*We weren’t able to address all of the questions and comments that flooded in during this webinar, so we’ve posted responses to some of them here. Thank you to our wonderful guest speakers for offering these responses, thereby extending the scope and relevance of our conversation about fostering compassion in healthcare.*

**[The Pause] seems like a compassion practice for both the healthcare professional and for the client who has just died or suffered.** That’s absolutely correct. Not only is [The Pause](http://www.thepause.me/) a self-compassion and respectful practice for the person that died; it also serves the family. They are honored in our practice by showing that they too matter, that we will stop and honor them. It also helps those in the vicinity – police officers, security officers, medical secretaries, EMTs, firefighters, anyone within ear shot. [The Compassionate Care Initiative](https://cci.nursing.virginia.edu/) [at UVA School of Nursing] is currently doing research on the Pause and that idea of non-dual benefit keeps arising.

**Many of the examples provided [during the webinar] focus on inpatient, hospital-based care in the academic setting. How do you see these strategies being implemented in an outpatient rural health setting that may have limited resources?** Nursing is all about assessment. Healing our staff is no less about this practice. Assess your resources by asking what strengths your staff provides. Use the Internet to search for videos that might support mindfulness practices, reach out to your staff resources and social workers. See if anyone in the community might offer yoga, for example, to support caring for the caregivers.

**I teach writing and a mindfulness practice and am being asked to do wellness work with police forces, but I have heard from trainer friends that this group is highly defended. I live in a region where tensions between police and people are high.** It will be important that you have someone from their circle co-presenting with you. Like veterans, first responders are reticent to hear from someone who has not walked the walk. Police are no different. I suggest you recruit a brother or sister in arms from their community to assist.

**It's interesting how the buoyant power of laughter often arises out of tears. Such a fine line between laughter and crying.**So true – laughter is healing. And there is evidence-based research to support this; [here](https://heartmdinstitute.com/stress-relief/healing-power-laughter/) are [here](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762283/) are two examples. There are actually acting exercises that explore the similarities between laughing and crying. It can be hard to tell the difference sometimes, and yet both actions lead to human interaction: condolence, comfort or camaraderie.

**Schwartz Center Compassion in Action Webinar**

**Fostering Compassion**

**March 21, 2018**

**Questions:**

*How can nursing students practice resilience in the midst of clinical and then later bring that resilience back to their respective college campuses?* Responded in session

*Are there any resources/literature regarding implementation of The Pause?* There are articles and research is ongoing. The web site <https://thepause.me/> has reference to articles and interviews. Actual research is really open at this point. Here is a link to an article about the Pause from 2014: <http://ccn.aacnjournals.org/content/34/1/74.full>

*We are using the Pause and other interventions, where do you get funding for your programs?* We have shown value added by launching programs. At first these programs were staffed by volunteers. As time passed value added was seen and programs began to be funded by benefactors. Now the hospital is seeing the potential and is interested in supporting through funding. Ideally if we show that there is a direct correlation with retention, more money will follow.

*Do you think it becomes embraced more from units/depts. taking on the practices more so than from an institutional level?*  The institution is made up of individuals and of units. As people start to practice and demand services that support self-care and resiliency, so too follows the ‘institutions’. I often have looked at the Google model of how to run an institution; people are supported through self-care practices (Yoga, mindfulness resiliency practices) by the company. Who would not want to go work for a hospital that takes care of its people?

*How do you handle a competitive environment when all want to be the expert, or prefer not to have one person be the leader on self-care practices?* Evaluate your resources. If you have ‘experts’ then tap into them and pull them under one umbrella. The practices that work will be supported by staff and the practices that are less than helpful….will fall away.

*Will you be publishing the observations from the retreat that occurred just prior to the white supremacist terror attack?  I think that would demonstrate the efficacy of these retreats.* I have thought about it and someone else suggested it. I will certainly look to at least write it up.

*What have been some obstacles to getting buy-in from the institution for these changes, and how did you overcome those obstacles?*

I chose not to use the word buy-in. For me that is a business term and I try to avoid its use. Getting staff and administration *engaged* I find is a better way to phrase and approach what we offer. The first obstacle we ran into was our failure to recognize that languaging plays a huge role in acceptance. We learned that how we both describe and define practices can either open acceptance or close the door. Avoiding ‘religious’ phrases can help open acceptance of practices like meditation (Mindfulness) and Yoga (stretching). Even journaling verses writing has sometimes been an issue. We have overcome ‘religious’ objection by pointing out that any practice we offer can be directly applied to whatever faith based groundwork practitioners come from.

Recognizing value has been a huge issue in the healthcare setting. We are in the process of showing that some of our interventions may play a direct role in retention and recruitment. Again I would argue, who wouldn’t want to go to an institution that cares for its employee’s?

*Have you tried to do the pause with police-people?* It has not yet happened…..that I am aware of, but there is no reason why they could not apply it in the work they do.

*I'd enjoy hearing a comparison of the compassion work among UVA physicians versus the School of Nursing-centered work described today.  E.G., Is there a difference in compassion culture between the nurses and physicians at UVA?*

It seems like there is from anecdotal experience in this workplace. That is not to say that one is better than the other, but we language compassion differently between groups. Also, training at the UVA school of medicine and the UVA school of nursing on compassion differs with regards to curriculum (even though the schools are across the street from each other). It would be fascinating to dig deeper into these differences and why they exist. That said, we do have lots of crossover between nursing students and medical students who engage in CCI programming as we try to keep our programs open to all who are interested.

*Do you have dedicated escape (rooms) for staff to decompress on their own? And if so, how were you able to convince Leadership that a dedicated physical space for staff is important?*Right now, as Tim discussed, we have a room in pediatrics. There is also a room at our transitional care facility, which is away from our main hospital campus. Just the other day I was approached by the medical director in the Medical ICU about starting just such a project. Our L&D unit has also requested a room. A challenge is that space is a hot commodity.

*Do some staff remove themselves from The Pause process when it occurs? For example, is there an option to "opt out" of the practice if a moment of pause in that context is seen by some people as intolerably uncomfortable?* Responded in session

*Do you need some type of critical mass of healthcare professionals in a healthcare organization to make some more organizational supports/changes to support resilience of staff? How do staff cope when they feel alone in terms of their self-care?* Responded in session

*What is the pause website?* <https://thepause.me/>

*What is humorous to some may be offensive to others.  How do you ensure that your humor is not offensive?*

We avoid gallows humor and call it out when we see its presence. Laughter is healing and being mindful that humor is not offensive is important.

*How does the pause best integrate with any debrief after a difficult death in the ED and/or any emotional crisis management meetings after a difficult death?*

The Pause is not necessarily a part of a debrief situation. The fact that it is not does not preclude that it can’t be. A debrief can be held and at the end a Pause can be implemented.

*What were your 1st steps in developing this at your Health System?* Responded in session

*What would you do if "the pause" led to someone going into "ugly cry" mode and it interfered with their work?  Would you want them to take a sick day?*

Offering to take them to a safe space where they can have a cathartic moment is probably the best approach. Tears are ok, but if that leads to uncontrolled catharsis in which staff emotion supersede the grieving family….that can be a problem. This may also point to the fact that this staff member may need a deeper level of support provided from staff support professionals.

*Who would you suggest approaching in the organization that would support and help build this.*

It is important to approach the early-adopters on your team and allow the work to grow naturally.

*Can Tim expand on the hard-to-assess areas?*

Hard to assess areas include considering the question as to whether a self-care practice is directly reducing the risk of burnout. What aspect of the practice? Is it the time taken for the practice, or just the intention of doing the practice? We believe that these practices can change hospital and unit culture, but there are always so many moving pieces and variables of change within a health system, it is very hard to control for everything to see if one intervention or new practice may be the cause of that change. Association is not causation. The benefit of many of these practices is that they are relatively low risk, voluntary and flexible.

*Can you repeat the compassion ? Website?*

www.compassion.virginia.edu