationship between demographic characteristics and CF risk profiles in a sample of DNP students.

Setting: The University of Arizona, College of Nursing between August 24, 2013 and November 19, 2013.

Participants: 59 graduate nursing students seeking nurse practitioner certification and a DNP degree self-selected to participate in the study.

Measurements: The Professional Quality of Life Scale-5 (ProQOL 5) was utilized to measure the components of CF: compassion satisfaction, burnout, and secondary traumatic stress. Patient demographics included: gender, age, years in nursing, nursing specialty, and employment status.

Results: The DNP student population appears to be at-risk for CF, with 69% of the sample falling outside of the “low risk” CF profile. Stamm’s (2010) five risk profiles were expanded to assign a level of risk to the 63% of participants who did not land in an existing profile. There were no statistically significant relationships between demographic variables and the expanded
CF risk profiles, consistent with previous studies on the individual ProQOL components. A weak trend of increasing CF risk with years of nursing practice suggests that accumulated exposure to suffering increases CF risk. However, a small sample size and self-normalization in the ProQOL 5 limit the generalizability of the findings.

**Conclusion:** DNP students are an at-risk population; therefore, we recommend incorporation of CF awareness and risk reduction into the DNP curriculum. Applicability of the ProQOL 5 test is hindered by scoring inconsistencies and self-normalization bias and we propose solutions. We additionally propose the concept of a single numeric index to quantify individual CF risk. Use of a single continuous variable pertaining to CF risk is likely to be crucial for future characterization, screening, and interventions.

**Key words:** Compassion fatigue and Doctor of Nursing Practice students
Introduction

While the positive aspects of professional caregiving are well known, its negative effects are a relatively recent focus of study. Described as the “cost of caring” (Figley, 2002, p. 2) compassion fatigue (CF) is defined as severe exhaustion resulting from providing ongoing care to individuals who are suffering (Sabo, 2006). It has been found to have pervasive, negative impacts on nurses’ physical, emotional, spiritual, and relational functioning (Abendroth & Flannery, 2006; Austin, Goble, Leier, & Byrne, 2009; Coetzee & Klopper, 2010; Figley, 1995; Jenkins & Warren, 2012; Perry, Toffner, Merrick, & Dalton, 2011; Ward-Griffin, St. Amant, & Brown, 2011). This diminished ability to cope and function leads the nurse to disengage from patients, be less effective at work, and increases the likelihood that the nurse will leave his or her job or the profession prematurely (Figley, 1995).

There is already growing concern about the mismatch between the number of clinicians available to provide care and the increasing number of Americans requiring primary care services (Cheng, 2012; Hanson-Turton, Ware, Bond, Doria, & Cunningham, 2013). At the start of 2014, the Patient Protection and Affordable Care Act will insure an additional 16 to 32 million Americans (Hanson-Turton et al., 2013; Hertz, 2012) coinciding with an estimated shortage of 60,000 primary care physicians in the US (Hanson-Turton et al., 2013). As primary care providers, doctors of nursing practice (DNPs) can play a critical role in alleviating the shortage of clinicians (American Association of Colleges of Nursing [AACN], 2006; Hanson-Turton et al., 2013). Yet despite the significant role that DNPs and future DNPs may play, we found no published studies describing CF risk in both students entering advanced practice and practicing nurse practitioners.
Critically, current knowledge of the factors associated with CF suggests that DNP students may be at risk. For instance, there is a known risk of CF among registered nurses (Abendroth & Flannery, 2006; Dominguez-Gomez & Rutledge, 2009; Elkonin & van der Vyver, 2011; Flarity, Gentry, & Mesnikoff, 2013; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Meadors et al., 2009; Robins, Meltzer, & Zelikovsky, 2009) and withdrawal from patient care is a defining characteristic (Coetzee & Klopper, 2010; Figley, 1995; Maytum et al., 2004; Perry et al., 2011; Yoder, 2010). Therefore, the purpose of this practice inquiry (PI) is to describe risk for CF among DNP students seeking NP certification.

Background

First described in nursing literature by Joinson (1992) as the inability to nurture, CF was extensively studied in the field of traumatology by Figley (1995). It has also been researched in social work and psychology and studied in various helping professions including therapists, social workers, nurses, physicians, child protective service workers, first responders, chaplains, and genetic counselors (Boyle, 2011; Smart et al., 2013). As a result of the multi-disciplinary but parallel study of CF, the term has been used interchangeably with overlapping but distinct concepts including vicarious traumatization, secondary victimization, emotional contagion, secondary traumatic stress, and burnout (Sabo, 2006).

The most widely used conceptual model for CF is Stamm’s (2010) professional quality of life model (ProQOL). According to the ProQOL, CF encompasses the negative aspects of caring and is comprised of two related but distinct concepts: burnout and secondary traumatic stress. Burnout is defined as emotional distress resulting from workplace or organizational factors (Maslach, Schaufeli, & Leiter, 2001). It is precipitated by the professional caregiver’s (PC) belief that he/she lacks the capacity, ability, and resources to provide adequate care (Figley, 1995).
Secondary traumatic stress stems from the PC’s emotional engagement with the suffering patient (Boyle, 2011). The PC may describe feeling overwhelmed by the patient’s trauma and report difficulty maintaining a work-life balance (Stamm, 2010). In contrast, compassion satisfaction is the positive aspect of caring. It is the pleasure the PC derives from the act of helping others (Stamm, 2002). Compassion satisfaction may motivate and sustain the PC through the potentially depleting and distressing aspects of patient care (Stamm, 2002, 2010). According to the ProQOL, CF results from unresolved burnout and/or secondary traumatic stress in combination with diminished compassion satisfaction (Stamm, 2010).

It is the both the relationship between burnout, secondary traumatic stress, and compassion satisfaction and the intensity of these individual components that explain and predict risk for CF. Stamm (2010) developed five risk profiles to interpret the combined ProQOL components:

- **One high-risk profile** involves high secondary traumatic stress and high burnout with low compassion satisfaction.

- **Two at-risk profiles** involve either high burnout or high secondary traumatic stress in combination with low levels of the other components. Progression to high risk is a concern for these individuals as secondary traumatic stress and burnout are positively related and burnout and compassion satisfaction are inversely related (Stamm, 2010).

- **One low risk profile** involves high compassion satisfaction with moderate to low burnout and secondary traumatic stress.

- **The final profile** is associated with high-risk situations like war or disaster work and involves high secondary traumatic stress with high compassion satisfaction and low burnout. Stamm (2010) does not expressly state a risk level for this profile and no
clear relationship between compassion satisfaction and secondary traumatic stress have been found (El-bar et al., 2013; Elkonin & van der Vyver, 2011; Hegney et al., 2013).

Although the study of compassion satisfaction, burnout, and secondary traumatic stress in isolation is insufficient to gauge CF risk, there is a dearth of literature evaluating the ProQOL components in combination. Therefore, the specific aims of this PI are to:

1. Describe the prevalence of burnout among DNP students.
2. Describe the prevalence of secondary traumatic stress among DNP students.
3. Describe the prevalence of compassion satisfaction among DNP students.
4. Describe risk profiles for CF in DNP students.
5. Describe the relationship between demographic characteristics (gender, age, years in nursing, nursing specialty) and CF risk profiles in DNP students.

Method

Setting and Sample

This PI is part of a larger study to implement and evaluate a 12-week primary prevention program for CF that took place at a large Western university between August 24, 2013 and November 19, 2013. The program consisted of 12 online learning modules describing CF, etiologies, symptoms, potential outcomes, and methods to reduce symptoms. Participants practiced skills through “homework” consisting of self-reflection, self-awareness, and self-care activities; these were documented in a weekly journal. Participants were evaluated for burnout, secondary traumatic stress, and compassion satisfaction prior to starting the study and at its completion. Only data obtained at the first time point was utilized in the PI. Analysis of self-reflection journals was beyond the scope of this PI.
The target population was graduate nursing students seeking nurse practitioner certification and a DNP degree. The inclusion criterion was DNP students enrolled in a mandatory health assessment course during the fall semester of 2013. Of the 64 second-year DNP students eligible for the study, 62 enrolled and 59 completed the study (the remaining three students withdrew from the course itself). Approval for the study was obtained from the participating university’s Institutional Review Board prior to data collection (Appendix A).

**Measures**

**Professional Quality of Life Scale.** The Professional Quality of Life Scale-5 (ProQOL-5) is a 30-item self-administered behavioral assessment developed by Stamm (2010) to screen for CF risk in helping professionals. It evaluates for burnout, secondary traumatic stress, and compassion satisfaction through psychometrically separate subscales, allowing for the creation of individualized risk profiles. Cut scores, outlined in Table 1, determine levels of each component (Stamm, 2010, p. 18). The ProQOL 5 has been validated for use in nurses and has established reliability (Stamm, 2010).

<table>
<thead>
<tr>
<th>Levels(^a)</th>
<th>Compassion Satisfaction (CS)</th>
<th>Burnout (BO)</th>
<th>Secondary Traumatic Stress (STS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>(\leq 44)</td>
<td>(\leq 43)</td>
<td>(\leq 42)</td>
</tr>
<tr>
<td>Moderate</td>
<td>45-56</td>
<td>44-55</td>
<td>43-55</td>
</tr>
<tr>
<td>High</td>
<td>(\geq 57)</td>
<td>(\geq 56)</td>
<td>(\geq 56)</td>
</tr>
</tbody>
</table>

\(^a\) Corresponding to the lowest, middle, and highest quartiles

**Demographic data.** The demographic data collected include gender, age, years in nursing, and nursing specialty. Participants were instructed to include this data in their self-reflection journal.
Procedure

The principle investigator (K.S.) described the study and provided an overview of CF (Module 1) during the first two health assessment classes that took place on campus the weekend of August 24, 2013. Students self-selected to either participate in the study or to complete equivalent weekly assignments during the study period. The author (K.K.) obtained informed consent (Appendix B) and non-course faculty graded alternate assignments. The course instructor (the principle investigator) remained blinded to student participation. Participants completed the initial ProQOL 5 the weekend of August 24, 2013 prior to accessing program modules 2-12 on the course website. Participants submitted pre- and post-intervention ProQOL 5 scales and de-identified self-reflection journals to the author on November 19, 2013, after grades had been awarded.

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS; IBM, Chicago, IL) version 22.0 for Mac. Descriptive statistics were used to summarize participant demographics and prevalence of compassion satisfaction, burnout, and secondary traumatic stress. Pearson’s correlation coefficients or the nonparametric equivalent, Spearman’s rank correlation coefficient, were used to assess relationships between ProQOL components. Relationships between risk profiles and continuous demographic variables were assessed using Kruskal-Wallis tests, as assumptions for parametric tests were violated. Owing to our small sample size, Fisher’s Exact tests were utilized to assess relationships between risk profiles and categorical demographic variables. The strength of correlations was determined as follows: values less than 0.3 are weak; values between 0.3 and 0.5 are moderate; and values greater than 0.5 are strong (Grove, 2007). Statistical significance was set at the level of $p < 0.05$. 
**Results**

**Demographics**

Ninety percent (n=53) of the 59 participants were female and the average age was 34 years (range=24-62). Nursing experience ranged from one to 40 years ($M=8.2$) in 13 different specialties. Specialties were combined to form six categories: ICU (n=17), ED (n=7), medical-surgical (n=14), pediatrics (n=8), administrative (n=4), and outpatient (n=4). In addition, twelve percent (n=7) of the sample indicated that they had stopped working one to 10 years prior to starting the DNP program. Consequently, employment status was added as a variable for analysis.

**Descriptive Statistics**

The ProQOL 5 subscales demonstrated good internal consistency (Polit & Beck, 2012) with a Cronbach’s alpha of 0.87 for compassion satisfaction, 0.83 for burnout, and 0.82 for secondary traumatic stress. Although this indicated that overall reliability was good, four scale items (16, 29, 2, 28) had inter-scale correlations at or below 0.3. Therefore, these items were poorly related to the overarching concepts of compassion satisfaction, burnout, and secondary traumatic stress in the sample population and are addressed in the discussion.

With the ProQOL 5 test largely validated for this population, mean raw scores for compassion satisfaction, burnout, and secondary traumatic stress were computed. Data screening revealed one to four missing items in 4 of 59 (6.7%) pre-intervention ProQOLs. However, missed responses did not exceed 10% for any given subscale; therefore, blank items were coded as zero (Stamm, 2005). These missing data did not alter the results presented here. Descriptive statistics for ProQOL component raw scores are shown in Table 2. The score distributions are plotted as histograms in Figure 1, with the best fit to a normal distribution overlaid.
Kolmogorov-Smirnov tests were performed to test assumptions of normality prior to inferential analyses. While compassion satisfaction and burnout scores were consistent with a normal distribution (p=0.200 and p=0.054, respectively), secondary traumatic stress was not normally distributed (p=0.006). Therefore, nonparametric tests were utilized for subsequent analyses involving secondary traumatic stress.

TABLE 2. Raw Score Statistics for ProQOL Subscales

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Compassion Satisfaction</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD)</td>
<td>35.5 (6.0)</td>
<td>26.3 (6.2)</td>
<td>25.4 (6.4)</td>
</tr>
<tr>
<td>Median</td>
<td>36</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Range</td>
<td>21-50</td>
<td>11-42</td>
<td>14-45</td>
</tr>
</tbody>
</table>

*Note. Maximum subscale score=50.*

**FIGURE 1.** Histogram of compassion satisfaction, burnout and secondary traumatic stress raw scores, with fits to normal distributions.

Raw scores were converted to T-scores according to the ProQOL 5 scoring protocol (Stamm, 2010, p. 16). As expected from the T-score conversion, the mean of each index is very close to 50 and each standard deviation was about 10. Cut scores were applied to determine levels of compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2010, p. 18). As illustrated in Table 3, 81% of DNP students sampled had moderate to high levels of burnout.
and 74% had moderate to high levels of secondary traumatic stress. At the same time, 71% had moderate to high levels of compassion satisfaction.

TABLE 3. Frequency Distribution of Sample by ProQOL 5 Component Levels

<table>
<thead>
<tr>
<th></th>
<th>Frequency (%)</th>
<th>Frequency (%)</th>
<th>Frequency (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High Risk</td>
<td>Moderate Risk</td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>16 (27%)</td>
<td>26 (44%)</td>
<td>17 (29%)</td>
<td>59 (100%)</td>
</tr>
<tr>
<td>Burnout</td>
<td>13 (22%)</td>
<td>35 (59%)</td>
<td>11 (19%)</td>
<td>59 (100%)</td>
</tr>
<tr>
<td>Secondary Traumatic Stress</td>
<td>12 (20%)</td>
<td>32 (54%)</td>
<td>15 (25%)</td>
<td>59 (100%)</td>
</tr>
</tbody>
</table>

Statistical tests were then performed to determine the relationships between the three ProQOL components. Because secondary traumatic stress follows a non-normal distribution (Figure 1), Spearman’s rank correlation coefficient tests were used with this variable and bivariate Pearson correlation coefficient tests were used with the others. The following results were noted:

1. As strong significant positive relationship was found between burnout and secondary traumatic stress (rho=0.615, p=0.000).

2. Burnout is negatively and significantly correlated with compassion satisfaction in the medium effect range (r=-0.412, p=0.001).

3. There was no significant relationship between compassion satisfaction and secondary traumatic stress (rho=-0.059, p=0.656).

Categorization of Compassion Fatigue Risk

Participants were categorized according to the fit between their respective compassion satisfaction, burnout, and secondary traumatic stress levels and Stamm’s (2010) five CF risk profiles. Ten of the 59 participants (17%) were at-risk or high-risk for CF, comparable to the 12
participants (20%) that screened at low-risk for CF. Since the five risk profiles only address 11 of the 27 possible component combinations, 63% of the participants did not fall into an existing CF profile. A majority of the participants with unassigned risk, 25 participants or 42% of the sample, landed in one of six combinations falling above the low-risk category, but below the two at-risk categories.

Since many of the unaddressed combinations of compassion satisfaction, burnout and secondary traumatic stress yield significant risk for CF, based on Stamm’s (2010) ProQOL model, the profile definitions were expanded as depicted in detail in Table 4. Expanded profiles were defined following the ProQOL model (Stamm, 2010) in combination with empirical evidence of relationships between components. For high-risk profile 1, one additional component combination was added. Burnout at-risk profile 2 did not change. Secondary traumatic stress at-risk profile 3 only contains one possible combination that, owing to the positive relationship between secondary traumatic stress and burnout, is essentially impossible to achieve (and was not seen in this sample). Profile 3 was therefore altered to mirror the requirements for profile 2, out of consistency. Profile 4, the low-risk profile, gained one new combination with low levels of both secondary traumatic stress and burnout. Five combinations, such as uniformly high or low component levels (H-H-H or L-L-L), which do not conform to the ProQOL model, joined “Unknown Risk” profile 5. Finally, a new “Intermediate risk” profile 6 was added to encompass the combinations of ProQOL components that lie above “low risk” but below “at risk”. These expanded definitions cover all possible ProQOL component combinations. These new groupings were included in subsequent analyses.
### TABLE 4. Potential Combinations of ProQOL Components with Expanded Profile Assignments and Frequencies for Current Study

<table>
<thead>
<tr>
<th>Compassion Satisfaction</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
<th>Assigned Risk</th>
<th>Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>H</td>
<td>H</td>
<td>1 – High</td>
<td>5</td>
</tr>
<tr>
<td>M</td>
<td>H</td>
<td>H</td>
<td>1 – High</td>
<td>2</td>
</tr>
<tr>
<td>L</td>
<td>H</td>
<td>M</td>
<td>2 – At risk (BO)</td>
<td>5</td>
</tr>
<tr>
<td>M</td>
<td>H</td>
<td>M</td>
<td>2 – At risk (BO)</td>
<td>0</td>
</tr>
<tr>
<td>M</td>
<td>H</td>
<td>L</td>
<td>2 – At risk (BO)</td>
<td>0</td>
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<tr>
<td>L</td>
<td>H</td>
<td>L</td>
<td>2 – At risk (BO)</td>
<td>0</td>
</tr>
<tr>
<td>L</td>
<td>M</td>
<td>H</td>
<td>3 – At risk (STS)</td>
<td>1</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
<td>H</td>
<td>3 – At risk (STS)</td>
<td>2</td>
</tr>
<tr>
<td>M</td>
<td>L</td>
<td>H</td>
<td>3 – At risk (STS)</td>
<td>0</td>
</tr>
<tr>
<td>L</td>
<td>L</td>
<td>H</td>
<td>3 – At risk (STS)</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>L</td>
<td>L</td>
<td>4 – Low risk</td>
<td>3</td>
</tr>
<tr>
<td>H</td>
<td>L</td>
<td>M</td>
<td>4 – Low risk</td>
<td>1</td>
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<td>M</td>
<td>L</td>
<td>4 – Low risk</td>
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<td>H</td>
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<td>M</td>
<td>4 – Low risk</td>
<td>6</td>
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<tr>
<td>M</td>
<td>L</td>
<td>L</td>
<td>4 – Low risk</td>
<td>2</td>
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<td>H</td>
<td>5 – Unknown risk</td>
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<td>5 – Unknown risk</td>
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<td>M</td>
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<td>M</td>
<td>6 – Intermediate</td>
<td>2</td>
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</table>

**TOTALS:** 59


### Compassion Fatigue Risk and Demographics

Relationships between both expanded and Stamm’s (2010) risk profiles and demographic variables gender, age, years of nursing practice, nursing specialty, and employment status were assessed. Table 5 shows the statistical tests used for each analysis and their results. There were
no significant relationships between CF risk and demographic variables regardless of risk profile system used. To demonstrate these analyses graphically, Figure 2 and Figure 3(a-d) plot demographic characteristics as a function of increasing CF risk. Profile 5 (unknown) was eliminated from analysis due to its uncharacterized CF risk. As shown in Figure 3b, there was a weak positive trend of CF risk with years of nursing practice.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Test type</th>
<th>Stamm (2010) profile results</th>
<th>Expanded profile results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing specialty with CF risk category (Figure 2)</td>
<td>Fisher’s exact test(^a)</td>
<td>ICU: (p=0.533)</td>
<td>ICU: (p=0.638)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ED: (p=0.624)</td>
<td>ED: (p=0.329)</td>
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<td></td>
<td></td>
<td>MedSurg: (p=1.000)</td>
<td>MedSurg: (p=0.477)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peds: (p=0.481)</td>
<td>Peds: (p=0.376)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Admin: (p=1.000)</td>
<td>Admin: (p=0.554)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient: (p=1.000)</td>
<td>Outpatient: (p=1.000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(p=1.000)</td>
<td>(p=0.329)</td>
</tr>
<tr>
<td>Gender with CF risk category (Figure 3a)</td>
<td>Fisher’s exact test(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in nursing with CF risk category (Figure 3b)</td>
<td>Kruskal-Wallis</td>
<td>(H(2)=2.535) ((p=0.282))</td>
<td>(H(2)=7.399) ((p=0.116))</td>
</tr>
<tr>
<td>Age with CF risk category (Figure 3c)</td>
<td>Kruskal-Wallis(^b)</td>
<td>(H(2)=1.356) ((p=0.508))</td>
<td>(H(2)=1.494) ((p=0.684))</td>
</tr>
<tr>
<td>Employment status with CF risk category (Figure 3d)</td>
<td>Fisher’s exact test(^a)</td>
<td>(p=1.000)</td>
<td>(p=0.660)</td>
</tr>
</tbody>
</table>

Note. \(^a\) Low and intermediate profiles were combined; at- and high- risk profiles were combined. \(^b\) At-risk profiles for burnout and secondary traumatic stress were combined.

The seven participants who were unemployed up to 10 years prior to enrolling in the DNP program were also examined for indications of attrition due to CF, and six of the seven unemployed participants had low to intermediate risk for CF. Additionally, while 29% of the sample population were ICU nurses, it is notable, but not statistically significant, that 42% of the
high risk population were also from this nursing specialty. An opposite trend was noted among administration; none were at- or high-risk for CF.

**FIGURE 2.** Plot of compassion fatigue risk by nursing specialty. (Note: Five participants did not indicate a nursing specialty. These omissions are labeled “Unknown” CF risk.)
FIGURE 3. Plots of compassion fatigue risk by: (a) gender, (b) years in nursing, (c) age, and (d) employment status.

Discussion

Assessment of Compassion Fatigue Risk in DNP Students

Through the administration of the ProQOL 5, compassion fatigue risk among DNP students can be described and compared with other nursing populations. Based on the limited
number of studies using the ProQOL 5, the current findings indicate that DNP students are an at-risk population. Nearly three-fourths of DNP students sampled had moderate to high levels of burnout or secondary traumatic stress, the components of CF. In addition, high levels of compassion satisfaction, thought to be protective against CF, were found in only 27% of the sample. Participants’ raw mean compassion satisfaction, burnout, and secondary traumatic stress scores are consistent with those of RN samples using the same measure (Flarity, Gentry, & Mesnikoff, 2013; Hegney et al., 2013; Smart et al., 2013; Young et al., 2011). This suggests that DNP student’s CF risk is comparable to that of the RN population (already considered at-risk). The current study’s scores most closely approximate those of Flarity, Gentry, and Mesnikoff (2013) and Young et al. (2011). This is not surprising given that these sample populations were predominantly comprised of critical care nurses; a potentially higher risk population (Young et al., 2011). However, the impact of this increased risk is not yet conclusive. While CF is associated with issues common to critical care including moral distress (Maiden, Georges, & Connelly, 2011), high patient acuity (Yoder, 2010), and frequent exposure to death (Maytum et al., 2004; Melvin, 2012), critical care nurses’ levels of secondary traumatic stress and burnout have not consistently been found to be significantly higher than those found in other nursing disciplines (Hooper et al., 2010; Smart et al., 2013). This finding is consistent with this PI, which also did not find significantly higher CF risk among critical care nurses.

**Compassion Fatigue Risk and Demographic Variables**

The lack of significant associations between demographic variables age, gender, years in nursing, nursing specialty and risk profiles is consistent with research focused on individual CF components (Abendroth & Flannery, 2006; Hegney et al., 2013; Hooper et al., 2010; Potter, Deshields, Berger et al., 2013; Potter, Deshields, Divanbeigi, et al., 2010). To our knowledge,
this PI is the first to recognize that overall CF risk bears the same insensitivity to basic demographics as its constituent components. For example, Hegney et al. (2013) studied anxiety and depression in relation to Stamm’s (2010) profiles, but did not assess basic demographics in relation to the profiles.

While neither risk profile classification system detected significant relationships, relationships between variables were more apparent with the expanded risk profiles. This is likely the result of the expanded risk profiles’ larger sample size overall as well as per category. However, stronger associations between added component combinations and the demographic variables collected cannot be ruled out.

Figure 2 and Figure 3 (a-d) show demographic trends in overall CF risk. It appears that nurses who have practiced for five or fewer years are, on average, at low or intermediate risk for CF. In contrast, the participants with the highest CF risk have practiced the longest. This trend suggests that accumulated exposure is an important element of CF risk. However, the trend of CF risk with age is dramatically weaker, suggesting that age is not the principal variable at work, but rather exposure to the suffering of others (Figley, 1995).

We anticipated that different nursing specialties would experience different levels of CF risk; however, this was not borne out statistically. Administrative specialties were slightly underrepresented in the highest risk profiles and ICU nurses were slightly underrepresented in the lowest risk category. These trends suggest that the intensity of patient contact impacts CF risk (Figley, 1995). However, this PI’s ability to conclusively distinguish between six nursing specialties across six CF risk profiles with only 59 participants is very weak.

We considered the possibility that students who were unemployed prior to entering the DNP program could represent CF-related attrition. However, this was not evident in the data. On
average, unemployed students were more likely to be at low to intermediate risk for CF, although the number of unemployed students was small (7 of 59, or 12%). We cannot eliminate the possibility that time away from direct care has lessened their CF symptoms.

**Limitations of the ProQOL 5 as Screening Tool**

This PI uncovered significant limitations in the ProQOL 5 as a screening tool. These limitations include (1) inappropriate boundaries for profiling, (2) self-normalization when scoring, (3) low inter-scale correlations for certain test items when posed to nurses and (4) a lack of defined protocol for handling missing data.

In the ProQOL 5, the assessment of component levels is done either by quartile tables of raw score (Stamm, 2010, p. 29) or by normalization to a t-score (Stamm, 2010, p. 16). The former method does not provide reasonable measures for the components of compassion satisfaction, burnout, or secondary traumatic stress. For example, in order to score at the 75th percentile for burnout, the participant must achieve a raw score of 42 (of 50 possible) on the burnout subscale. This requires answering extreme values (Very Often or Never) for nine of the 10 burnout screening items. In contrast, responses this extreme graded on the ProQOL 4-R scale would score at the 99th percentile, as expected.

At the same time, the alternate method, the computation of t-score (Stamm, 2010, p. 16) is critically flawed in that it enforces self-normalization of the data. Since CF risk is not calculated in reference to Stamm’s (2010) normative population, t-score results always yield a mean of 50 and an SD around 10 regardless of a population’s intrinsic CF risk. Consequently, a sample of nurses with extreme burnout would yield a mean “normal” burnout score of 50; 25% of them would show high burnout levels and 25% would have low burnout levels. This would occur even though the entire sample is intrinsically well above average for burnout. The
information needed to normalize the t-scores properly to Stamm’s (2010) normative sample: means and SD of raw scores for the three subscales, is not provided.

Thirdly, subsets of test items appear to decrease the reliability of the each subscale when posed to nurses. For example, item two states, “I am preoccupied with more than one person I [help].” On average medical-surgical nurses are responsible for between four and eight patients during a shift (Welton, Unruh, & Halloran, 2006). Therefore, high endorsement of this item would be expected and would not necessarily reflect poor boundaries indicative of secondary traumatic stress. In another example, item 29 states, “I am a very caring person”. Since caring is a foundational value for nursing (AACN, 2008), it is not surprising that 58 out of 59 participants answered positively regardless of their level of burnout. As written, these items are inadequate to gauge CF risk in nurses.

Lastly, the ProQOL 5 does not have a protocol for handling missing data, despite changes to scoring methods since the ProQOL 4-R (Stamm, 2005). Consistent handling of missing data is necessary for the accuracy and reproducibility of findings.

**Study Limitations**

The most significant limitations of this PI are sample size, composition and a cross-sectional design. The participants represented a self-selected, convenience sample at a single university. Therefore, this sample may not be representative of the greater DNP student population, potentially limiting the generalizability of these findings. With 59 participants, there was insufficient statistical power to detect small effects, particularly in analyses involving multiple sub-categories such as nursing specialty. This PI was also subject to limitations inherent in a cross-sectional design; the results represent a fixed point in time. Since ProQOL measures are sensitive to changes in mood (Stamm, 2010), participants’ score may be influenced by
immediate events and, therefore, cannot be considered absolute. Finally, the responses of individuals who are unemployed are subject to recall bias and, therefore, may less accurately reflect CF risk.

**Implications and Practice Recommendations**

Although risk for CF appears comparable to that of the practicing RN population, few DNP students are low risk. Indeed, 69% of the sample profiles are above the low-risk category for CF. Since CF has been found to negatively impact nurses’ physical, emotional, and relational functioning as well as their work performance (Coetzee & Klopper, 2010; Jenkins & Warren, 2012; Perry et al., 2011) anything above low risk is cause for concern. This is especially the case since the clinician role is also associated with moderate to high risk for burnout (Robins et al., 2009) and high risk for secondary traumatic stress (El-bar et al, 2013; Wallbank, 2010).

As an at-risk population, DNP students need to be made aware of CF, recognize its signs and symptoms, and learn skills to reduce risk and ameliorate symptoms. A natural place to incorporate CF prevention and risk mitigation is in the DNP curriculum. To the best of our knowledge, no studies have been published regarding CF prevention programs in nursing education. However, there is growing literature on interventions targeting CF among RNs. Programs that included CF education and skills to reduce risk, such as creating a work-life balance, relaxation techniques, augmenting social support, and practicing self-care, effectively reduced secondary traumatic stress and burnout and increased compassion satisfaction in nurses (Berger & Gelkopf, 2011; Potter, Deshields, Berger, et al., 2013). In addition, mindfulness-based stress reduction (MBSR) and cognitive behavioral interventions (CBI) are skill-building techniques validated in nursing to reduce burnout and stress (Bazarko et al., 2013; Brunero et al., 2008; Foureur et al., 2013; Orly et al., 2012; Wolever et al., 2012). Moreover, MBSR and CBI
can be effectively taught remotely (Bazarko et al., 2013; Wolever et al., 2012), facilitating their incorporation into existing online DNP curricula. Promotion of CF awareness and self-care in the DNP curriculum could not only reduce risk among students but it could also provide them with the skills to mitigate CF as future clinicians.

To our knowledge, this PI is the first attempt to explore compassion fatigue risk in DNP students. Additional research is needed with larger more heterogeneous samples from geographically different settings to validate these findings. Additional qualitative study is also warranted to explore whether CF mediates DNP student’s decision to return to school. Here we present expanded risk profiles that improve the applicability of the ProQOL as a screening tool. They will build a knowledge base that will help quantify and predict a nurse’s individual CF risk. However, these expanded risk profiles need to be more broadly validated through qualitative and quantitative measures of CF symptomatology such as absenteeism, somatic symptoms, and medication errors. In addition, combinations inconsistent with the ProQOL model, such as uniformly high levels of compassion satisfaction, burnout and secondary traumatic stress, warrant further study.

While stratifying CF risk through qualitative categorization is useful, a numeric index would be more beneficial. It would provide both an individualized risk score and a more robust and precise measure for determining protective and contributing factors and, ultimately, for predicting risk. However, before a specific index definition is pursued, additional research is needed to determine the nature and strength of each CF component’s contribution to overall CF risk. This will facilitate component weighting, if indicated, and inform how the components are related mathematically.
Finally, until the limitations of the ProQOL 5 are addressed, it is inadequate to assess CF risk and an alternative measure is needed.

Conclusion

DNP students, like nurses throughout the nation, are at risk for CF. They may be seeking the DNP program to escape CF and without awareness and self-care techniques to mitigate it, their CF is likely to follow them. As a consequence, these future clinicians may not reach their full potential and may leave the profession at this critical time of provider shortage.
APPENDIX A:

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER FOR INCORPORATING COMPASSION FATIGUE INTO NURSE PRACTITIONER (DNP) CURRICULUM
**HSPP Correspondence Form**

**Investigator:** Kate G Sheppard PhD, RN, FNP, PMHNP-BC, FAANP  
**Department:** College of Nursing  
**Project No./Title:** 13-0332 Incorporating Compassion Fatigue into Nurse Practitioner Curriculum  
**Expiration Date:** No Expiration

### IRB Committee Information
- **Administrative Action:** Administrative Review – New Project
- **FWA Number:** FWA00004218

### Documents Reviewed Concurrently
- F200 (signed 2013-03-29; revised 2013-05-09)
- Consenting Instruments:
  - ICF (version 2013-05-09)
  - F107 (version 2013-05-09)
- Site Authorizations:
  - Nursing
  - Rosenfeld
- Recruitment Materials:
  - Slides
- Data Collection Instruments:
  - ProQOL
- Grant
  - Application AANP
  - Award AANP
- Other (define):
  - CV Sheppard
- Project Timeline

### Determination
**Approved** as submitted effective as of the signature date below

**Regulatory Determination(s)**

- **Exempt Approval 45 CFR 46.101(b)(1)(ii):** Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
- **Exempt Approval 45 CFR 46.101(b)(2):** Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.

**Reminder:** No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.
APPENDIX B:

INCORPORATING COMPASSION FATIGUE INTO NURSE PRACTITIONER (DNP)
CURRICULUM CONSENT FORM
The University of Arizona Consent to Participate in Research

Study Title: Incorporating Compassion Fatigue into Nurse Practitioner (DNP) Curriculum

Principal Investigator: Kate Sheppard PhD, RN, FNP, PMHNP-BC, FAANP

Sponsor: American Academy of Nurse Practitioners Foundation

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your friends and family and to ask questions before making your decision whether or not to participate.

You may or may not benefit as a result of participating in this study. Also, as explained below, your participation may result in unintended or harmful effects for you that may be minor or may be serious, depending on the nature of the research.

1. Why is this study being done? To help DNP students better understand compassion fatigue (the negative physical and emotional symptoms that can occur from taking care of patients), the symptoms of compassion fatigue, how compassion fatigue affects our mental and physical wellness, and what we can do to reduce the risk of developing compassion fatigue.

2. How many people will take part in this study? About 50 DNP students.

3. What will happen if I take part in this study? You would take a short survey about compassion fatigue, and then participate in weekly activities over the semester. Your participation is voluntary, whether you participate or not, your grade will not be affected. The course chair will not know who has agreed to participate until after you have completed the semester and grades are filed. The activities include brief weekly learning modules that discuss compassion fatigue. All students in the course are required to keep weekly journals of about 3-4 paragraphs, in which they describe their weeks, what went well, what did not go well, and how they might address what did not go well. Your journal would be different. Starting with the third week of class, and you would be asked to keep a journal (3-4 paragraphs per week), discussing your own physical and mental feelings. Starting with the fifth week of class, you would be asked to do some simple self-care activities such as taking a walk, visiting a friend, listening to music, or whatever you identify as helping you in times of stress. You would then journal how those activities affected you physically and mentally. After
the last Health Assessment on-campus activity, you would be asked to submit your
written journal. At the end of the semester, you would take the same short survey
about compassion fatigue to see if any of the education and self-care made a
difference.

4. How long will I be in the study?
The study starts with the first week of the semester and ends a few weeks before the end
of the semester.

5. Can I stop being in the study?
Your participation is voluntary. You may refuse to participate in this study. If you
decide to take part in the study, you may leave the study at any time. The course chair and
principle investigator will not know who is participating, and she will not know about
your participation or withdrawal until after your grade in the course has been submitted.
If you decide to withdraw, you would just stop reading the modules; there is nothing
further you need to do. No matter what decision you make, there will be no penalty to you
and you will not lose any of your usual benefits. Your decision will not affect your future
relationship with The University of Arizona. If you are a student or employee at the
University of Arizona, your decision will not affect your grades or employment status.

6. What risks, side effects or discomforts can I expect from being in the study?
There is minimal risk of participation. It is possible that as you learn more about
the symptoms of compassion fatigue, you may become more psychologically
sensitized to any negative emotions of providing care.

7. What benefits can I expect from being in the study?
Through education, self-reflection, and heightened self-awareness, you may better
recognize risk factors of compassion fatigue, identify symptoms, and develop self-
care activities to protect and even prevent you from developing compassion
fatigue.

8. What other choices do I have if I do not take part in the study?
You may choose not to participate without penalty or loss of benefits to which you are
otherwise entitled.

9. Will my study-related information be kept confidential?
Efforts will be made to keep your study-related information confidential. However, there
may be circumstances where this information must be released. For example, personal
information regarding your participation in this study may be disclosed if required by state
law.
Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies
- The University of Arizona Institutional Review Board or Office of Responsible Research Practices
- The sponsor supporting the study, their agents or study monitors

10. What are the costs of taking part in this study?

There is no cost to participate in this study.

11. Will I be paid for taking part in this study?

You will not be paid to participate in this study.

13. What are my rights if I take part in this study?

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

You will be provided with any new information that develops during the course of the research that may affect your decision whether or not to continue participation in the study.

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled.

An Institutional Review Board responsible for human subjects research at The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

14. Who can answer my questions about the study?

For questions, concerns, or complaints about the study you may contact Kate Sheppard at 530-277-4645 (kate.sheppard@arizona.edu).

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://orr.arizona.edu/hssp.
Signing the consent form

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

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Investigator/Research Staff

I have explained the research to the participant or the participant’s representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or the participant’s representative.

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