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Compassion Fatigue and Burnout of Critical Care Nurses

Lyndsey Brooke Couch

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Compassion Fatigue and Burnout of Critical Care Nurses

by

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A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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Abstract

The purpose of this study was to explore levels of compassion satisfaction, compassion fatigue, burnout, and secondary post-traumatic stress of critical care nurses. Compassion fatigue is a combination of physical, emotional, and spiritual depletion that caregivers experience when they care for patients who are in physical or emotional distress. Compassion fatigue has affected many nurses and has a direct effect on patients' satisfactions. Jean Watson's Theory of Human Caring served as the theoretical framework for this study. The literature shows that there is a prevalence of compassion fatigue of acute care nurses. A quantitative study was performed using the ProQOL tool and the participants' demographics to determine the level of compassion satisfaction, burnout, and post-secondary traumatic stress. Descriptive statistics were used and the results showed critical care nurses had an average level of compassion satisfaction and burnout with a low secondary post-traumatic stress level. This study serves to add to the current literature.

Keywords: Compassion fatigue, compassion satisfaction, burnout, secondary post-traumatic stress, and critical care nurses

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CHAPTER I

Introduction

Nurses care for other's loved ones on a daily basis and are exposed to many different aspects of patients' lives. Some of the experiences and interactions with patients are wonderful and others are very depressing and traumatic. Nurses care for patients across the life spectrum, from birth until death. Many have helped deliver babies, while others have held patients' hands as they have taken their last breaths. These experiences can create stressful situations for nurses which can lead to a decrease in compassion satisfaction and an increase in compassion fatigue, burnout, and secondary traumatic stress.

Significance

Nursing is a very complex, stressful field. Nurses are responsible for the lives of patients they care for and they often forget to take care of themselves due to putting their patients' needs first. Acute care nurses, are caregivers, who have always been at high risk for burnout and stress that is associated with their role (Kelly, Runge, & Spencer, 2015). Nurses are very compassionate about what they do and can obtain professional satisfaction in what they do; but, nurses who provide compassionate care to patients who experience events that are life threatening and deal with the aftermath of critical illnesses are at a high risk for compassion fatigue (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015).

Compassion fatigue is a combination of physical, emotional, and spiritual depletion that caregivers experience when they care for patients who are in physical or emotional distress. Compassion fatigue is a term that is used to describe the combination of secondary trauma and burnout (Figure 1). The symptoms of burnout and compassion

fatigue are similar since they are related. There are emotional, physical, and work-related symptoms of compassion fatigue. Emotional symptoms vary from person to person. Some people become very irritable or have mood swings, memory loss, poor concentration, and depression. One of the main physical symptoms is fatigue; other symptoms may include headaches, diarrhea, or sleep disturbances. Work-related symptoms are when a nurse: calls out of work frequently, dreads working with patients with a particular diagnosis, does not show empathy towards patients and patients' families, and who has a lack of joy. Any of the symptoms discussed above could validate the occurrence of compassion fatigue but normally a nurse would have more than one symptom (Lombardo & Eyre, 2011). According to Lombardo and Eyre (2011) compassion fatigue not only affects the nurse in terms of job satisfaction and emotional and physical health, but also the workplace environment by decreasing productivity and increasing turnover.

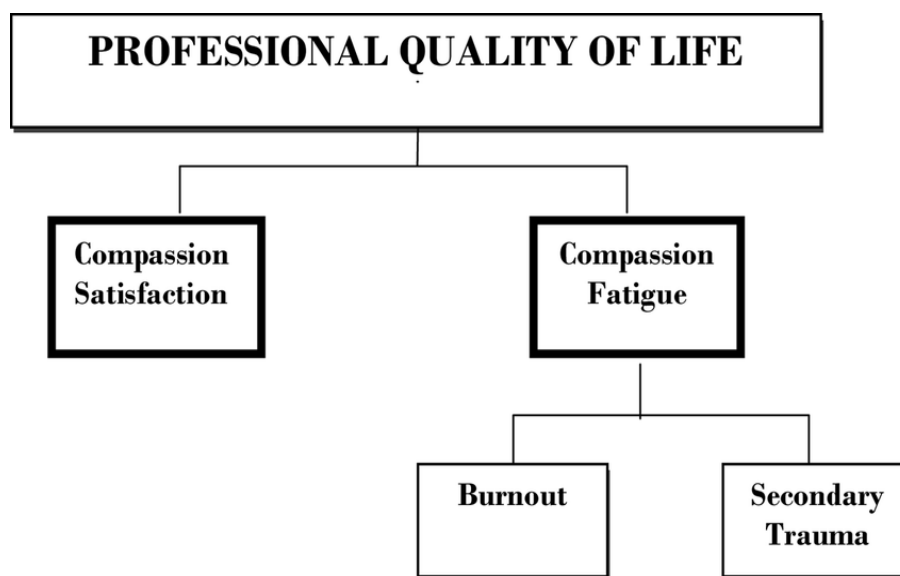


Figure 1. Profession Quality of Life Model (Stamm, 2012)

Garrett (2008) found that job dissatisfaction for nurses is four times higher than the average rate for all United States workers and one in five nurses reported that they intended on leaving their current job within a year. Dr. Christine T. Kovner found that 13% of newly hired registered nurses changed jobs after only one year (Rosseter, 2014). The rate for nurse turnover in 2015 increased to 17.2% from 16.4% in 2014. In 2016, a *National Healthcare Retention & RN Staffing Report* was released and stated:

the cost of turnover can have a profound impact on the already diminishing hospital margin and needs to be managed. According to the survey, the average cost of turn over for a bedside RN ranges from \$37,700 to \$58,400 resulting in the average hospital losing \$5.2M-\$8.1M. Each percent change in RN turnover will cost/save the average hospital an additional \$373,200. (Colosi, 2016, p. 4)

There are many things that contribute to turnover costs. Some cost are contributed to the pre-hiring phase while other costs are incurred during the actual hiring process. Some of the costs that are contributed to entire turnover costs are advertising and recruitment for the new job opening, orientation and training, knowledge deficits, hiring, decreased productivity and vacancy (Jones & Gates 2007). Vacancy cost money because one must hire a temporary nurse from an agency, which cost more than a full time floor nurse, to cover that nurse's position. Organizations that do not want to hire a temporary nurse from another agency, have current nurses pick up extra shifts, which places them in costly overtime.

Problem Statement

There is a huge connection between continuous high work related stress and levels of compassion fatigue. Being stressed can cause a decrease in energy, lower one's

concentration, decrease reactive time, preoccupation with past situations, irritable, and much more. Nurses are potentially placing themselves in harm's way as well as the patients they care for when they are mentally and physically exhausted. Patient satisfaction and, more importantly, patient safety has been directly linked to nurses' job satisfaction. Nurses who work in overly stressed environments have higher turnover rates, more missed days off work, and have higher rates of attrition (Sacco et al., 2015).

There will always be a need for nurses; as long as there are patients to be cared for. The aim of healthcare is patient-centered care, and nurses are the ones who spend the most time with the patients and their families. Nurses who work in acute care or critical care units, not only work long shifts but deal with a lot of stress. Nurses often put their personal needs aside to care for their patients.

Purpose

The purpose of this thesis was to see if nurses, who work in critical care units, were experiencing compassion fatigue and burnout more often than compassion satisfaction.

Research Questions

1. What is the critical care nurses' level of compassion satisfaction, burnout, compassion fatigue, and secondary traumatic stress?
2. Do years of experience or working day shift verses night shift influence the critical care nurses' level of compassion satisfaction, burnout, compassion fatigue, and secondary traumatic stress?

Theoretical Framework

Jean Watson's Theory of Human Caring (1985) served as the theoretical framework for this study. Watson's theory was developed over a five year span and is based on her own views of nursing. It has been used nationally to guide healthcare delivery. Watson believes that nursing focuses on caring, while medicine focuses on curing. She essentially believes that nursing, or caring, is an intersubjective human process, where a high value is placed upon the caring relationship between the nurse and the recipient of care (Watson, 1985).

Watson's theory focuses on the 10 caritas processes and the concepts of transpersonal caring relationships, caring awareness, and caring-healing modalities.

Watson used the word carative instead of curative. The 10 caritas include: to practice love and kindness, having a belief system and hope, having your own spiritual practices and beliefs and opening it to others, sustaining a trusting relationship, listening to others and being supportive, caring-healing process, teaching and learning, giving a healing environment, being able to help patients' essential needs, and to let yourself and patients believe in miracles (Watson, 1985). All 10 of these are interventions that should be used by nursing and are all needed to care for someone. Her original writings have grown dramatically since 1979 and have transformed into a caring science.

Transpersonal caring relationships are the foundation of Watson's work. Smith and Parker (2015) stated that transpersonal caring is both immanent, fully physical and embodied physically, while also paradoxically transcendent, beyond physical self. A transpersonal nurse cares for the mind, body and the soul of the patient; they do not just see or treat the disease/illness but the whole patient. The goal of transpersonal caring is to

connect and embrace the spirit or soul of another by caring and healing (Smith & Parker, 2015).

A caring moment and caring occasion is another element of Watson's theory. A caring occasion occurs when a nurse and another come together and share their life histories in a human-to-human transaction (Watson, 1985). A caring moment involves a choice or an action by both the nurse and the other person. The coming together moment present each person with the opportunity to decide what to do with the moment (Watson, 1985). This process can lead to new possibilities for healing because the two are connected not only physically but spiritually.

Caring (healing) consciousness is another aspect Watson's theory. The entire caring moment is affected by the nurse's consciousness. Caring-healing-loving consciousness is combined into one single caring movement. The one caring and the one being cared for are interconnected (Smith & Parker, 2015). The combined consciousness exists and transcends time and can be dominant over the physical dimensions (Smith & Parker, 2015).

Definition of Terms

- *Compassion fatigue*: Lombardo and Eyre (2011) stated that compassion fatigue is a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress.
- *Burnout*: This term was coined in the 1970s by Herbert Freudenberger. It is described as consequences of severe stress and high ideals experienced by people working in the "helping" professional. Nurses and other healthcare professionals

who sacrifice themselves for others who are physically and mentally exhausted and unable to cope (Johnson, 2013).

- *Compassion satisfaction*: Is a term used to describe taking pleasure in caring for others. It is taking pleasure in knowing what you are doing and are making a difference.
- *Secondary traumatic stress*: Melvin (2015) defines it as the natural, consequent behaviors, and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person that affects caregivers.

Summary

In this thesis, compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress were all explored. Many nurses are choosing to leave their critical care units because it has drained them not only physically but emotionally. Critical care nurses are a specific nursing population that deal with extraordinarily stressful situations on any given day and compassion fatigue can result from these highly stressful situations.

CHAPTER II

Literature Review

The purpose of this study was to better understand compassion satisfaction, compassion fatigue, and burnout of critical care nurses. This chapter explored the concepts of compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress. The following databases were used: Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed.

Literature Related to Problem Statement

Sacco et al. (2015), examined compassion fatigue and compassion satisfaction in adult, pediatric, and neonatal critical care nurses. In 2010, they conducted a cross-sectional study in nine different hospital units. The nine units were: three intensive care units (ICUs; medical, surgical, cardiovascular), three mixed ICUs and progressive care units (PCUs; one medical, two surgical), one pediatric ICU, one pediatric mixed-acuity unit, and one neonatal ICU (Sacco et al., 2015). A demographic questionnaire and the ProQOL survey was emailed to all of the qualified nurses. Two hundred and twenty-one nurses completed the survey and the demographics page, yielding a 38% participation rate. Over 94% of the participants were female and 71% had a bachelor's degree. Participants scored within an average range for all three categories of the ProQOL. The subscale results were: compassion satisfaction $\alpha=0.91$, burnout $\alpha=0.45$, and secondary traumatic stress was $\alpha=0.73$ (Sacco et al., 2015). In this sample, the nurses have an effective balance with their compassion satisfaction and compassion fatigue.

Kelly et al. (2015) explored compassion fatigue and compassion satisfaction of acute care nurses across multiple specialties. The study used a cross-sectional,

quantitative research approach which consisted of the Professional Quality of Life Scale (ProQOL), demographics, and asked if they had ever received meaningful recognition. Four hundred and ninety-one nurses completed the survey, yielding a 35% participation rate. In this study, the respondents had a normal or were in an average range for burnout and compassion satisfaction but were in the low range for secondary traumatic stress. The reliability “for each subscale was also computed and determined to be acceptable for burnout ($\alpha=0.83$), STS ($\alpha=0.79$), and CS ($\alpha=0.92$)” (Kelly et al., 2015, p. 525). Nurses who had received meaningful recognition had more compassion satisfaction than those who did not. Researchers found that the younger generation are experiencing burnout and secondary traumatic situations that are making them leave their current position or even the profession. They concluded organizations should increase compassion satisfaction and increase meaningful recognition because it can combat compassion fatigue and promote nurse retention.

Klopper, Coetzee, Pretorius, and Bester (2012), examined the relationship between critical care nurses’ practice environment to their job satisfaction and burnout in South Africa. South Africa has a dual-health care system. The public sector is responsible for approximately 80% of the population and offers free healthcare to the impoverished population. The private sector is responsible for approximately 20% of the population but consumes 60% of the health expenditures. The private sector “comprises for-profit organizations and individuals, which serves the population that can either afford medical insurance or pay from their own pockets” (Klopper et al., 2012, p.685-686). Nine hundred and thirty five critical care nurses completed the RN4CAST survey and the Practice Environment Scale of the Nursing Work Index (PES-NWI). RN4CAST is a

survey that consists of nine specific aspects of a job: work schedule flexibility, opportunities for advancement, independence at work, professional status, wages, educational opportunities, annual leave, sick leave and study leave (Klopper et al., 2012). The PES-NWI measures elements of the nurses' practice environment. The researchers concluded from the results that there is a high degree of burnout for multiple reasons: inadequate staffing for leaves, dissatisfaction of wages, and lack of nurse participation in hospital affairs.

Alharbi, Wilson, Woods, and Usher (2016) conducted a study in Saudi Arabia, to measure critical care nurses' level of burnout and job satisfaction and to determine if the two variables had a relationship. A questionnaire that incorporated the Maslach Burnout Inventory (MBI), demographic variables, and the job satisfaction survey (JSS) were distributed to critical care nurses in three different hospitals. MBI is an instrument that is used to not only measure the symptoms of burnout but to determine its characteristics and has three subscales: emotional exhaustion, depersonalization, and personal accomplishment. The JSS is a survey that assess employees' attitudes about their job and consists of 36 items and responses are scored on a 6-point Likert's scale. One hundred and fifty Saudi national critical care nurses completed the combined survey for the study. According to the demographics the participants' age ranged from 20 and 45 years old; but majority of the participants were between 26 and 30. Only 1/3 of the participants had an associate's degree, bachelor's degree, or an advance practicing degree. 84% of the nurses reported high levels of emotional exhaustion and 77% reported high levels of depersonalization, while only 42% had high levels of perceived personal accomplishment. Job satisfaction scores negatively correlated with "emotional exhaustion

($\beta = -0.41$, $t(19) = 2.53$, $P < 0.05$), decreasing by 0.41 for every extra point of emotional exhaustion” (Alharbi et al., 2016, p. 714). Emotional exhaustion is a component of burnout therefore burnout is a predictor for low job satisfaction according to these findings (Alharbi et al., 2016).

A study was conducted in China between December of 2010 to March of 2011 by Liu, While, Li, and Ye. The aim of the study was to explore cardiac critical care nurses’ views of their job satisfaction and to examine the related personal and work-factors. Participants were asked to complete demographic characteristics, Mueller-McCloskey Satisfaction Scale (MMSS), the Maslach Burnout Inventory (MBI), the Practice Environment Score of the Nursing Work Index (PES-NWI), the Simplified Coping Style Questionnaire (SCSQ), and the Social Support Rating Scale (SSRS). Surveys were distributed to the nurse managers of each cardiac unit and they were asked to distribute to nurses who have at least three months experience in the cardiac critical care unit. The MMSS is a five-point Likert type scale which is comprised of 31 items. The MBI is also a Likert scale but is a seven-point scale comprised of 22 items. The PES-NWI is comprised of 31 items and answered with a four-point rating scale. SCSQ is also a four-point rating scale comprised of 20 items. The SSRS has some items that use a four point Likert’s scale and also some items that are multiple choice questions. Two hundred and fifteen of the 220 qualified nurses participated in the study. Over half of the participants were satisfied with their jobs but were dissatisfied with their extrinsic rewards, responsibilities, work-life balance, scheduling and professional opportunities. Their data was inputted into a logistics regression analysis and determined that years of experience and holiday entitlement take a huge part in job satisfaction. Nurses with less than 20

years of experience were 4.484 times more likely to be satisfied with their job than nurses who have worked more than 20 years. A little over half of the participants were experiencing a high level of emotional exhaustion. Only 39.4% of the participants were experiencing depersonalization but 75.9% of the participants reported having a very low level of personal accomplishment. Over 80% of the respondents reported that their current environment was favorable except for staffing. 58.1% of the cardiac critical care nurse were satisfied with their job (Liu, While, Li, & Ye, 2015).

Meltzer and Huckabay (2004) studied the relationship between critical care nurses' perceptions of futile care and its effects on burnout in Southern California. Futile medical treatments or care occurs when a patient is receiving life-sustaining interventions but the treatments do not have any medical benefit for the patient. Moral distress occurs when a person perceives the right course of action but is not able to implement the actions due to institutional restraints. Continued emotional stress can be an occupational hazard and is considered burnout. Sixty nurses who worked for at least one year full-time in an adult ICU, coronary care, or neurological ICU at two hospitals participated in the study. Each subject completed a sociodemographic data survey that the researchers developed as well as the Moral Distress Scale and the Maslach Burnout Inventory. The researchers contacted Corley who developed the Moral Distress Scale to omit four of the items because they did not pertain to this study. A Pearson product moment correlation analysis "indicated a significant positive correlation ($r=0.317$, $P=.05$) between scores on the MBI emotional exhaustion subscale and scores on the MDS frequency subscale" (Metzer & Huckabay, 2004, p. 205). Moral distress accounted for 10% of the variance in emotional exhaustion. According to this study, younger nurses and nurses who float

between multiple ICUs have a greater chance of burnout due to depersonalization compared to the older nurses or nurses who work only in one unit (Metzer & Heckabay, 2004).

Mealer, Shelton, Berg, Rothbaum, and Moss (2007) conducted a study in Georgia to determine if there is an increased prevalence of post-traumatic stress symptoms or other psychological symptoms in critical care nurses compared to general nurses. A total of 351 full-time nurses (230 ICU and 121 general) were surveyed from three different hospitals and 140 ICU nurses were surveyed from the metropolitan area. A questionnaire survey that included a demographic information, Post-Traumatic Stress Syndrome 10 Question Inventory (PTSS-10), and a Hospital Anxiety and Depression Scale (HADS) were answered anonymously by the participants. The entire survey was also mailed to 415 members of the American Nurses Association of Critical Care Nurses who lived within a 100 mile radius of Atlanta (Mealer et al., 2007). ICU nurses and general nurses reported an equivalent amount of stress outside of the workplace. Twenty-four percent of the ICU nurses reported symptoms of PTSD compared to 14% of general nurses. Both ICU nurses and general nurses had similar results when it came to symptoms of possible anxiety and depression according to the HADS questionnaire. The results were compared to the 140 ICU nurses who completed the survey who worked in the surrounding hospitals; 29% of the nurses tested positive for PTSD. Their research concluded that critical care nurses are more likely to have symptoms of PTSD compared to those who work on a general medical/surgical unit (Mealer et al., 2007).

McMeekin, Hickman, Douglas, and Kelley (2017), explored the relationship among postcode stress, PTSD symptom severity, and coping behaviors of critical care

nurses who had participated in an unsuccessful cardiopulmonary resuscitation within the last year. Four-hundred and ninety critical care nurses participated in the study. The researchers used electronic advertisements for the study that were disseminated by the American Nurses Association of Critical Care Nurses. There were three instruments and a demographics page that were used in the study: Post-Code Stress Scale (PCSS), the Brief COPE inventory (BCOPE), and the Impact of Event Scale-Revised (IES-R). The PCSS measures the magnitude of ones' stress associated with cardiopulmonary resuscitation; it is a 14 item questionnaire that uses a 5-point Likert scale. BCOPE assesses coping behaviors of those who have be exposed to an unsuccessful cardiopulmonary resuscitation by using a 28 item questionnaire that uses a 4-point Likert scale. The IES-R is a 22 item questionnaire that measures PTSD symptom severity and uses a 5-point Likert scale. Data was analyzed by SPSS software and showed that postcode stress and PTSD symptom severity were weakly associated ($r=0.20$, $P=.01$) (McMeekin et al., 2017). Median scores for PTSD symptom severity were significantly higher for females (20.0) compared to males (7.0). Researchers concluded that nurses had ineffective coping strategies after an unsuccessful cardiopulmonary resuscitation which has resulted in PTSD.

Denat, Gokce, Gungor, Akgullu, and Zencir (2016) conducted a study in Turkey to determine the relationship between critical care nurses levels of anxiety and burnout as well as the prevalence of atrial and ventricular arrhythmias. Burnout and anxiety have been shown to have a negative effect on one's quality of life, including, one's mental and physical health. Critical care nurses who were allowed to participate in the study were ones who have not been diagnosed with structural heart disease, hyperthyroidism,

asthma, and had no active infection or fever. Nurses who were taking antidepressant or an antiarrhythmic were excluded as well (Denat et al., 2016). Fifty-one nurses participated in the study. Each participant took the Beck's Anxiety Inventory (BAI), Maslach Burnout Inventory (MBI), and had echocardiographic studies which included an ultrasound of the heart (ECHO) and were connected to a Holter electrocardiogram (ECG) monitor for 24 hours. The ECHO results were normal for all of the participants. ECG showed 21.6% of the nurses had ventricular arrhythmias and 35.3% had atrial arrhythmias (Denat et al., 2016). No difference was found between the burnout scores of ones who had arrhythmias or not. There was only a positive correlation between the nurses who have personal accomplishment (part of burnout) and number of arrhythmias ($p < 0.001$) (Denat et al., 2016). Anxiety and emotional exhaustion levels were very low; the researchers concluded this was because the nurses had only 1 to 10 years of experience.

A study was conducted in Thailand to investigate the effect of nurse burnout on nurse-reported quality of care and patient adverse events and outcomes (Nantsupawat, Nantsupawat, Kunaviktikul, Turale, & Poghosyan, 2015). Data was collected from 2,084 registered nurses who work in 94 community hospitals across Thailand. Each participant filled out the Maslach Burnout Inventory and answered questions on quality of care and patient outcomes based off their last shift. Descriptive statistics were used to analyze the data. There are three parts of burnout: 32% of the nurses showed having high emotional exhaustion, 18% had high depersonalization, and 35% has low personal accomplishment (Nantsupawat et al., 2016). Sixteen percent of the nurses reported that the quality of care and patient outcomes was fair or poor on their previous shift. Nurses have 2.63 times chance of reporting medication errors or quality of care of patient being fair or poor when

experiencing high emotional exhaustion. When a nurse is also experiencing high levels of depersonalization they are 3.21 times more likely to have a decrease in quality of care and report medication errors and infections. Low personal accomplishment among nurses also showed an increased odds of 1.73 in reporting care as fair or poor. These findings show that nurse burnout is associated with increased odds of negative patient outcomes (Nantsupawat, 2015).

Toscano and Ponterdolph (1998) conducted a study to see if there is a relationship between burnout and personality hardiness of critical care nurses. Hardiness in this study is a personality trait that “moderates the effects of stress on health. People with hardy personalities have been shown to encounter less illness, despite the stressful situations they face, because they possess three adaptive characteristics: commitment, control, and challenge” (Toscano & Ponterdolph, 1998). Two-Hundred and fifty critical care nurses who were registered with the American Association of Critical Care Nurses were asked to participate in the study but only 100 completed the entire survey. Participants were asked to complete a demographic form, the Maslach Burnout Inventory, and the Third Generation Hardiness Test. The Third Generation Hardiness Test consists of 50 items that explores one’s control, commitment, and challenge. One hundred percent of the participants were women and ages ranged from 26-58. Seventy-four percent of the nurses worked full-time and years of experience had a huge range from 1 to 38 years. The “alpha coefficient for the MBI was .7909 and the alpha coefficient for the Third Generation Hardiness Test was .8718” (Toscano & Ponterdolph, 1998). The Pearson’s correlation did not show a relationship between the variables.

Shahriari, Shamali, and Yazdannik (2014), explored the relationship between fixed and rotating shifts and burnout of critical care nurses in Isfahan in 2013. A rotating shift consists of any shift (morning, evening, and night) that alternates during a month. A fixed shift consists of either morning, evening or night shifts that stay consistent during the month (Shahriari et al., 2014). The participants had to work in either rotating or fixed shifts for at least a year. A total of 850 critical care nurses worked at the six selected hospitals and 170 of them were chosen randomly to participate in the study; 85 in rotating shift and 85 in fixed shifts. Two instruments were used to collect data: the Maslach Burnout Inventory (MBI) and a version of the Human Services Survey (HSS). The MBI-HSS measures burnout in terms of emotional exhaustion, depersonalization, and personal accomplishment. The two groups of participants did not differ significantly in their demographic traits. The scores for depersonalization and emotion exhaustion were significantly high in the participants who worked fixed shifts; but the mean score for personal accomplishment had no difference between the two shifts. The rotating shift nurses had pretty low results with their burnout aside from personal achievement: 12.9% in emotional exhaustion and 29.4% in depersonalization. The nurses who worked fixed shifts had high burnout with 60% in emotional exhaustion and 48.1% in depersonalization (Shahriari et al., 2014). This study revealed that critical care nurses who work a fixed shift schedule displayed more burnout than those who work a rotating shift schedule.

Ninety-eight critical care nurses, who had worked at least one year full-time in Northern State of Spain, participated in a study conducted by Losa Iglesias, Becerro de Bengoa Vallejo, and Salvadores Fuentes (2010). They believed that experiential

avoidance may be associated with burnout. Experiential avoidance occurs when a person is unwilling to experience certain negative experiences; one modifies their response by using avoidance tactics (Losa Iglesias et al., 2010). Eighty of the 98 critical care nurses agreed to complete the entire survey which consisted of a demographics page, the Maslach Burnout Inventory, and the Acceptance and Action Questionnaire (measures experiential avoidance). The Acceptance and Action Questionnaire consists of nine items that use a 7-point Likert scale. The MBI showed the nurses had a high level of emotional exhaustion, low level of personal accomplishment, and a moderate level of depersonalization. Pearson product moment correlation analyzed the data and showed that there was a significant “inverse correlation between the MBI personal accomplishment subscale and scores on the AAQ frequency ($r=0.237$, $p=0.05$). More significant was the positive correlation between depersonalization and AAQ scores ($r=0.525$, $p=0.01$) and between emotional exhaustion and AAQ scores ($r=0.507$, $p=0.01$)” (Losa Iglesias et al., 2010, p. 33).

This particular study showed that when nurses try to control their feelings to avoid negative situations, behavioral consequences of burnout syndrome are noted. Researchers concluded that nurses who experience burnout and experiential avoidance can have a decrease in the quality of care their patients receive, have high turnover rates, and have a decrease in their own well-being.

Zhang, Tao, Ellenbecker, and Liu (2013) explored job satisfaction of critical care nurses and general ward nurses in China. The researchers distributed 1,700 questionnaires to nine different hospitals; they received 446 back from critical care nurses and 1,118 from general ward nurses. The questionnaires had a cover letter, demographic

sheet, and the Chinese Nurse Job Satisfaction Scale (CNJSS). This scale consisted of 38 items and responses were scored on a five-point Likert scale. There were eight subscales that measured job satisfaction: administration, workloads, co-workers, work itself, pay, professional opportunities, praise/recognition, and family/work balance (Zhang et al., 2013). The report showed that general ward nurses had more satisfaction when it came to “co-workers ($t=5.796$, $p<0.001$), family/work balance ($t=5.305$, $p<0.001$), administration ($t=4.619$, $P<0.001$), praise/recognition ($t=5.826$, $p<0.001$), workloads ($t=4.473$, $P<0.001$), work itself ($t=6.090$, $P<0.001$) and pay ($t=2.965$, $P=2.965$)” (Zhang et al., 2013, p. 1730). In this study, general ward nurses were overall more satisfied with their job than critical care nurses ($t=6.899$, $P<0.001$) (Zhang et al., 2013).

Strengths and Limitations of Literature

The literature adds to global research that studies nurses who are experiencing burnout. One of the limitations of the literature was that almost every study used a cross-sectional, convenience sample. When using a convenience sampling method, it limits the generalizability of the results. The results could be bias because nurses who experience high levels of burnout would have a lack of motivation to participate. The sample sizes seemed large in most studies but each sample size was focused on a few hospitals in surrounding areas; the sample size of the national studies were microscopic.

Summary

The research showed that many nurses who work in critical care unit across the world are experiencing compassion fatigue, burnout, and secondary traumatic stress. Critical care nurses showed low compassion satisfaction and lower overall job satisfaction than those who work in a general unit. Compassion fatigue has been shown to cause numerous health problems and lack of concentration and was dangerous not only for the nurse experiencing it but for the patients' she or he is caring for.

CHAPTER III

Methodology

The purpose of this study was to better understand compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress of critical care nurses. This chapter discussed the research design, setting, sample size, and how the data was gathered and analyzed.

Research Design

A quantitative research design was used to conduct this study. A form of paper surveys was used in this study.

Setting

This study was conducted at a nonprofit, 101-bed rural hospital located in the southeast United States. The county's population as of July 2016 was 81,168 (U.S. Census Bureau, 2016). The hospital was relocated and rebuilt in 2010 when it became part of a larger organization. There are three floors in the facility and two medical office buildings which are attached and not included in the bed size. The units in the hospital include: medical, telemetry, critical care, obstetrics, and the emergency department. The medical office buildings house many doctors' offices and an infusion center. The doctor offices are for surgeons, obstetrics and gynecology, urology, and oncology/hematology. For this study, the critical care unit was used. The critical care unit is a 10-bed unit. Unlike the rest of the hospital, one is able to visit their loved ones at any time during their stay but only three visitors are allowed in the rooms at one time.

Sample

The target population for this study was registered nurses or advanced registered nurses who work or float to the critical care unit and provide direct patient-care by working at the bedside at least once a week. A convenience sample of 34 nurses were asked to participate in this study.

Protection of Human Subjects

Prior to the study taking place, approval was obtained from both the educational institution and the research institution. This research was deemed to have minimal risks for participants. Participants were provided with an informed consent (Appendix A). Participation in the study was voluntary. Participants had the right to refuse to participate in any part of the study or to drop out of the study at any time with no penalty.

Instruments

Participants were asked to complete a demographic tool (Appendix B) and the Professional Quality of Life Scale (ProQOL) (Appendix C). The demographic tool was developed by the researcher and was used to describe the population. The ProQOL was developed by Dr. Beth Hudnall Stamm and has been used since 1995. Before 1995, the scale was called Compassion Fatigue Test. There have been revisions since 1995 and the most current version is ProQOL 5 (Stamm, 2012).

The Professional Quality of Life Scale measures compassion satisfaction and compassion fatigue. Compassion fatigue has two subscales: burnout and secondary trauma. The instrument uses 30 questions which are rated on a scale of one to five. A five point Likert scale includes responses of one=never, two=rarely, three=sometimes, 4=often, and 5=very often. Certain questions relate to the compassion satisfaction,

burnout, and secondary traumatic stress. Scores are tallied for each section to determine a participant's level of compassion satisfaction and compassion fatigue.

According to Stamm (2005), the alpha reliabilities for compassion satisfaction is $\alpha=.87$, burnout is $\alpha=.72$, and compassion fatigue is $\alpha=.80$. The data has suggested that the test has good reliability with a small standard error. The validity of the test was established with over 200 peer-reviewed articles. Compassion satisfaction scale has a 5% shared variance with burnout and a 2% shared variance with compassion fatigue/secondary trauma. While the shared variance between compassion fatigue/secondary trauma and burnout is 21%, this is because they both have distress but are two different scales (Stamm, 2005).

Data Collection Procedure

An envelope containing a letter explaining the purpose of the study, an informed consent, a demographics sheet, and the ProQOL scale was placed in each qualified nurse's mailbox in the critical care unit. Nurses were notified of the envelopes being placed in their boxes by an announcement in daily huddle. The nurses were given two weeks to complete the survey. Completed surveys were placed in a secured box in the critical care unit's breakroom.

Data Analysis

Data was analyzed using the Statistical Package for Social Sciences (SPSS). Descriptive statistics were used.

CHAPTER IV

Results

Critical care nurses may experience compassion satisfaction, compassion fatigue, and secondary post-traumatic stress from intense relationships they build with patients. The purpose of this study was to explore compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress levels of critical care nurses.

Sample Characteristics

Twenty-four of the 34 critical care nurses participated in the study yielding a 70.59% participation rate. According to the demographics, day shift (0700-1900) and night shift (1900-0700) had equal representation in the study with 12 participants from each shift. The participants' years of experience as a registered nurse ranged from 1 to 32 years with a reported mean of 10.83 (sd=8.29). The participants' years of experience in a critical care unit ranged from 1 to 25 with a reported mean of 7.00 (sd=5.93). Experience levels are displayed in Table 1.

Table 1

ProQOL by Years of Experience and Critical Care Experience (n=24)

	Min	Max	M	SD
Years of Experience	1	32	10.83	8.29
Critical Care Experience	1	25	7	5.93

Major Findings

Nurses who participated in the study completed the ProQOL survey. According to the ProQOL, low scores are classified as less than or equal to 22, average scores are 23-41, and high scores are greater than or equal to 42 (Stamm, 2012). Results of the ProQOL

survey demonstrated that high levels of compassion satisfaction were reported by 33.3% (n=X) of participants, while 66.67% (n=X) of participants reported moderate levels of compassion satisfaction. Low burnout was reported by 41.67% (n=X) of participants, while 58.33% (n=X) of participants reported an average level of burnout. Low secondary post-traumatic stress was reported by 87.5% (n=X) of participants, with 12.5% (n=X) reporting an average level of secondary post-traumatic stress.

Overall critical care nurses reported an average level of compassion satisfaction (m=38.2, sd=6.4), average burnout (m=23.1, sd=3.4), and low secondary traumatic stress (m=18.9, sd=3.9). Results are displayed in Table 2.

Table 2

Overall Average of ProQOL Results (n=24)

	M	SD
Compassion Satisfaction	38.2	6.4
Burnout	23.1	3.4
Secondary Post-Traumatic Stress	18.9	3.9

There were minimum differences found between shift worked and the nurses' level of compassion satisfaction, burnout, and secondary traumatic stress. For compassion satisfaction, first shift had a mean of 41.2 (sd =6.3), while second shift had a mean of 35.3 (sd=5.0). The mean for burnout for first shift was 22.8 (sd=4.0), while second shift had a mean of 23.5 (sd=2.9). Secondary Post-Traumatic Stress had a mean of 18.8 (sd=5.0) on first shift and a mean of 19.0 (sd=2.6) for second shift. Results are displayed in Table 3.

Table 3

ProQOL Results by Shift (n=24)

	1 st Shift		2 nd Shift	
	M	SD	M	SD
Compassion Satisfaction	41.2	6.3	35.3	5.0
Burnout	22.8	4.0	23.5	2.9
Secondary Post-Traumatic Stress	18.8	5.0	19.0	2.6

There were minimal differences found between years of experience and nurses' level of compassion satisfaction, burnout, and secondary post-traumatic stress. Participants with one to five years of experience had mean scores of 36.5 (sd=6.8) for compassion satisfaction, 21.5 (sd=4.4) for burnout, and 18.2 (sd=3.2) for secondary post-traumatic stress. Participants with six to ten years of experience had mean scores of 36.8 (sd=5.2) for compassion satisfaction, 24.2 (sd=3.2) for burnout, and 20.7 (sd=4.6) for secondary post-traumatic stress. Nurses who had 11-20 years of experience had mean scores of 42.3 (sd=6.1) for compassion satisfaction, 22.0 (sd=2.0), and 19.3 (sd=2.0) for secondary post-traumatic stress. Nurses who had 20 or more years of experience had mean scores of 37.7 (sd=9.3) for compassion fatigue, 25.3 (sd=3.5) for burnout, and 14.3 (sd=3.1) for secondary post-traumatic stress. Results are displayed in Table 4.

Table 4

ProQOL Results by Years of Experience (n=24)

Years of Experience		
	M	SD
Compassion Satisfaction		
1-5	36.5	6.8
6-10	36.8	5.2
11-20	42.3	6.1
20+	37.7	9.3
Burnout		
1-5	21.5	4.4
6-10	24.2	3.2
11-20	22.0	2.0
20+	25.3	3.5
Secondary Post-Traumatic Stress		
1-5	18.2	3.2
6-10	20.7	4.6
11-20	19.3	2.0
20+	14.3	3.1

Summary

The overall findings showed that nurses who work in the critical care unit reported experiencing average levels of compassion satisfaction, average levels of burnout, and low levels of post-secondary traumatic stress. According to this study, there were minimum differences between years of experience and shift worked in relation to their compassion satisfaction, compassion fatigue, burnout and secondary post-traumatic stress.

CHAPTER V

Discussion

The purpose of this study was to gain a better understanding of compassion fatigue and burnout of critical care nurses. The literature showed that many nurses who work in critical care units experience some level of compassion fatigue, burnout, and secondary traumatic stress. The results from this study validated the presence of average compassion fatigue among critical care nurses.

Implication of Findings

The overall findings showed that nurses who work in critical care unit reported experiencing average levels of compassion satisfaction, average levels of burnout, and low levels of post-secondary traumatic stress. Stamm (2010) stated that the most important thing to keep in mind that the ProQOL is not a diagnostic test. The test can help bring awareness to issues that need to be addressed. For example, a person who has a “high score on burnout or secondary traumatic stress or a high score on both with a low score on compassion satisfaction, can be an augury of clinical depression that deserves treatment” (Stamm, 2010, p. 18). According to Stamm (2010), the ProQOL can be a guide for companies or “organization’s balance of positive and negative experience...high scores on compassion satisfaction are a reflection of engagement with the work being done” (p.19).

When comparing the results to the literature, this study had a better participation rate but had an average level of compassion fatigue instead of a high level. This is perhaps due to the timeframe in which the study was conducted. The survey was distributed at the end of summer when the participants had already had vacation times

and census had been very low so many participants had been on call a lot. If the survey would have been completed during the winter, perhaps there would have higher levels of compassion fatigue. Six employees left the critical care unit due to fatigue two weeks prior to the study. Compassion fatigue exists and needs to be acknowledged.

Application to Theoretical/Conceptual Framework

Watson's Theory of Human Caring was a great choice for the theoretical framework in guiding this study because the ProQOL is a questionnaire that asks how you "care" or "help" others and how you feel when doing so. This all leads back to the fundamentals of Watson's Theory of Caring. Results of this study showed that the critical care nurses are experiencing average levels of compassion fatigue as well as average levels of compassion satisfaction which could impact nursing as a whole. Empathy and caring is a huge part of Watson's theory and if compromised from compassion fatigue, patients and nurses will both suffer. Leaders should focus on ways to increase compassion satisfaction and decrease compassion fatigue.

Limitations

A potential limitation of this study was that only one critical care unit was surveyed. Since there were only 34 possible participants the data could be biased to this particular unit. The second potential limitation of this study was the timing; the study, was conducted at the end of the summer and census was at an all-time low. Another potential limitation of the study was the tool that was used. The tool is not specific for critical care nurses.

Implications for Nursing

This study serves to add to current literature of critical care nurses who experience compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress. Though this study did not show concerns regarding compassion satisfaction, compassion fatigue, or burnout, nurses, who work in the critical care units, are still at risk in for developing these due to the stressful environments they work in. Healthcare organizations should acknowledge that compassion fatigue is a problem and provide a supportive network for all nurses. Nurses also need to develop self-awareness of compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress. This study suggested that nurses need to be educated on signs of compassion fatigue, burnout, and secondary post-traumatic stress and ways to reduce them as well.

Recommendations

Continual research on compassion fatigue and efforts on how to address compassion fatigue are needed. Educational opportunities should be readily available for nurses and nurses should feel free to discuss their concerns with their employers and leaders. Leaders should discuss compassion fatigue and compassion satisfaction with the staff to see if there can be anything to be changed with the work environment since there is a huge connection between continuous high work related stress and levels of compassion fatigue (Sacco et al., 2015). Relationships between a healthy work environment and compassion satisfactions needs to be further investigated.

Conclusion

Being stressed can cause a decrease in one's energy, lower one's concentration, decrease reactive time, preoccupation with past situations, irritable, and much more. Critical care nurses are potentially placing themselves in harm's way as well as the patients they care for when they are mentally and physically exhausted (experiencing compassion fatigue or burnout). Nurses who work in acute care or critical care units, not only work long shifts but deal with a lot of stress and it starts to have a toll on the body and a decrease in patient satisfaction. Even though this study only showed an average level of compassion satisfaction as well as an average level of compassion fatigue, it showed that it is still prevalent and showed that it needs to be addressed. There will always be a need for nurses; as long as there are patients to be cared for, which is why nurses need to have high levels of compassion satisfaction and low levels of burnout.

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Appendix A

Informed Consent

I freely and voluntarily and without any force or coercion, consent to participate in the research project entitled “Compassion Fatigue and Burnout of Critical Care Nurses.”

This research project will be conducted by Lyndsey Brooke Couch, R.N., BSN, who is a graduate student at Gardner-Webb University. She is under the guidance of Dr. Tracy Arnold who is a faculty member in the Gardner-Webb’s Hunt School of Nursing.

PURPOSE: The purpose of this research study is to better understand the prevalence of compassion satisfaction, compassion fatigue, and burnout of critical care nurses.

PROCEDURE: You are being asked to complete a demographic tool and the Professional Quality of Life Scale. The approximate time required to complete both surveys is 10 minutes. Upon completion of the surveys you have no further obligation to the research study.

VOLUNTARY PARTICIPATION: Participation in this study is completely voluntary and confidential. Your decision to participate or not to participate will not impact your employment with Carolinas HealthCare System- Lincoln or relationship with Gardner-Webb University at any time. Should you choose to participate in this research study, you have the right to withdraw at any time without consequence. Additionally, you have the right to refuse to answer any question(s) for any reason, without consequence.

RISKS AND BENEFITS: There is a minimal level risk involved in participating in this study; however, if you experience any type of distress from completing the survey, please contact the Employee Assistance Program at Carolinas HealthCare System-Lincoln at 704-355-5021.

There are no direct benefits associated with participating in this study; however, it is hoped that your input will help nursing and organizational leaders understand the critical care nurse’s professional quality of life.

If you have questions, want more information or have suggestions about the research you may contact the researcher at ljohnson7@gardner-webb.edu. You may also contact my professor, Dr. Tracy Arnold at tarnold@gardner-webb.edu or at 704-406-4359. If you have concerns about your rights or treatment, or the risks and benefits related to this study you may contact the Gardner-Webb University Institutional Review Board at 704-406-4724.

CONFIDENTIALITY: Participation and responses to the survey questions will be anonymous and confidential. Please do not disclose identifying information on the surveys.

All survey results and data analysis will be stored on the researcher's password protected personal computer. The collected data and results will be retained by the Hunt School of Nursing for three years in a secured location.

CONSENT TO PARTICPATE: By completing this survey you are voluntarily consenting to participate in this research study. If you choose not to participate in this study, please discard this survey.

Appendix B
Demographics Profile

1. Years of experience as a nurse _____
2. Years of experience as a critical care nurse _____
3. Which shift do you work?
 - 0700-1900
 - 1900-0700
 - Other: Please specify: _____

- _____ 29. I am a very caring person.
- _____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress _____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about

- *1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

the effects of helping when you are not happy so you reverse the score

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High