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# Compassion Fatigue: Exploring the Impact on Emergency Department Nurses

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Compassion Fatigue: Exploring the Impact on Emergency Department Nurses

by

Lauren E. Pittman

A thesis submitted to the faculty of  
Gardner-Webb University Hunt School of Nursing  
in partial fulfillments of the requirements for the  
Master of Science in Nursing Degree

Boiling Springs, North Carolina

2016

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## Abstract

The purpose of this thesis project was to explore levels of compassion fatigue in emergency department nurses. Compassion fatigue has directly affected many nurses' lives as well as impacting the field of nursing in various ways. Jean Watson's Theory of Human Caring served as the theoretical framework for the study. The literature maintains that the prevalence of compassion fatigue has been established, yet severity varies among institutions and specialties. A quantitative study to determine the level of compassion fatigue in ED nurses was conducted by utilizing a group on the social media site Facebook that is specific to travel nurses throughout the U.S. Descriptive statistics from the study reveal an "average" range of burnout and secondary traumatic stress, determining that compassion fatigue is prevalent among the study sample. This study serves to add to the literature the impact that compassion fatigue may have on nurses.

*Keywords:* Compassion fatigue, nursing, self-care, emergency department, Theory of Caring

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## **CHAPTER I**

### **Introduction**

#### **Problem Statement**

Compassion fatigue has directly affected many nurses' lives as well as impacting the field of nursing in various ways. Bedside nurses often witness marked human suffering, which sometimes leads to their own suffering. The phenomenon of compassion fatigue (CF) has been referenced in a variety of nursing settings. Carla Joinson (1992) first coined the term "compassion fatigue" in her work with emergency room personnel and described it as "the loss of the nurse's ability to nurture due to repeatedly caring for patients in life-altering or life-threatening situations" (p. 121).

#### **Justification of Research**

Researching further into this problem was important in order to more fully understand the prevalence of compassion fatigue in nursing. Emergency department nurses have higher exposure to death, violence, overcrowding, and trauma than other nurses in the hospital, yet studies are somewhat limited in regard to this population. Existing studies on CF focus mostly on other nursing specialties and even nurses from other countries besides the United States. Gaining a greater understanding of what ED nurses in the U.S. experience daily in terms of CF will bring a greater awareness to the issue. A thorough review of existing literature, utilizing CINAHL and PubMed, further justified the need for additional study of the prevalence of CF in ED nurses.

#### **Purpose of Study**

The purpose of this study was to explore levels of CF in emergency department nurses. The researcher intends to disseminate study results by educating nurse managers

and administrators with the intent of impacting healthy work environments for nurses.

The project question was as follows:

What is the level of compassion fatigue in travel nurses who work in the emergency department setting?

### **Theoretical Framework**

In 1979, Dr. Jean Watson released a grand theory, which she titled Theory of Human Caring. In some texts, it is known as the Theory of Transpersonal Caring (Jesse & Alligood, 2014). She drew from the sciences and humanities as sources to develop her framework and found theorists like Nightingale, Leininger, Peplau, Rogers, and Newman to be inspirations to her work (Jesse & Alligood, 2014). This theory includes attentiveness to human needs, sensitivity, and developing a nurturing relationship of hope and trust. After reviewing Jean Watson's Theory of Caring, connections can easily be made between her theory and the concept of compassion fatigue. Watson's Theory of Human Caring is based on the fundamental relationship between the nurse and their patient. Caring, empathy, and interpersonal skills are at the core of nursing and at the core of the relationship between nurse and patient. During this caring relationship, there is a potential for both positive and negative feelings to arise. While a positive, caring relationship between nurse and patient is what we all aim to achieve, caring too much can cause compassion fatigue to occur.

Watson expresses through her theory that when nurses include caring in their work, they realize that nursing is more than just a job. It is at this point that nurses might internalize and assume the responsibility of everything the patient is feeling and experiencing, whether they are negative or positive feelings and experiences. This is

where caring too much becomes problematic and causes nurses to become emotionally and physically exhausted from assuming this responsibility. The Professional Quality of Life Tool (Pro-QOL 5) (Appendix A) that was used as the tool of measurement consists of components regarding caring and helping that may be tied back into the Theory of Human Caring.

## **Definitions**

### **Compassion Fatigue**

Carla Joinson (1992) first coined the term “compassion fatigue” in her work with emergency room personnel and described it as “the loss of the nurse’s ability to nurture due to repeatedly caring for patients in life-altering or life-threatening situations” (p. 121). Diverse understandings and definitions of CF persist among various sources. CF can be conceptualized as emotional, moral, and physical distress, which occurs as a consequence of caring and bearing witness to the suffering of others (Crowe, 2016). Stamm (2010) asserts that compassion fatigue is comprised of two parts. “Burnout” is “associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively” (Stamm, 2010, p. 13). “Secondary Traumatic Stress” is the second element of CF that is caused by work-related, secondary exposure to people who have experienced extremely or traumatically stressful events” (Stamm, 2010, p. 13). To understand CF, one must recognize the third aspect of The Professional Quality of Life. “Compassion satisfaction” is known as “the pleasure one derives from being able to do one’s work well” (Stamm, 2010, p. 12). For the purpose of this study, compassion fatigue was operationally defined as a score of 57 or higher using the Pro-QOL 5 survey (Stamm, 2010).

### **Emergency Department Travel Nurses**

An emergency department (ED) travel nurse is defined as a Registered Nurse who is contracted to work in any level emergency department within the United States. For the purpose of this study, the ED travel nurse is hired to work in a specific location for a limited amount of time. The time frame is usually 13-week increments that may not exceed 12 consecutive months at any given location.

### **Social Media**

For the purpose of this study, the social media site Facebook was utilized. The study was conducted through the “Travel Nurse Network- The Gypsy Nurse” Facebook group.

## CHAPTER II

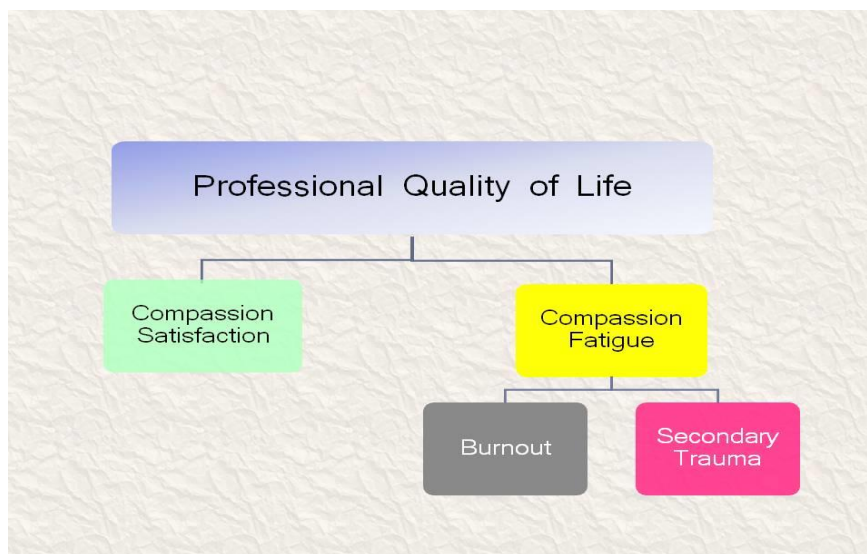
### Research Based Evidence

The purpose of this research study was to explore levels of compassion fatigue in emergency department nurses. An extensive literature review was conducted using PubMed and Cumulative Index for Nursing and Allied Health Literature (CINAHL). Key word searches included the terms “compassion fatigue,” “burnout,” “emergency,” “nursing,” and “stress.” Result findings were limited to publication years of 2011 to 2016 due to currency of topic. There were 21 potential articles, which were further limited to seven key studies for the purposes of this research. Articles were categorized by the following: “Prevalence of Compassion Fatigue” and “Theory of Human Caring.” The following literature review also includes a description of literature used to support the Theory of Human Caring by Dr. Jean Watson, which was the theoretical framework used to guide this study.

### Literature Related to Instrument of Measurement

The Professional Quality of Life Tool (Pro-QOL 5) was the instrument of measurement used in the study. Charles Figley created the original version of the tool in the late 1980s with collaboration from Beth Stamm beginning in 1988 (Stamm, 2010). Through a joint agreement between Figley and Stamm, the measure shifted entirely to Stamm in the late 1990s and has since evolved through several versions (Stamm, 2010). Pro-QOL 5 consists of three subscales used to measure compassion fatigue and compassion satisfaction (Stamm, 2010) as shown in Figure 1. Two of the subscales, burnout and secondary traumatic stress, are components used to measure compassion fatigue. The third subscale is compassion satisfaction. Reliability and validity of this

tool have been previously established, and it is a widely used tool to measure aspects of caring and CF throughout literature.



*Figure 1.* Professional Quality of Life Model (Stamm, 2010)

A study was conducted by Dasan, Gohil, Cornelius, and Taylor (2015) to estimate prevalence and explore potential causes and consequences of CF and compassion satisfaction in emergency medicine consultants. Six hundred eighty-one emergency medicine physicians responded to the e-survey, which included the ProQOL questionnaire. An electronic survey was conducted via SurveyMonkey. The survey was administered nationally to all emergency medicine physicians in the United Kingdom. Raw ProQOL scores were converted to standardized scores prior to analysis. The

ProQOL questionnaire was noted to be a useful tool in measuring CF and recommended it be used more in the future to detect CF among staff sooner for earlier intervention.

While levels of CF among this group were found to be low, varied work environments such as trauma centers and years in practice both showed correlations with higher CF scores. Administrative pressures such as “time-based targets” and “achieving key indicators” were also pinpointed by researchers as possible contributors to developing CF (Dasan et al., 2015, p. 593). Researchers visited the urgent need to further research the emergency care workforce and high-intensity workload associated with this specialty due to increasing numbers of patients presenting to emergency departments. They recommended changing factors of the work environment such as “varying job plans to reduce intensity” and “implementing individual coping plans” (Dasan et al., 2015, p. 594).

Hunsaker, Chen, Maughan, and Heaston (2015) surveyed 1,000 emergency department nurses throughout the United States in their non-experimental, descriptive study to determine the prevalence of CF, compassion satisfaction, and burnout. Hunsaker et al. (2015) used the definition from Sabo (2011) to describe CF as “emotional, physical, and spiritual exhaustion from witnessing and absorbing the problems and suffering of others” (p. 187). Hunsaker et al. (2015) used the definition from Stamm (2010) to describe compassion satisfaction as “the positive aspect of helping others” (p. 187). They also examined which demographic and work-related components (such as education levels, number of years as a nurse, etc.) influence the development of CF, burnout, and compassion satisfaction. The study used the ProQOL scale to measure prevalence, while a multiple regression was employed to determine which variables of demographics and



work-related characteristics predicted the prevalence. Survey packets included a demographic questionnaire as well as the ProQOL 5 tool and were mailed to a sample of participants who were members of the Emergency Nurses Association.

Results revealed that 56.8% of the ED nurses in the study fell into the average level of CS and 65.9% of the ED nurses were in the low level for CF (Hunsaker et al., 2015). The “lack of managerial support” contributed to higher levels of CF. Age, number of years as a nurse, and educational background were also found to influence the prevalence of CF. Findings revealed that “improving recognition and awareness of these elements might prevent emotional exhaustion” as well as “help identify interventions that will help nurses remain empathetic individuals” (Hunsaker et al., 2015, p. 192). In their discussion, Hunsaker et al. (2015) stated that “happy, healthy work environments that include shared decision making, manager support, and recognizing nurses’ contributions to practice may lead to decreased CF and increased compassion satisfaction among nurses” (p. 192).

Kelly, Runge, and Spencer (2015) administered a cross-sectional electronic survey in their study to examine compassion satisfaction and CF in acute care nurses across multiple specialties in a hospital-based setting. Researchers surveyed 491 acute care nurses across specialties at a large Southwestern U.S. hospital using the ProQOL questionnaire to examine CF in relation to differences among demographics, specialties, and intent to leave their current position. These researchers purport that the ProQOL scale has been used extensively in burnout research and is deemed reliable in assessing CF and CS in the nursing population. In this study, the 30-item ProQOL questionnaire was distributed through employees’ email.

Findings from the use of the ProQOL tool in this study revealed levels of CF falling in the “average” range, aligning with findings from other similar studies. Researchers identified “the age group of 21-33 was more prone to CF and burnout” (Kelly et al., 2015, p. 526). Researchers used the nomination for a formal recognition award at the hospital, an organizational factor, as a variable and found that this meaningful recognition did correlate with lower CF scores (Kelly et al., 2015, p. 525). The study findings also draw clear implications that CF has on nurse retention and quality of care. For instance, organizations with an increased number of nurses with CF have increased risk for lower patient satisfaction scores, which can lead to decreased reimbursement and decreased patient volume (Kelly et al., 2015).

### **Literature Related to Statement of Purpose**

Berg, Harshbarger, Ahlers-Schmidt, and Lippoldt (2016) employed a focus group methodology in their qualitative study to measure CF within a trauma team and explore perceptions of related stress triggers among participants. Twelve “practitioners” of a Midwestern Level I trauma team participated in the study. The Holmes-Rahe Life and Stress Inventory 43-item scale was used to examine how stressful life events can contribute to illness. The ProQOL 30-item questionnaire was the tool used to measure CF. A script of questions regarding positive aspects of the job, traumatic events that are upsetting and trigger reactions, experience with event triggers, and self-care and coping mechanisms were also included in the study’s methodology. Findings revealed that 58.3% of the team scored at “moderate” to “high” levels of CF and burnout. There was also a consensus that certain events are more stressful than others, including events

involving “children, family members, avoidable situations, and those similar to personal experiences” (Berg et al., 2016, p. 7).

Berger, Polivka, Smoot, and Owens (2015) aimed to determine the prevalence and severity of CF among pediatric nurses and variations in prevalence based on respondent demographics. A cross-sectional survey of 239 pediatric RN’s was conducted in an urban, five hospital system utilizing the 30-item ProQOL questionnaire as well as two open-ended questions. Researchers found that 29% of pediatric nurses in their study are in the “high” range for CF and 48% are in the “moderate” range for CF (Berger et al., 2015, e13). Researchers also stated that CF has a “negative impact on quality of patient care and nurse wellbeing” (Berger et al., 2015, p. e16).

Sung, Seo, and Kim (2012) studied the relationship between CF and turnover intention in 142 hospital nurses with use of the Compassion Satisfaction/Fatigue Self-Test for Helpers and found that the mean level of CF among their subjects was “very high.” Sung et al. (2012, p. 1091) detected a “positive correlation between CF and turnover intention”. Sung et al. (2012, p. 1093) went on to conclude in the discussion that changes in work environment such as “providing opportunities for breaks may alleviate stress contributing to CF” and that “strategies should be established in the workplace to reduce CF”.

Smart et al. (2014) conducted a cross-sectional survey in a community hospital in the Northwestern U.S. to examine levels of CF among 139 RNs, physicians, and nursing assistants. Relationships among individual and organizational variables were also explored. Caregivers for critical patients showed evidence of lower CF scores in comparison to those working in non-critical units. Overall levels of CF fell into the

“average” range. Smart et al. (2014) also expressed that limited information is available on individual and organizational variables that may be contributing to the prevalence of CF.

### **Literature Related to Theoretical Framework**

Dr. Jean Watson’s Theory of Human Caring is based around the nurse establishing a caring relationship with the patient and providing a holistic approach to treatment (Jesse & Alligood, 2014). Watson’s theory evolved to better define the profession of nursing as separate from but still complementing the field of medicine. The main concepts of Watson’s theory are based around 10 carative factors, which evolved over time as her ideas evolved and her perspectives expanded. These factors were based around elements such as developing a trusting relationship, building interpersonal teaching and learning, promoting expression and acceptance of positive and negative feelings, etc. (Jesse & Alligood, 2014).

The Theory of Caring has guided many studies on compassion fatigue and burnout in the past, according to Hunsaker et al. (2015). Lombardo and Eyre (2011) stated that “Watson’s Theory of Human Caring is grounded in the basic empathic relationship between the nurse and the patient, therefore advocating for relationship-based nursing.” They also noted “the empathy and the communication of this empathy to the patient and family that is at the core of this relationship may sometimes lead to compassion fatigue if appropriate steps are not taken to prevent it” (Lombardo & Eyre, 2011).

Watson’s theory serves as a framework in the study conducted by Mason et al. (2014) to bring meaning and focus to the nursing-patient caring relationship. The

theoretical framework “encompasses carative factors; transpersonal caring relationships, which affect the patient and nurse; and the genuine caring moments in which the nurse is empathetic, nonjudgmental, and warm” (Mason et al., 2014, p. 218). Providing an authentic caring interaction means both the patient and the nurse benefit from allowing the patient and/or family to choose the perceived best action for themselves at that time with hope in the future for potential growth (Mason et al., 2014).

### **Strengths and Limitations of Literature**

Many of the studies showed strong evidence that supports the prevalence of compassion fatigue in nursing and other disciplines working in the ED. The variety of research questions that have been explored on the topic of compassion fatigue provided a solid foundation for further research. However, the strongest and most utilized studies on this topic were greater than five years old and could not be used in this literature review. There was not an abundance of research from the 2011 to 2016 as in the 5-10 years prior to that. The research available on prevalence of compassion fatigue has regressed instead of progressed over the past five years, which was a crucial reason to revisit this topic. In the past five years, there is an increased medical complexity among emergency departments nationwide. Patients’ acuity levels are higher than even 5 or 10 years ago with chronic illnesses and comorbidities on the rise. Staffing shortages are an ongoing concern as well as management issues from government mandates, etc. Because of these changes in healthcare, an exploration of CF needed to be revisited.

There were also conflicting and varied findings among some studies. While studies visited correlations between CF and certain demographics, very few of the core studies reviewed for the purpose of this study actually explored the prevalence of CF in

ED nurses alone. Rather, many studies focused on other nursing specialties or other members of the healthcare team within the ED. Some of the previous studies were also conducted in other countries, which do not draw the most accurate depictions or parallels of nursing issues in the U.S.

### **Highlights of Literature**

The literature maintains that CF is an apparent problem in nursing but asserts that more research is required on the topic. Findings from literature showed a variation in levels of CF based on years of experience, age, gender, etc. Prevalence of CF has been established, yet severity varies among institutions and specialties. The literature outlines several areas of nursing that are impacted by the problem of CF. Evidence based literature offers suggestions for identifying symptoms and possible solutions and interventions.

## **CHAPTER III**

### **Methodology**

A quantitative study to determine the level of compassion fatigue in ED nurses was conducted by utilizing a group on the social media site Facebook that is specific to travel nurses throughout the U.S. The Facebook group is called “Travel Nurse Network- The Gypsy Nurse.” A link to the Informed Consent, Purpose of Survey, and Survey was posted in the Facebook Group for those interested in participating to click and complete. Registered Nurses who self-identify as “Travel Nurses” who work in “Emergency Department” settings were encouraged to participate.

With the administration of a ProQOL 5 survey (Stamm, 2010) to a convenience sample of nurses employed in emergency departments throughout the U.S., compassion fatigue was measured through the use of the burnout and secondary traumatic stress subscales on the ProQOL 5 tool. Data was collected by the researcher and analyzed with Microsoft Statistical Package for the Social Sciences (SPSS).

### **Design**

The quantitative study used a self-administered, online survey to identify levels of self-reported compassion fatigue.

### **Setting**

The study was conducted utilizing a social media platform through the “Travel Nurse Network- The Gypsy Nurse” Facebook group that is specific to travel nurses throughout the U.S. Permission to utilize the group was granted by the administrator of the site and founder of The Gypsy Nurse.

### **Sample**

A convenience sample was used for the purpose of the study and was drawn from emergency department nurses throughout the United States. Currently, there are 32,324 members of the group with varied experience levels and nursing specialties. The total number of members who are emergency department nurses was unknown. Those who self-identified as an ED nurse were included. The survey was posted for five days. It was removed after 100 responses were collected.

### **Protection of Human Subjects**

All methods of research were granted IRB approval from the University where the researcher is enrolled in graduate study. Informed consent was provided prior to beginning the survey. It explained that participation in the study was completely voluntary and that participants' answers would remain anonymous. Confidentiality of participants was protected by not collecting any identifiable demographics. There was no identifiable risk to participating nurses associated with this research. Nurses had the option to refuse and had the ultimate right and privilege to not participate. Participants' information was returned directly to the Nurse Researcher electronically and was remain locked with password protection.

### **Instruments**

The Professional Quality of Life Tool (Pro-QOL 5) was the instrument of measurement used in the study. Pro-QOL 5 consists of three subscales used to measure compassion fatigue and compassion satisfaction (Stamm, 2010). Two of the subscales, burnout and secondary traumatic stress, are components used to measure CF. The third subscale is compassion satisfaction. Reliability and validity of this tool have been



previously established, and it is a widely used tool to measure aspects of caring and CF throughout literature. The instrument has been tested extensively and found to be reliable ( $\alpha$  reliabilities of compassion satisfaction= .87, burnout= .72, and compassion fatigue= .80) and valid as a measure of the three separate concepts (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). Permission to use the tool was granted by the publisher (Appendix B).

### **Data Collection Procedure**

After approval of University IRB, the study began. The Nurse Researcher provided the study in electronic format utilizing SurveyPlanet. A link to the survey was posted on the Facebook group “Travel Nurse Network- The Gypsy Nurse” with the information “If you are a Registered Nurse who practices in the Emergency Department setting, please consider participating in this quick survey.” The link directed the participants to a separate webpage where they were provided with informed consent and information on the purpose of the survey. Participants had the option to agree to the informed consent (Appendix C) and open the survey for completion.

SurveyPlanet has a free option for creating surveys. The survey designed by the nurse researcher cut off at 100 responses. Participants were asked to check a box to confirm understanding of informed consent. Through the use of the online survey portal SurveyPlanet, participants answered 30 questions included on the ProQOL 5 tool. Upon completion of the survey, participants were directed to a separate webpage that had the voluntary option to submit their name and email address for a drawing. The drawing was for a \$30 gift card to Target stores, a national chain store, and a random person was

drawn to receive the incentive. They were notified by email and then email addresses were destroyed.

### **Data Analysis**

Quantitative data was analyzed utilizing Microsoft Statistical Package for the Social Sciences (SPSS), version 22. The researcher entered the data into SPSS. Raw data was converted to *t* scores as indicated in the ProQOL manual. Descriptive statistics were utilized to calculate means, percentages, and standard deviations for CF. Through the use of *t* scores, a standardization of each subscale was produced and allowed for conversion to categorical levels such as “low,” “average,” and “high.” The ProQOL manual outlines that scores of 43 or less would be considered “low” range for each measure, scores of 44 to 56 would be considered within the “average” range, and scores 57 or greater would be considered “high” range for each measure (Stamm, 2010).

## CHAPTER IV

### Results

Emergency Department nurses may suffer from compassion fatigue as a result of intense work environments. The purpose of this research study was to explore levels of compassion fatigue in emergency department nurses. When emergency department nurses experience compassion fatigue, it may negatively affect the empathetic relationship between the patient and the nurse.

The project question was as follows:

What is the level of compassion fatigue in travel nurses who work in the emergency department setting?

### Sample Characteristics

Participant demographics were not collected. The final sample size was a convenience sample of 100 with no nonresponses or withdrawals. Participants were self-identified travel emergency department nurses who were members of the Facebook group “Travel Nurse Network- The Gypsy Nurse.”

### Major Findings

The ProQOL 5 consists of three subscales: burnout, secondary traumatic stress, and compassion satisfaction. In the sample studied, the mean t-score for burnout was 50.83 ( $sd = 8.26$ ). The mean t-score for secondary traumatic stress was 48.54 ( $sd = 8.33$ ). The mean t-score for compassion satisfaction was 48.88 ( $sd = 7.69$ ). Burnout scores ranged from 35 to 69, secondary traumatic stress scores ranged from 35 to 64, and compassion satisfaction scores ranged from 27 to 64. Average scores for compassion satisfaction, burnout, and secondary traumatic stress are presented in Table 1.

Table 1

*Descriptive Statistics Based on t-scores for Burnout, Secondary Traumatic Stress, and Compassion Satisfaction for the Sample*

| ProQOL 5 Subscale          | N   | t-score (SD) | Score Range | Level   |
|----------------------------|-----|--------------|-------------|---------|
| Burnout                    | 100 | 50.83 (8.26) | 35 to 69    | Average |
| Secondary Traumatic Stress | 100 | 48.54 (8.33) | 35 to 64    | Average |
| Compassion Satisfaction    | 100 | 48.88 (7.69) | 27 to 64    | Average |

According to Stamm (2010), creator of the ProQOL tool, it is imperative to analyze all three subscales when determining compassion fatigue among a sample because compassion satisfaction acts as a moderator/mediator between the burnout and STS subscales. Each represents an important element of the overall picture but should still be recognized as individual subscales. Because each of the subscales is distinct, the results of the subscales could not be combined to give a single score. The ProQOL manual outlines that scores of 43 or less would be considered “low” range for each measure, scores of 44 to 56 would be considered within the “average” range, and scores 57 or greater would be considered “high” range for each measure (Stamm, 2010). The mean scores in Table 1 demonstrate the sample of ED nurses would be considered in the “average” range for burnout and STS, thus demonstrating an average level of compassion fatigue among the sample.

### **Summary**

Descriptive statistics from the study revealed an “average” range of burnout and secondary traumatic stress, determining that compassion fatigue is prevalent among the study sample. An “average” level of burnout suggests both a combination of positive and negative feelings about one’s ability to be effective at work (Stamm, 2010). An “average” level of secondary traumatic stress suggests that while there may be something associated with work that is frightening or traumatizing, it is not at a concerning or high level (Stamm, 2010).

## **CHAPTER V**

### **Discussion**

The results of this project validated the presence of compassion fatigue at an “average” level among emergency department nurses. Nurses who were offered the option to participate in the study showed a willingness to assist in further understanding CF. With the prevalence of CF comes an obligation from nursing leadership to further understand and prevent the occurrence of CF. Compassion fatigue has the potential to influence the field of nursing as well as other areas of healthcare, which is why exploring the implications of CF is necessary.

### **Implication of Findings**

Stamm (2010) notes that the most important element of interpreting the ProQOL is to realize that it is not diagnostic. Stamm (2010) does not indicate that any personal action be taken for “average” scores on the ProQOL. However, “high” burnout and STS scores can be indicative of deeper internal issues. If a person scores “high” in the categories of burnout or secondary traumatic stress, it may be necessary to seek professional help as these are usually “auguries of clinical depression” (Stamm, 2010). As they relate to a professional work situation or job, one may want to reexamine their current work environment and whether this may be a cause of “high” burnout and STS (Stamm, 2010). Individuals with “low” levels of burnout and STS may continue to have a strong sense of altruism and be highly effective and positive in their work environments (Stamm, 2010).

With the study results revealing an “average” level of compassion fatigue comes the need to further explore and educate. Understanding the idea of compassion fatigue as

well as signs of it will assist nurses in upholding their compassionate and caring attitudes toward patients and their families. Demonstrating that the problem of compassion fatigue exists will allow for further discussion and acknowledgment. As compared to results in literature, the data aligns with several results from past studies.

### **Application to Theoretical/Conceptual Framework**

Specifically related to the concept of compassion fatigue is Watson's idea that in order to be able to provide "authentic caring" for others, nurses "must first be able to engage in compassionate self-care practices for themselves" (Rosa, 2014, p. 224). With an increase in self-awareness based on the nurse's daily practices and self-reflection, nurses may apply concepts from Watson's 10 Caritas Processes as a way of dealing with their own compassion fatigue. Not only can parallels be drawn with Watson's concepts of caring between CF and self-care of the nurse, but commonalities can also be drawn between CF and care of the patient.

The appropriateness of Watson's theoretical framework in guiding the study is apparent. The ProQOL tool used in this project has specific questions to determine levels of helping and caring, which tie back in to the fundamental basis of Watson's Theory of Caring. Results of the study have shown that compassion fatigue is prevalent. Therefore, the empathy that is a vital part of Watson's 10 Caritas Processes could be compromised and threatened when a nurse suffers from CF. In order to keep the empathetic relationship between the nurse and patient from being further compromised, organizational leadership must focus on recognizing and preventing compassion fatigue in the future.

### **Limitations**

A potential limitation of this project was the use of a group of travel nurses only, which narrowed the overall characteristics of the sample. Had the study not limited the sample to only nurses that move around to different facilities all over the country on a regular basis, there may have been a different outcome. Another potential limitation is that there are very few instruments available for the specific purpose of measuring CF. Furthermore, the tool is not specific to a particular group of nurses, for example, emergency department nurses. Another limitation was the inability to collect categorical demographic data due to a social media collection technique.

### **Implications for Nursing**

Because nurses are such an important part of healthcare, they largely influence patient care and outcomes. Therefore, healthcare organizations must acknowledge that CF is a problem and provide a nourishing workplace for nurses to thrive (Harris & Griffin, 2015). “Putting compassion fatigue on meeting agendas, acknowledging worker contributions, and providing education” are all ways in which organizational leadership can provide some resolution to the existing problem (Harris & Griffin, 2015, p. 84). Several influencing factors that are ultimately out of nurses’ hands but may be contributing factors to CF include patient-nurse ratios, unfair staffing assignments and shortages, lack of support from management, and a lack of supplies and equipment. Nursing management must not overlook these crucial influences. Lachman (2016) suggested workplace strategies for management of holding debriefing sessions after emotionally charged events, helping nurses regain perspective, and offering employee assistance programs and support groups. Lachman (2016) further explored the threat that



CF places on ethical practice in nursing, stating CF is “personally deleterious to the nurse and impacts his or her ability to provide quality, ethical care to patients and their families” (p. 278). With nursing being founded on solid ethical principles, compromising those principles with a problem like CF could be detrimental to the profession.

Nurses may put internal pressure on themselves to achieve a certain impact or outcome and may feel guilty about the limited time or resources they have to give their patients (Mendes, 2014). Therefore, it is important for nurses to realize their own professional capacity and limitations so that CF does not become a greater issue internally. With this also comes the importance of nurses realizing their own personal internal struggles and factors that may lead to CF such as lack of sleep, stress at home, etc. Having resources available in the workplace may make it easier for nurses to seek assistance when they realize that an internal struggle exists.

### **Recommendations**

Before it becomes problematic for healthcare providers, compassion fatigue needs to be better understood in order to identify and treat it. There are additional potential study areas that may benefit the future of nursing. The relationship between the implications of compassion fatigue and a healthy work environment requires further investigating. Little research has been published in the way of Advanced Practice Registered Nurses. They are invaluable to healthcare and the nursing profession, and it is important to evaluate for the presence of CF among them as well.

Studying coping strategies to improve quality of life for both experienced and inexperienced nurses is another area of possible exploration. According to an integrative literature review by Sorenson, Bolick, Wright, and Hamilton (2016), self-care was

“reported to be the most significant preventative measure healthcare providers could take to protect themselves from CF” (p. 462). Health promotional behaviors may also contribute to nurses’ well-being in countering CF (Neville & Cole, 2013). Perhaps a deeper look is needed into determining what specific coping, self-care, and health promotional strategies are most effective.

### **Conclusion**

This study serves to add to the literature the impact that compassion fatigue may have on nurses. It is necessary to bring awareness to a problem that appears to have gone unnoticed in the past by organizational leadership. Several areas of further investigation regarding compassion fatigue have been identified and have emphasized the need for additional research. Overall results of this study revealed “average” level of burnout and secondary traumatic stress, resulting in an average occurrence among ED nurses of compassion fatigue. With an increase in the complexity of emergency departments and health care in general, it is important to understand the gravity of compassion fatigue and the impact it may have on the future of nursing.

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## Appendix A

## Pro-QOL tool

# Professional Quality of Life Scale (ProQOL)

## *Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)*

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].

9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case *[work]* load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind

me of frightening experiences of the people I [help].

24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

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## Appendix B

Permission to use Pro-QOL 5 Tool

**Permission for Use of the ProQOL  
(Professional Quality of Life Scale:  
Compassion Satisfaction and Compassion  
Fatigue) [www.proqol.org](http://www.proqol.org)**

This document grants you permission to use for your study or project

***The ProQOL (Professional Quality of Life Scale:  
Compassion Satisfaction and Compassion Fatigue)  
[www.ProQOL.org](http://www.ProQOL.org)***

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.

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*Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at [www.proqol.org](http://www.proqol.org) and [www.proqol.org/Donate\\_Data.html](http://www.proqol.org/Donate_Data.html). Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.*

## Appendix C

### Consent for Participation in Research

I volunteer to participate in a research project conducted by Lauren Pittman and in conjunction with Gardner-Webb University. I understand that the project is designed to provide information about the impact of compassion fatigue on emergency department nurses.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I decline to participate or withdraw from the study, there will not be any punitive action taken nor will it affect my job in any way.
2. I understand that participation involves completing an electronic survey. I understand that my name or any identifiers will not be used for this study.
3. I understand that the researcher will not identify me by name in any documents that are submitted for this research project and that my confidentiality as a participant will remain secure.
4. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
5. I further understand that all documents will be submitted to Gardner-Webb University upon completion and final thesis submitted into ProQuest.
6. I have been given a copy of this consent form.

By checking yes, you acknowledge electronic receipt of this consent form and will continue with the rest of the survey.

- Yes, I acknowledge electronic receipt of this consent form and interested in completing this survey.
- No, I am not interested in participating at this time.