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The Presence of Compassion Fatigue in the Private Practice Setting

Santisha Lynette Walker

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The Presence of Compassion Fatigue in the Private Practice Setting

by

Santisha L. Walker

A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
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Abstract

Nurses play an intricate role in healthcare and may carry a burden while providing patient care. Bearing this burden could lead to a significant level of stress, which in turn could cause compassion fatigue. Many nurses face issues of stress and fatigue during their daily nursing practice, leading to unsafe conditions for patients and a decrease in quality of life. The purpose of this study was to assess nurses' perception of the presence of compassion fatigue for nurses working in the private practice setting. This quantitative study, guided by the Neuman Systems Model, consisted of a non-randomized convenience sample of 15 nurses at a private neurology practice. The measurement tool used for the study was the Professional Quality of Life, Version 5 (ProQOL V5), consisting of 30 questions on a 5-point Likert scale. The ProQOL V5 includes three subscales: compassion satisfaction, burnout, and secondary traumatic stress. The burnout and secondary traumatic stress subscales combine to form compassion fatigue; therefore, the data analysis was focused on questions related to burnout and secondary traumatic stress. One sample t-test portrayed minimal difference between the responses to the questions about burnout ($M = 48.27$, $SD = 6.724$, $p = .335$) and secondary traumatic stress ($M = 47.00$, $SD = 8.552$, $p = .196$) when compared to previous responses from the ProQOL V5 questionnaire measuring compassion fatigue ($M = 50$, $SD = 10$). Findings from the study indicated that although compassion fatigue, consisting of the subscales burnout and secondary traumatic stress, was present in the private practice setting, there was minimal difference in the prevalence of compassion fatigue in the private practice setting compared to other healthcare settings.

Keywords: compassion fatigue, burnout, nurse stress, private practice, outpatient nurse, Betty Neuman, Neuman Systems Model.

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In loving memory of my grandmothers who were caretakers

Esther Mae Farrar

(1940-2015)

Mary Catherine Temple

(1929-1973)

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CHAPTER I

Introduction

Background

The profession of nursing plays a significant role in the healthcare field, and will continue to contribute to healthcare's overall operation. Because of the nurse's contribution to healthcare, nurses tend to carry a burden while providing patient care. With this burden comes a significant level of stress during patient interactions, which could lead to compassion fatigue. According to Bao and Taliaferro (2015), compassion fatigue is comprised of burnout and secondary traumatic stress. Burnout stems from frustration, powerlessness, and the inability to achieve work goals, while secondary traumatic stress is the manifestation of resulting emotional stress caused by experiencing and being a part of patients' traumatic stress through empathy. Compassion fatigue historically has been studied in populations other than nursing, however it is common in healthcare today. Over the past 20 years, the dynamics of compassion fatigue have received more attention within the realm of caregiving stress, considering a wider array of other healthcare professionals (Boyle, 2011). Compassion fatigue is experienced by individuals who help others in distress; therefore, it results from caring for patients in physical and/or emotional pain or distress. Symptoms of compassion fatigue may onset acutely and can lead to over involvement of care (Lombardo & Eyre, 2011). Compassion fatigue may reduce nurse's capacity to be compassionate for their patients and could potentially interfere with their professional quality of care, which could ultimately lead to compromised quality of care for patients. Some evidence suggests that compassion

fatigue contributes to a high turnover rate and decreased productivity (Bao & Taliaferro, 2015).

Nurses who experience compassion fatigue may demonstrate anxiety both at work and home, difficulty sleeping due to stress, and judgement errors. There is an inverse relationship between compassion fatigue and compassion satisfaction; therefore, a nursing environment consisting of poor nurse staffing, unhealthy work environments, high workloads, and the increasing complexity of healthcare can contribute to decreased nurse satisfaction and lead to the development of compassion fatigue (Henson, 2017). Many nurses face these types of issues during their daily nursing practice, which could contribute to unsafe conditions for patients and to nurses' decreased quality of life. Taking time to understand individual nurses and their environments can lead to the development of support programs and adaption of the work environment to prevent compassion fatigue (Henson, 2017).

Problem Statement

The problem of concern is that nurses are experiencing compassion fatigue. The nursing profession consists of high levels of stress due to being one of the most demanding professions globally when compared to other professions and the nursing profession is characterized by immense workloads, intensity of work, and is fast paced (Fradelos et al., 2014). Compassion fatigue may have a direct relationship to decreased quality of care provided for patients due to decreased productivity; therefore, whenever compassion fatigue occurs, there may be a failure to recognize when patients are in distress (Potter et al., 2010). Compassion fatigue also has a direct impact on the nurse's quality of life, leading to burnout and secondary traumatic stress, which are both

considered negative aspects of professional quality of life (Stamm, 2010). Burnout correlates with a decrease in job satisfaction, which may stem from exhaustion and disinterest (Stewart & Terry, 2014). If nurses become exhausted it may be more challenging to complete the day to day tasks and demands of the job. This challenge has a direct effect on patient care and therefore should be addressed.

Significance

Due to the essential role of nurses regarding patient safety, taking time to understand the issue of nurse compassion fatigue and the effect it has on the nursing profession is imperative. There could be professional consequences involved with compassion fatigue, and there are vital implications for the well-being of the nurse, as well as the safety of patients when considering compassion fatigue for nurses (Fradelos et al., 2014). Understanding how to adequately promote and maintain nurses' compassionate care is critical for nurses to be able to deliver quality care to patients with optimal outcomes (Bao & Taliaferro, 2015). Nurses experiencing the burnout aspect of compassion fatigue can have a negative impact on the quality of care provided to patients and could jeopardize positive intentions for care due to emotional and physical withdrawal from patients (Lee & Akhtar, 2011).

When a culture of safety is created, nurses assume the role of problem solvers and competently carry out the nursing process by identifying complications that can be shared with the interdisciplinary team for solutions (Allen et al., 2015). Quite often nurses experience exhaustion, skip meals to provide patient care, and receive pressure to work extra shifts, which each could impact patient safety (Lin & Liang, 2007). In order to develop a positive and nurturing practice environment for nurses, it is essential to grasp a

better understanding of how nurses are affected by compassion fatigue and burnout (Potter et al., 2010). Dissatisfied nurses in the workplace has been directly related to negative implications for the safety of the patient (Lin & Liang, 2007). Stresses that nurses encounter may lead to compassion fatigue and burnout; therefore, it is imperative to provide the necessary changes in healthcare to positively affect the nursing profession.

Purpose

The purpose of this study was to assess nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. Current literature addresses compassion fatigue in primarily the hospital setting, and there is limited information about compassion fatigue in the private practice setting. The aim of this study was to investigate nurses' perception of the presence of compassion fatigue in the private practice setting.

Theoretical Framework

The theory used to guide this study is Betty Neuman's Systems Model. Neuman's System's Model (NSM) emphasizes that:

Nursing can be readily conceptualized as a complete whole, with identifiable smaller wholes or parts, [and] the complete whole structure is maintained by interrelationships among identifiable smaller wholes or parts through regulations that evolve out of the dynamics of the open system. (Smith & Parker, 2015, p 166)

Neuman believed in the transfer of energy throughout the entire system, and that there is a direct connection between the individual and their environment. Neuman (1989) stated:

The client is an interacting open system in total interface with internal and external environmental forces or stressors; the client is in constant change, with reciprocal environmental interaction, at all times moving either toward a dynamic state of wellness or toward one of illness in varying degrees. (p 12)

Neuman believed in “lines of defense” and “lines of resistance” as part of the “client-to-client” system, also known as the individual person, to help protect the “basic structure energy resources”, which are core and basic survival factors. Neuman believed that environmental stressors can affect the normal stability level of an individual (Smith & Parker, 2015). NSM reviews the four domains of nursing, which consists of the individual person, including their lines of defense, lines of resistance and energy resources, the person’s environment, the person’s health, and the role of nursing in maintaining stability throughout the entire system (Smith & Parker, 2015). The NSM is based on the notions of stress and the reaction to stress (Neuman, 1989). It is possible for a nurse’s basic energy structure to be affected when they experience compassion fatigue because of the effects of burnout and traumatic stress on their quality of life. Burnout tends to extend into the personal lives of nurses, although it may stem from their work environment (Fradelos et al., 2014). According to the Neuman Systems Model, an individual is no longer considered well if their environmental stressors have affected their energy structure and the individual becomes unstable (Smith & Parker, 2015).

Definition of Terms

For the purposes of this study, compassion fatigue is considered the negative aspect of professional quality of life and breaks into two parts. The first part being burnout, which typically includes exhaustion, frustration, anger, and depression; and the

second part being secondary traumatic stress, which is considered a negative feeling driven by fear and work-related trauma (Stamm, 2010).

Summary

Most research regarding compassion fatigue has been completed in the in-patient setting. This study assesses the presence of compassion fatigue in the private practice setting. Nurses are vital to the healthcare system and interdisciplinary team. It is essential for the nurses' level of stress and fatigue to be assessed to ensure they can perform daily tasks and provide safe care to patients. Burnout affects nurses both professionally and personally. Exposure to distress can negatively impact a nurse's quality of life, leading to burnout and secondary traumatic stress, two forms of compassion fatigue.

CHAPTER II

Evidence-Based Research

The purpose of this study was to assess nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. Current literature provides information on the topic of compassion fatigue in an in-patient setting. The literature revealed there is limited material about compassion fatigue in the private practice setting. Compassion fatigue may affect many areas of the nurses' daily practice. The aim of this study was to investigate nurses who are working in the private practice setting perception of compassion fatigue.

Review of Literature

A literature review was conducted to discover evidence-based, peer-reviewed studies related to compassion fatigue. The sources used for this literature search were Cumulative Index for Nursing and Allied Health Literature (CINAHL) and ProQuest Nursing and Allied Health Database. The keywords used to explore for the study were: compassion fatigue, burnout, nurse stress, compassion fatigue in private practice, outpatient nurse burnout, Betty Neuman, Neuman Systems Model.

Literature Related to the Study's Purpose

Compassion Fatigue

A descriptive, cross-sectional study analyzing a quality-improvement evaluation of oncology healthcare staff was conducted in both inpatient units and outpatient clinics at a large National Cancer Institute in midwestern United States to determine the prevalence of compassion fatigue and burnout among nurses working in oncology (Potter et al., 2010). Potter et al. (2010) pointed out the importance of understanding how

compassion fatigue and burnout burdens the caregiving professional as well as affects the workplace, leading to decreased productivity, increased sick days, and higher turnover. They also bring attention to how workplace stress for oncology nurses are leading to compassion fatigue and burnout, and how gaining a better understanding of how oncology nurses are affected by compassion fatigue and burnout is crucial for the positive development of the nursing environment. Potter et al. (2010) believed the study to be the first step toward the design of a comprehensive mindfulness-based stress-reduction (MBSR) program to assist healthcare providers in the recognition and management of compassion fatigue and burnout (Potter et al., 2010).

The study consisted of a group of nurse managers from the institute creating a work group to examine the issue of compassion fatigue among the staff. Through observing and speaking with staff, consisting of a sample of Registered Nurses (RN), Medical Assistants (MA), and Radiology Technicians (RT), totaling 153 healthcare providers, the managers noticed the possibility of symptoms of compassion fatigue and burnout. A quality-improvement evaluation was conducted with inpatient and outpatient oncology staff, which included five inpatient oncology units, four outpatient chemotherapy infusion areas, and three physician office practice areas (Potter et al., 2010). The evaluation consisted of a total of 448 survey packets which were distributed in staff mailboxes, and an information brochure describing the evaluation was posted on all units. Nurse managers held staff meetings and used the brochure for talking points. The completed evaluation was returned in specially marked envelopes placed in each clinical setting (Potter et al., 2010). The instrument used for the evaluation was the 30 question ProQOL R-IV, which measures compassion fatigue, compassion satisfaction,

and burnout (Potter et al., 2010). Results of the study reported a total of 153 healthcare providers participating in the study, most of which were RNs (N = 132). The average compassion satisfaction score among all study participants was 38.3 (SD = 7.2), with the average score among previous users of the ProQOL R-IV being 37. The average burnout score for the study's participants was 21.5 (SD = 6.4), which compared with an average score of 22 for previous ProQOL R-IV users. The average compassion fatigue score among participants was 15.2 (SD = 6.6), which was higher than the average score of 13 by previous ProQOL R-IV users (Potter et al., 2010). Findings were statistically significant for the relationship between compassion satisfaction and work setting ($p = 0.008$) (Potter et al., 2010). Staff working on inpatient nursing units had the highest percentage of high-risk compassion satisfaction scores. The percentages of high-risk scores for compassion fatigue were relatively equal among inpatient and outpatient staff, with scores of 37% and 35%, respectively. Although 44% of inpatient staff scored at high risk for burnout compared to 33% for outpatient staff, the difference was not statistically significant. The study suggests there is value in analyzing the prevalence of compassion fatigue and burnout among oncology healthcare providers, and understanding the needs of distinct demographic groups offers valuable direction for intervention program development. The study also highlights the need for an intervention for staff at risk for compassion fatigue and burnout, and implementing evidence from the study to design a stress-reduction program will better equip healthcare providers to recognize and manage compassion fatigue and burnout (Potter et al., 2010).

A strength of the study was prior approval of the quality improvement evaluation was obtained by the Human Research Protection Office of the affiliated university and

the cancer center's Protocol Review and Monitoring Committee (Potter et al., 2010). Another strength was reporting that the ProQOL R-IV instrument had undergone psychometric evaluation in an effort to improve subscale reliability and validity. Construct validity testing has verified that the subscales on the ProQOL R-IV do measure different constructs, with $\alpha = 0.87$ for compassion satisfaction, $\alpha = 0.72$ for burnout, and $\alpha = 0.8$ for compassion fatigue (Potter et al., 2010). A weakness of the study was the small sample size, particularly with respect to a very small number of respondents who were medical assistants and radiology technicians. A larger sample size would offer a broader range of analysis with regard to demographic variables. Another weakness was those who chose not to respond to the survey could have had higher or lower levels of risk for burnout and compassion fatigue, and due to the study being a cross-sectional design, the analysis does not provide an understanding of whether the prevalence of burnout and compassion fatigue changes over time (Potter et al., 2010).

Lombardo and Eyre (2011), Psychiatric-Mental Health Clinical Nurse Specialists employed by a large teaching hospital system in the midwestern part of the United States, discussed compassion fatigue for nurses. They provided a theoretical perspective about compassion fatigue, based on Watson's Theory of Human Caring. Also discussed were symptoms related to compassion fatigue, practical interventions, and the need for future research to better prevent and perfect the topic of compassion fatigue among nurses. Lombardo and Eyre (2011) provided two case studies. One was centered around a reactive nurse who did not seek help for her continuing stress versus a proactive nurse who avoided developing compassion fatigue.

Both case studies took place in a hospital setting. The first case study of a reactive nurse discussed a new graduate nurse working on a busy telemetry unit. She quickly acquired the nursing skills needed to be successful on the unit and became a unit leader. She experienced the deaths of three of her patients, the patient census remained high, and her workload remained intense. She no longer enjoyed her work and it became a chore. Changes in her behavior were noticed by co-workers and nurse manager, as she struggled to obtain work-life balance. To assist, her schedule was adjusted but the adjustment was not effective. She moved to an outpatient clinic; however, this new work environment did not diminish her over involvement with certain patients and their families and she continued to provide care for patients with end-of-life and cardiac-disease processes. Eventually, she left this position to pursue a less stressful work environment (Lombardo & Eyre, 2011). The second case study was about a proactive nurse who portrayed anxiety and job dissatisfaction on a regular basis due to being overwhelmed with the complex patient assignments, and she expressed sadness about her patients' social and emotional concerns to the point where she was frequently tearful. She felt a lack of support from some of her peers and supervisors, had difficulty sleeping, worried about work on her days off, and talked openly about wanting to leave the hospital. The nurse reached out to several clinical nurse specialists who helped her focus on achieving a healthy work-life balance. Although attempts were made to help improve the situation on her unit, she continued to experience anxiety and dissatisfaction. Despite her growing unhappiness, she identified a specific area of nursing in which she had always wanted to work, and the proper arrangements were made to speak with the

supervisor and schedule a shadowing experience in the area. She transferred to the new area and has since made a positive adjustment (Lombardo & Eyre, 2011).

Watson's Human Caring Theory was used as a theoretical perspective for nursing compassion fatigue due to the theory's advocacy for relationship-based nursing (RBN). Lombardo and Eyre (2011) pointed out empathy being the core of RBN. They also identified the three core relationships for transforming practice using RBN, which consisted of the nurse's relationship with patients and families, the nurse's relationship with self, and the nurse's relationship with colleagues. They believed that the nurse's relationship with self is a core concept in managing compassion fatigue. The terms compassion fatigue, secondary traumatic stress, and burnout are distinguished in the discussion.

Lombardo and Eyre (2011) highlighted work-related, physical, and emotional symptoms of compassion fatigue to assist in understanding how to identify indicators, as well as provided practical interventions to assist with coping with compassion fatigue. In addition, they discussed the need for future research to better prevent and perfect the topic of compassion fatigue among nurses. They confirmed their desire for compassion fatigue to be studied in its entirety to include identifying specific characteristics and experiences precipitating the phenomenon, studies to investigate factors that contribute to the development of symptoms, and studies to identify the effectiveness of interventions to combat compassion fatigue in a variety of work settings. Lombardo and Eyre (2011) indicated it was vital that individual nurses, nursing leaders, and healthcare facilities work together to find answers to prevent and alleviate compassion fatigue.

A study was conducted to assess burnout and quality of life (QOL) in nurses working in hospitals in the broader area of Athens, Greece, as well as to examine correlations between burnout, QOL and the social environment. The study also investigated the differences in the levels of burnout and QOL for nurses working in general and mental health hospitals (Fradelos, et al., 2014). The study hypothesized that burnout levels can be influenced by various parameters, such as age, gender, and working facilities. Fradelos et al. (2014) suggested there was a negative correlation between burnout and QOL, and a negative correlation between social support and burnout. Fradelos et al. (2014) pointed out the central role nurse's play throughout the world in the delivery of health care, and that studies indicate that work experiences and satisfactions of nurses in several countries are modest. They also highlighted that many nurses report negative attitudes and diminished psychological and physical well-being, resulting in a desire to leave the profession.

Fradelos et al. (2014) reviewed the literature and discovered that in the effort to prevent and cope with burnout syndrome, various strategies have been suggested with social support being well documented as a highly effective intervention for coping with burnout. Research indicates that there are at least two specific aspects to social support: perceived and received social support (Fradelos et al., 2014). The study included a purposive sample consisting of a cohort of 139 nurses who were recruited from general and mental health hospitals located within the broader area of Athens. The inclusion criteria were: (a) 18 years of age and older, (b) ability to speak and read Greek, and (c) a registered nurse working in the public or private sector. The study's investigators reviewed demographic information to determine participants met the inclusion criteria.

For those who did not meet the inclusion criteria, the data was discarded (Fradelos et al., 2014). A Greek version of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), consisting of a 22-item Likert scale questionnaire to help measure perceived burnout, was used to collect data. In addition, a 36-item Short Form Health Survey (SF-36), which is a multi-purpose, short form health survey providing an eight-scale profile of functional health and well-being scores, as well as composite physical and mental health summary measures, was utilized to collect data (Fradelos et al., 2014).

The results of the study revealed correlations between QOL and burnout effects, correlations between QOL and social support, and correlations between burnout levels and social support. The p value of all results was $p = .000$. Correlations between QOL and burnout effects showed the “Emotional Exhaustion” subscale of the burnout scale appears to be strongly and negatively correlated with the subscales “Energy Fatigue”, “Emotional Well-Being” and “Social Functioning”. A less pronounced correlation is observed with the values of subscales “Pain”, “Physical Functioning” and “General health”. There was a somewhat strong negative correlation between the subscales “Depersonalization”, “Emotional Well-being”, and “Social Functioning”, and a less strong correlation between subscales “Depersonalization”, “Energy Fatigue”, “Pain”, “General health”, and “Physical Functioning”. The “Personal Accomplishment” subscale of the burnout scale exhibits, as expected, the opposite behavior. It is positively correlated with subscales “Energy Fatigue”, “Emotional Well-Being”, “Social Functioning”, “Pain” and “General Health”. Finally, no time related variables, such as “age, years of experience in the same field, years of working on the same job/tasks” were found to be related to burnout levels in any way (Fradelos et al., 2014, p 105-106).

Correlations between QOL and social support displayed most social support scores are positively, yet weakly correlated to QOL items, with the subscale “Significant Others” correlating to subscales “Physical Functioning”, “Energy Fatigue”, “Emotional Well-Being”, “Social Functioning”, “Pain”, and “General Health”. Among other social support scores, the subscale “Friends” is correlated with subscales “Physical Functioning”, “Energy Fatigue”, “Emotional Well-Being” and “Social Functioning”. Social support total (“ToT”) is similarly correlated with subscales “Physical Functioning”, “Energy Fatigue”, “Emotional Well-Being” and “Social Functioning” (Fradelos et al., 2014, p 105-106). Correlations between burnout levels and social support show that upon examination, the “Emotional Exhaustion” subscale of the burnout scale appears to be negatively correlated with the subscale “Significant Others”. Similarly, an equal in magnitude correlation exists between the scale of “Depersonalization” and “Significant others”. The “Personal Accomplishment” subscale of the burnout scale exhibits, as expected, quite the opposite behavior. It is positively correlated with “Significant others”, “Family”, and “Friends” (Fradelos et al., 2014, p 105-106).

The study also revealed results for differences in the levels of burnout between nurses working in mental health and general hospitals. The mean of each subscale for burnout was compared using a t-test between two groups: (1) nurses working in general hospitals and (2) nurses working in mental health hospitals. It was noted that the differences in the mean values of burnout effects were not considerably large (Fradelos et al., 2014). The study goes on to portray differences in the levels of burnout and quality of life between nurses of different gender, educational level, and degree of responsibility,

and indicates “controlling for gender, mean differences in burnout levels were small and t-test results were not found to be statistically significant (p-values range from 0.966 to 0.199)” (Fradelos et al., 2014, p 106). The study indicated that the significance levels of the one-way ANOVA analysis were not adequately low, $p < .263$, to allow for a solid conclusion to be inferred regarding the assumption of mean burnout levels being different between groups of nurses with varying educational backgrounds (Fradelos et al., 2014). Also, the study showed that the mean values of the QOL scores of men and women who participated in this study were not categorically different based on the statistical evidence available (p-values for values for all QOL subscales range from 0.79 up to 0.96). Controlling for the amount of responsibility associated with each group’s tasks, no significant differences between QOL means were observed. Finally, the same behavior was observed when controlling for educational level, and no conclusions can be drawn (Fradelos et al., 2014). Studies such as this study conducted by Fradelos et al. (2014), could contribute in the development of health care services and the management of health professionals. Discussed in the study was that quality of life and social support may play an essential role and could be identified as a new area for psychological intervention among nurses (Fradelos et al., 2014).

Strengths of this study were that the literature was searched to provide background data surrounding burnout, quality of life and social support, a well-known valid and reliable instrument measuring burnout was used, ethics was addressed confirming the authorization granted by the ethics and scientific committees of the institutions where the study was conducted and written consent with voluntary participation provided. Also, another strength was the limitations of the study were

included. A weakness is that the sample size was small (N = 139), which may not be a full presentation of the nursing population in Greece.

A qualitative study in Sweden conducted by Billeter-Koponen and Frede (2005), addressed nurses experiencing long lasting stress and burnout, and the effects on professionalism and the patient–nurse relationship. The study included background knowledge regarding the original development and introduction to the concept of stress, and how it has been the theme for several differing research studies (Billeter-Koponen & Frede, 2005). Billeter-Koponen and Frede (2005) discussed the difference between acute versus chronic stress, the differing effects on the body, how stress leads to burnout, and the effects stress has on the nurses' role. They suggested that there are many theories which described the nursing profession with the goal to increase the quality of nursing; however, theories often exclude expectations placed upon nurses.

During the study, Billeter-Koponen and Frede (2005) conducted a total of 13 qualitative interviews. The data was collected by way of tape-recording. The interviews lasted one hour, were semi-structured, and resembled a themed-conversation, with the main themes being burnout experience, effects on the work, the working situation, and support (Billeter-Koponen & Frede, 2005). Nurses who participated in the study had experienced long-term stress or burnout, as well as had been two months or longer away from their work. They were all women between the ages of 30 and 61, working as a nurse between 5 and 40 years, and had been employed at the same place between 1 and 31 years (Billeter-Koponen & Frede, 2005). During the beginning of the study, the participants were older experienced nurses, then additional participants were recruited to the study to obtain as many differences as possible and to maximize the opportunity to

elicit data regarding variations in the dimensions of the categories. Billeter-Koponen and Frede (2005) confirmed the participants included younger nurses working in hospitals on various wards as well as in community care.

Results of the study showed a comparison about lived experiences of the participants, along with similar quotations. Billeter-Koponen and Frede (2005) reported steps were taken to ensure quotations from every participant appeared. The results portrayed a core category, which was powerlessness in influencing the valuation of the work of nurses, along with its relation to five separate categories. The five categories consisted of: (1) faces of professionalism, (2) expectations on a nurse, (3) social support, (4) the process leading to powerlessness, and (5) expressions of powerlessness. Results showed eleven subcategories, which were: (1) novice to expert, (2) nurse-patient relationship, (3) changes of the nurse's role, (4) leadership, (5) expectations on oneself, (6) expectations from others, (7) being a nurse and other roles (giving support), (8) social network (receiving support), (9) left alone (missing support), (10) more tasks, and (11) changes in staff. According to Billeter-Koponen and Frede (2005), "the subcategories build up a category and all the categories form the core category" (p 22). Billeter-Koponen and Frede (2005) highlighted that nurses interviewed for this study loved their work, yet felt powerless and could not avoid burnout. Some of the nurses were at the novice level, while some were at the competent level of nursing, and others were experts. Each nurse knew the importance of understanding and supporting a patient; however, the capacity to do so was lacking, which confirmed their feelings of inadequacy. Billeter-Koponen and Frede (2005) states:

It must be considered important to create a working environment that promotes the health of professionals, so that they can do good work...that is why further areas of study could be, how new management philosophy and working instruments reflect the nursing theories and support the daily work of nurses. (p 26)

Strengths of the study consisted of a theoretical framework being presented, providing a thorough method for data collection, and ethical considerations for participants provided. Also, content validity was addressed and described through the inner logic of the study. The study's weaknesses are there was no clear indication of how the sample was chosen, although it appears to be purposive due to adding additional participants based on specific criteria. Also, there is no alpha provided for validity, and no mention of reliability.

A quantitative study consisting of a random sample of 1,190 nurses working in 43 public hospitals in Hong Kong was conducted by Lee and Akhtar (2011) to examine the effects of the workplace social context and job content on nurse burnout. Lee and Akhtar (2011) discussed that the nursing profession is consistently recognized as a stressful occupation and the subject of burnout among nurses has been extensively researched. Findings from this study contribute to the extant literature in three ways: (1) focusing on immediate nursing job content, such as patient care responsibilities, workload, work pressure, etc., is necessary, but not adequate, for developing effective interventions, (2) examining the role of emotional exhaustion as an arbitrator in the relationship between workplace social context and job content and depersonalization, and (3) proposing empirically grounded management interventions for reducing burnout among nurses (Lee & Akhtar, 2011). Lee and Akhtar (2011) emphasized a particular concern in nursing

which is the emotional challenge of working intensively with other people in need or crisis, including patients and their families, and the adverse impact burnout has on the quality of services offered to the patient and the health of caregivers. The aim of this study was to reduce these negative outcomes, identify sources of burnout among nursing professionals and formulate interventions (Lee & Akhtar, 2011).

Lee and Akhtar (2011) received assistance from Operations and Human Resource Division of the Hospital Authority of Hong Kong, and selected a random sample of 5,154 registered nurses from across Hong Kong's public hospitals to represent more than 50% of the nursing population, with 1,190 nurses returning usable questionnaires, generating a response rate of 23%. Respondents of the study were 89% women and 11% men (Lee & Akhtar, 2011). Among the group of nurses who responded, 65% were from general acute hospitals with 24-hour accident and emergency services, 19.1% were from hospitals offering a mix of acute and nonacute services, 8.7% were from acute service hospitals with particular care missions, 5.7% were from psychiatric hospitals, and the remainder were from nonacute or infirmary hospitals (Lee & Akhtar, 2011). Overall the results of the study indicated that the sample of registered nurses was fairly representative of the general nursing population in Hong Kong's public hospitals.

Five survey tools were used to measure job burnout, workplace social context, and job content. The Maslach Burnout Inventory was selected to measure the three dimensions of job burnout: (1) emotional exhaustion ($\alpha = .90$), (2) depersonalization ($\alpha = .82$), and (3) decreased personal accomplishment ($\alpha = .79$). Measures of the workplace social context consisted of five dimensions which mirror the extent of perceived imbalance or lack of reciprocity in nurses' social exchange relationships. Three of the

dimensions were measured by items adapted from the Health Professions Stress Inventory: (1) lack of professional recognition ($\alpha = .81$), (2) professional uncertainty ($\alpha = .78$), and (3) interpersonal and family conflicts ($\alpha = .69$). The fourth dimension, tension in professional work relationships ($\alpha = .69$), was assessed using four items from the Nursing Stress Scale. Also, the fifth dimension, tension in nurse-patient relationships ($\alpha = .78$), contained three items devised specifically for the Nursing Stress Scale. Job content consisted of three dimensions. The first dimension, patient care responsibilities ($\alpha = .63$), was assessed based on five items adapted from Wolfgang's Health Professions Stress Inventory. To measure the second dimension, job demands ($\alpha = .87$) in terms of workload and work pressure, seven items were adapted from Karasek. The third dimension, role conflict ($\alpha = .85$), was measured using an eight-item scale devised by Rizzo, House, and Lirtzman (Lee & Akhtar, 2011).

Lee and Akhtar (2011) indicated that the results of the study suggested that although both the workplace social context and job content have significant effects on burnout dimensions, the effects of the workplace social context were significantly stronger. In addition, the study indicated that workplace social context had a significant negative effect on personal accomplishment, whereas job content influenced personal accomplishment positively (Lee & Akhtar, 2011). Lee and Akhtar (2011) pointed out that although human resource managers must focus on job content factors by examining the possibilities of job redesign, while also developing intervention strategies, this does not solve the issue entirely, and explicit interventions at the organizational level may be even more productive in counteracting burnout (Lee & Akhtar, 2011). Indications from the study were that intervention strategies to reduce burnout focus primarily on

individual-centered solutions, such as changing one's work behaviors and developing effective coping skills; however, individual-level intervention is insufficient to ease burnout among nurses unless managers are also willing to improve the work setting (Lee & Akhtar, 2011). Strengths of the study are there was an adequate sample size to represent Hong Kong's nursing population for public hospitals, and reliable and valid survey tools were used to gather data with representation by alpha coefficients.

Gandi, Wai, Karick, and Dagona (2011) conducted an exploratory study among Nigerian nurses with the main purpose of investigating the role of stress and level of burnout associated with nurses' job performance. Objectives of the study consisted of assessing the prevalence of burnout, examining the role of work characteristics, and determining work to home and home to work interference regarding burnout for Nigerian male and female nurses. Gandi et al. (2011) indicated that the general taxonomy of job performance includes assessing performances, analyzing job demands and the methods of job elements. Work-related stress can impact an organization in many ways, including workplace and work-team relations, productivity, quality, absenteeism, employee turnover, accidents, and customer complaints. In addition, context (organizational culture and function) and content (work environment and equipment) are crucial in determining the experience of work-related stress (Gandi et al., 2011).

The study was conducted among nurses in selected states of Nigeria, and of the 210,306 nurses in Nigeria, 2,245 were selected as study participants using stratified random sampling from the six geopolitical zones (Gandi et al., 2011). The participating states were Bauchi State (N = 373, northeast), Plateau State (N = 37, north-central), Kaduna State (N = 375, northwest), Lagos State (N = 375, southwest), Cross River State

(N = 373, south-south), and Enugu State (N = 375, southeast). In all participating states, the variables or factors considered in the sampling stratification techniques were gender (sex) and religion. Participants of the study consisted of 598 male and 521 female Christians (N = 1119), 520 male and 595 female Muslims (N = 1115), and seven male and four female others (African Traditional Religion) (N = 11) (Gandi et al., 2011, p 187). Initially, the study's population was sampled with the aid of their respective personal files, which were accessible from the registry of study hospitals in each participating state. First, registry staff sorted the files, in confidence, according to sex/gender of the nurses. The researchers blindly selected a number of files from each category (male and female) of the sex/gender stratification. Using the file-sorting technique, 2,300 nurses were listed as proposed participants. Thereafter, registry staff retrieved and resorted the files of the 2,300 nurses based on belief systems/religious affiliations which included Islam, Christianity, and others (African Traditional Religion). Again, the researchers randomly selected a number of files, using a specific ratio, based on the overall available number of files in each category. Nurses and study hospitals in each participating state were briefed and given appropriate orientation regarding their participation. Not all 2,300 proposed participants actually took part in the study because 55 nurses declined at the point of signing informed consent. The actual number of study participants were 2,245 nurses who signed individual informed consent for participation. Appropriate administration, retrieval, and collation of the instruments were facilitated by research assistants. The researchers coded all data resulting from the collated instruments and measures (Gandi et al., 2011). A total of seven measurement tools were utilized in the study. Burnout was measured using the Maslach Burnout Inventory-General Survey

version which contained 22 items and three scales: (1) emotional exhaustion ($\alpha = 0.89$), (2) depersonalization ($\alpha = 0.68$), and (3) reduced personal accomplishment ($\alpha = 0.75$). Responses for the Maslach Burnout Inventory-General Survey were made on a six-point scale (0 = never to 6 = every day). Workload was measured using the eight-item Job Autonomy Questionnaire ($\alpha = 0.87$). Responses for the Job Autonomy Questionnaire were made on a four-point scale (1 = never to 4 = very often). Job control was measured using the four-item Inventory of Feelings of Motivation and Demotivation questionnaire ($\alpha = 0.72$). Social support was measured by three separate subscales using the Organizational Stress-Doetinchem (VOS-D) questionnaire ($\alpha = 0.82$). Each of the three subscales assessed the social support received from supervisor/colleague, partner and family/friends, and items were rated on a four-point scale (1 = never to 4 = always). Work content was measured using the five-item Job Diagnostic Survey ($\alpha = 0.82$), based on a four-point scale (1 = never to 4 = very often). Work-Home Inference (WHI) ($\alpha = 0.90$) and Home-Work Inference (HWI) ($\alpha = 0.84$) were measured using two scales, consisting of a total of 13 items. Responses for WHI and HWI were made on a five-point scale (1 = never to 5 = always) (Gandi et al., 2011).

The results of this study indicated a need to reduce the pace of nursing work and the number of patients per nurse in Nigeria, as this will lead to a decrease in workload, which should then decrease emotional exhaustion. Results of the study showed a decrease in work demands is especially beneficial for women, since work stresses are linked both to exhaustion and distancing from patients. At the same time, for male nurses, improving available resources such as better social relations and increased autonomy are important due to being linked with all three burnout outcomes (Gandi et al.,

2011). Gandhi et al. (2011) pointed out that low work to home inference (WHI) is a protective factor against negative work characteristics, whereas high WHI is an important risk factor; therefore, precise attention should be provided to a future public health policy that would enhance a healthy work-life balance for nurses. Indications from results of the study are that the HWI level in the sample was very low, which is a predictor of burnout. With HWI no gender differences were observed, and both men and women are equally vulnerable (Gandhi et al., 2011). Conclusions from the study are that there is a need for further studies with more representative samples and possible replications elsewhere. Gandhi et al. (2011) alluded that intervention studies will help remedy intrinsic concerns and/or prevent them.

Strengths of the study were, it is based on a theoretical framework (grounded in the perceived stress effect and the job demands-resources (JD-R) model). The purpose for the study was clearly indicated and addressed, and the study was approved before proceeding. The Maslach Burnout Inventory was utilized, which is the most utilized measurement tool for burnout in the literature. All participants were briefed and oriented regarding their participation, and limitations of the study were addressed.

Nursing Setting and Work Environment

A systemic review was conducted by van Mol, Kompanje, Benoit, Bakker, and Nijkamp (2015) to investigate literature related to emotional distress among healthcare professionals in the Intensive Care Unit (ICU), with an emphasis on the prevalence of burnout and compassion fatigue and available preventive strategies. They indicated that although personal and organizational consequences of burnout and compassion fatigue have been previously published, very few studies have addressed the effectiveness of

preventive strategies. The goal addressed in this study was to provide a starting point for “clinical practice guideline developers” (p 4) and summarize interventions to prevent negative consequences of emotional distress among healthcare professionals in the ICU (van Mol et al., 2015).

van Mol et al. (2015) conducted a literature review with the goal of evaluating original literature. Pre-determined search strategies were followed and computerized databases, such as Embase, Medline OvidSP, CINAHL, Web-of-science, PsychINFO, PubMed publisher, Cochrane, and Google Scholar, were used to retrieve evidence based literature. Medical Subject Headings (MeSH) that were utilized consisted of burnout, empathy, and fatigue. van Mol et al. (2015) supplemented the search with compassion fatigue and secondary traumatic stress as free text words, and the Boolean indicator ‘AND’ was used to select the applicable studies. All terms were tailored to the thesaurus of each database. Local unpublished surveys, unpublished reports, and academic theses were not included (van Mol et al., 2015). Quality eligibility criteria was also applied as guidelines to conduct the review process. van Mol et al. (2015) confirmed that a set of quality criteria was developed to assess the methodological soundness of the literature. They confirmed the systemic review study did not need ethical approval nor was individual consent needed.

The results showed that the review process began with 2,580 references retrieved from the electronic databases. After deleting duplicate references (N = 1620) and a manual search (N = 3), the result was 136 relevant publications after the first selection round (van Mol et al., 2015). The references only published as an abstract (N = 39) or non-English (N = 30) were removed. A few studies were excluded because prevalence

could not be calculated from the presented data, or effects of the intervention were not measured. In the end, a sample of 30 eligible literature about the prevalence of emotional distress, and 10 associated intervention studies were appraised as methodologically sound and included for extensive review (van Mol et al., 2015). There is strong implication that working at an ICU correlates with a considerable risk of emotional distress, and each of the included studies underscored the stressful environment that resides in the ICU. van Mol et al (2015) highlighted that this anomaly might be explained through unique personal qualities, such as resilience, empathic ability, coping mechanisms or emotional intelligence, and environmental factors, such as training, mental support, organizational culture, or the differences between cultures and countries. van Mol et al (2015) alluded that it is even more striking to find contradictory results with lower percentages or means on Burnout (BO), Compassion Fatigue (CF) or Secondary and Post Traumatic Stress (S/PTS) in the ICU compared to other clinical areas. van Mol et al. (2015) added a few new viewpoints in the lack of common understanding of the theoretical constructs; however, the true magnitude of the emotional distress in the ICU healthcare professionals remains unclear due to a lack of unity in measurements. van Mol et al. (2015) suggested that policymakers introduce interventions to prevent the negative consequences of emotional distress, and a longitudinal experimental study is needed to examine the emotional distress among ICU professionals in relation to their communication skills, educational sessions on stress management, and mindfulness. Strengths of the study are a thorough review of the literature, containing an effective search strategy and quality criteria.

An exploratory study assessing which educational interventions reduce burnout and promote well-being among nurses and care workers in secure settings, such as prisons and forensic mental health settings, was conducted by Stewart and Terry (2014). They conducted a systematic review of health, educational, and criminal justice literature to evaluate relevant studies and identify educational interventions that were effective in reducing burnout. The study aimed to provide guidance to enlighten practice and identify future research opportunities on the topic of burnout (Stewart & Terry, 2014).

Stewart and Terry (2014) developed inclusion and exclusion criteria using the Population, Intervention, Comparison, Outcome (PICO) formula. During the study's scoping searches, databases were explored to determine if there were enough studies of suitable quality to conduct the review, and full literature searches. Electronic databases were searched using MeSH terms or appropriate permutations, for example 'forensic mental health nursing' and 'reducing burnout', 'burnout' and 'prison nursing', or 'secure nursing' and 'educational interventions' (Stewart & Terry, 2014). To guarantee all potentially relevant articles were identified, the study included a cautious increase of the sensitivity and specificity of the searches, using the most suitable search terms. Stewart and Terry (2014) confirmed that the "scoping searches retrieved a substantial number of relevant articles, therefore justifying the research question. The full search was restricted to articles based on studies published between 1991 and 2012" (p 38).

The methodical and systemic approach used in the study found issues with the overall validity of the studies being appraised. The study suggested for example, "the quality of reporting in the qualitative studies and the weak statistical significance in the quantitative studies... [and believes] these issues may compromise the generalizability of

study findings to other settings” (Stewart & Terry, 2014, p 41). For reliability, Stewart and Terry (2014) mentioned that a range of appraisal tools and frameworks was used to review the quality and reliability of the studies found in the literature search, then data was extracted and synthesized. They also reported that in some of the studies, there was a possible source of researcher bias due to the primary researchers not being blinded to the experimental group; and in review of the quantitative studies, appraisal tools were not always externally validated and in several studies important demographic information was not presented. Also, the study showed that, data on non-participants were not discussed, which affects the representativeness of studies (Stewart & Terry, 2014).

Findings of the study showed the total number of retrieved articles from all searched databases was 8,737; and of these, 78 articles were selected initially as being relevant to the research question. There were two additional selection phases to decide which final articles were to be included in the review (Stewart & Terry, 2014). The excluded articles provided helpful contextual information and aided in expanding ideas about burnout in nurses and care workers in secure settings (Stewart & Terry, 2014). The study indicated that many of the eight articles rejected disclosed the types of stressors faced by nurses and care workers and provided evidence of high rates of burnout, but also failed to mention or test interventions to decrease burnout. Stewart and Terry (2014) indicated that a broader range of educational interventions focused on reducing burnout should be implemented and evaluated, as well as future research should be more rigorous, to increase validity and reduce bias potential. The study hypothesized that a literature search would disclose a wide range of educational interventions tested both in “prisons and forensic mental health settings”; however, Stewart and Terry stated, “there appears to

be a lack of high-quality research in this area” (p 44). A strength within the study was the provision of a very thorough process of how databases and the literature was searched systemically. In addition, the method of using the PICO formula was highlighted, inclusion and exclusion criteria was listed, limitations were included, and validity and reliability was mentioned.

Bao and Taliaferro (2015) conducted a cross-sectional study testing the correlations between Compassion Fatigue (CF) and Psychological Capital (PsyCap) in nurses working in acute care settings. They believe that understanding the role of PsyCap on CF provided a new method for the future progress of interventions that could possibly improve resilience and improve the negative effects CF has on quality of healthcare. In positive organizational behavior, PsyCap is labeled “as a whole as self-efficacy, hope, resilience, and optimism... [and] has the potential to enable nurses to be resilient and flourishing in overwhelming situations” (Bao & Taliaferro, 2015, p 35). Bao and Taliaferro (2015) pointed out recent studies have indicated that the prevalence of CF is negatively impacting both the quality of caring for patients and the professional quality of life for nurses. This study suggested that nurses are vulnerable to CF, and literature has suggested the prevalence of CF in numerous specialties of nursing, as well as the presence of valid and reliable tools used to measure CF in nursing.

Bao and Taliaferro (2015) highlight that literature concentrating on CF in nurses working in hospitals has demonstrated that the prevalence of CF symptoms was elevated enough to permit additional research. No study was located on the topic of exploring broader modifiable PsyCap for its potential opposing effect on the development of CF; therefore, this study was intended to fill this gap. Bao and Taliaferro (2015) confirmed

that the “knowledge of how to promote and maintain nurses’ compassionate care is crucial for the nursing profession to be able to deliver quality nursing care with optimal patient outcomes” (p 35).

This study took place in a 1,188-bed acute care adult comprehensive teaching hospital located in a city population of 300,000 and a county of more than one million in the midwest of the United States (Bao & Taliaferro, 2015). A non-probability convenience sample of 260 registered nurses were surveyed over a course of four weeks using two different instruments, with one being the PsyCap Questionnaire (PCQ) and the other the Professional Quality of Life (ProQOL V5). The PCQ measures the four subscales, efficacy ($\alpha = .88$), hope ($\alpha = .89$), optimism ($\alpha = .89$) and resilience ($\alpha = .89$). The PCQ’s validity and stability were empirically established in various disciplines including nursing. The PCQ’s wording was adjusted for the workplace and consisted of a 24-item, 6-point Likert-like scale. There were three items requiring reverse scoring. Inclusion criteria were: (1) age greater than 19 years old, (2) registered nurse, (3) English-speaking, and (4) direct contact with patients on a daily basis. There was no exclusion criterion. The response rate was 60%. Participants’ ages ranged from 22 to 64 years and the mean of age was 35.33 (Bao & Taliaferro, 2015). The ProQOL V5, which is the most frequently used instrument to measure compassion fatigue, was utilized as the measurement tool. The tool contains three subscales: (1) compassion satisfaction ($\alpha = .862$), (2) burnout ($\alpha = .685$), and (3) secondary traumatic stress ($\alpha = .805$), with each subscale containing 10 items. ProQOL V5 is a 30-item, 5-point Likert scale, with five items in the scale to be scored reversely. It does not yield a composite score due to the complex relationship between the subscales. The reliability to use ProQOL V5 in nurses

has been relatively consistent in many research reports and dissertations written by nurses, and the construct validity of the scale has been well established with over 100 peer-reviewed papers in the literature (Bao & Taliaferro, 2015).

The results from the study indicated that the reliability test for ProQOL V5 in this study demonstrated a Cronbach's alpha (α) of .768 for the burnout subscale, .809 for the secondary traumatic stress subscale, and .894 for the compassion satisfaction subscale, and all three subscales had high inter-item reliability. The reliability for the PCQ scale was strong at $\alpha = .920$ (Bao & Taliaferro, 2015). Bao and Taliaferro (2015) indicated that the instruments used in this study had satisfactory performance. Findings from the study indicated that the nursing profession does not seem to increase or decrease the level of PsyCap, meaning nurses who work in hospitals have PsyCap scores that are consistent with those of other disciplines. Findings also indicated that PsyCap had moderate to strong negative correlation with CF for nurses working in acute care settings, nurses in the present study had higher average burnout scores compared with the average across 20 different disciplines, secondary traumatic stress subscale level in the study's sample had higher average scores compared to ProQOL V5 database, and compassion satisfaction mean score in this sample was higher than the mean score in ProQOL V5 database (Bao & Taliaferro, 2015). Bao and Taliaferro (2015) concluded that the results may indicate that nurses working in hospitals need higher level of PsyCap to sustain compassion satisfaction and to prevent burnout or secondary traumatic stress. Strengths of the study were its ethical considerations indicated by approval from the Institutional Review Board of Washington University in St. Louis (the IRB of the hospital), a response rate of 60%, disclosure of the study's limitations, and providing recommendations. A weakness of the

study was the use of a convenience sample, as there was an automatic bias and did not fully represent the population.

The prevalence of compassion satisfaction and compassion fatigue in adult, pediatric, and neonatal critical care nurses was researched by Sacco, Ciurzynski, Harvey, and Ingersoll (2015) in a cross-sectional study, with a desire to describe potential contributing demographic, unit, and organizational characteristics. They discussed that although critical care nurses gain satisfaction from providing compassionate care to patients and patients' families, the nurses are also at risk for fatigue. Sacco et al. (2015) highlights that in studies assessing the reasons employees remain in their role as caregivers despite high levels of compassion fatigue, findings indicated that employees tend to gain a sense of compassion satisfaction. Sacco et al. also mentioned that the balance between satisfaction and fatigue was considered professional quality of life. This study highlights that numerous studies have recognized nurses working in overly stressful conditions are more prone to mental and physical exhaustion when compared with nurses working in a less stressful environment. Also, the study highlights that patient satisfaction and patient safety, are directly linked to nurses' job satisfaction (Sacco et al., 2015).

The study took place at a large 739 bed Magnet designated academic tertiary medical center in western New York. The sample was taken from all critical care nurses (registered nurses and licensed practical nurses) working in single-acuity units (intensive care patients only) and mixed-acuity units (intensive care patients, progressive care patients, and general care patients in the same unit). The targeted units included three adult intensive care units (medical, surgical, and cardiovascular), three adult mixed

intensive care units (ICUs) and progressive care units (one medical and two surgical), one pediatric ICU, one pediatric mixed-acuity unit, and one neonatal ICU. Nurses invited to participate in the study had to be 18 years or older and employed full-time, part-time, or per diem in one of the targeted units (Sacco et al., 2015). The ProQOL V5, survey was used in the study, with selected items on the survey individualized to make applicable to a targeted audience. The study indicated that previous testing showed acceptable levels of internal consistency reliability for each of the subscales compassion satisfaction ($\alpha = .88$), burnout ($\alpha = .75$) and secondary traumatic stress ($\alpha = .81$) (Sacco et al., 2015).

Findings from the study portrayed that the total number of nurses who responded to the survey was 221, which is a 38% participation rate. The highest percentages were from the neonatal ICU at 30% and pediatric ICU at 16%. The results were consistent with the nurse demographics of the hospital, with the majority of the sample being female at 94.6% and had a bachelor's degree (71.0%). The three subscales of the ProQOL V5 instrument showed Cronbach α values of 0.91 for compassion satisfaction, 0.45 for burnout, and 0.73 for secondary traumatic stress. In general, nurse participants scored within the average range for all three ProQOL V5 subscales; however, group and individual findings in the compassion satisfaction and compassion fatigue measures differed significantly (Sacco et al., 2015).

Sacco et al. (2015) pointed out that understanding the values of nurses' professional quality of life can have a positive effect on the work environment and, ultimately, outcomes of patient care. They indicated that publicizing information about professional quality of life for bedside nurses is essential because everyone has a role in improving the work environment, and once the relationships are fully understood,

interventions to improve the balance between compassion satisfaction and compassion fatigue can be developed and tested. Strengths of the study included, receiving permission to use the ProQOL V5 measurement tool, receiving approval by the medical center's institutional review board before beginning research, and incorporating limitations into the study. Weaknesses of the study included offering a beverage coupon for completion of survey, as this may not portray true responses due to participants completing for an incentive.

A multilevel cross-sectional study was completed by Leineweber et al. (2014) to investigate nurses' practice environment and work-family conflict in relation to burnout. They considered the associations between the work practice environment, which was measured at the department level, and work-family conflict, measured at the individual level. The study indicated that a large body of literature has described the effect of modifiable scopes of nurses' work environment and workload on burnout rates, with most decisions affecting the work practice environment for nursing care are made at different organizational levels (Leineweber et al., 2014). Leineweber et al. (2014) confirmed that to date, only a few studies have considered issues at different organizational levels; and no factors on the individual level were included as potential explanatory factors. The purpose of this study was to add to the body of literature.

The survey focused on Swedish registered nurses (RNs) working in medical-surgical adult in-patient care, or working in intensive care units. The RNs were approached through hospitals via the member register of the Swedish Association of Health Professionals, which covers 80% of all clinically-active RNs. All RNs working in medical and surgical departments were selected (N = 33,083). At the end of the data

collection period 23,087 surveys were returned, with a response rate of about 70%. Those RNs who responded, but did not meet the inclusion criteria were excluded from the final database; therefore, the database consisted of self-reported survey data from 11,015 RNs working with direct inpatient medical/surgical care from all acute care hospitals in Sweden. All departments with fewer than 10 respondents and all hospitals with fewer than three departments were omitted in order to get correct group-level variance estimates. This process provided a final analytic sample of 8,620 RNs from 369 departments in 53 hospital levels (Leineweber et al., 2014). For the individual-level, the variables included were: age, sex, baccalaureate degree in nursing, years of work experience as RN, and work-family conflict. The work environment on the department level was measured by the Practice Environment Scale of the Nursing Work Index (PES-NWI), a validated and commonly-used tool for investigating the nurse practice environment. Three subscales of the PES-NWI were used, consisting of (1) staff adequacy ($\alpha = 0.78$), (2) leadership and support for RNs ($\alpha = 0.76$), and (3) nurse-physician relationship ($\alpha = 0.89$). The two subscales of the PES-NWI, nurse impact on hospital affairs and nursing care model, were not included in the analysis due to showing “high multicollinearity” with the other dimensions (Leineweber et al., 2014, p 2).

Results of the study revealed that the mean age of participants was 41 years, and revealed that the sample was highly skewed regarding sex, with males representing 6.6% of the RNs. More than half of the RNs had a baccalaureate degree in nursing and mean work experience was 11.7 years. In the study’s sample, about one third of the RNs experienced a low degree of work-family conflict, about 40% experienced a medium degree of work-family conflict, and slightly less than one quarter experienced high levels

of work-family conflict. In general, RNs reported high values of personal accomplishment and lower values of emotional exhaustion and depersonalization (Leineweber et al., 2014). Results continued to reveal that nearly one-third of the RNs (N = 2,540) were categorized as emotionally exhausted, and fewer RNs suffered from depersonalization (N = 674) or low personal accomplishment (N = 786). The study indicated a relationship between work-family conflict and emotional exhaustion, but no relationship was found between work-family conflict and depersonalization or personal accomplishment (Leineweber et al., 2014). Leineweber et al. (2014) identified that on the department level adequate staffing, good leadership, and support for nurses reduces the risk of emotional exhaustion and depersonalization.

The study concluded that the relationship between work-family conflict and burnout has been well researched previously, and it further reinforced previous findings regarding the non-relationship between work-family conflict on one hand, and emotional exhaustion and personal accomplishment on the other. Also, other studies have found work-family conflict to be related to emotional exhaustion and depersonalization, but not to personal accomplishment; therefore, this study deviates from previous research in regard to the relationship with depersonalization (Leineweber et al., 2014). The findings in this study suggested that adequate staffing, leadership and support for nurses are crucial for RNs' mental health. It also highlights the importance of hospital managers developing policies and practices to facilitate the successful combination of work with private life for employees (Leineweber et al., 2014). Strengths of the study included ethical considerations, indicating approval by the relevant research ethics committee, and participants received written information about the study and an informed consent. A

validated and commonly-used tool for investigating the nurse practice environment was utilized.

Lin and Liang (2007) addressed the nursing work environment to promote patient safety. They assessed the problem associated with the nursing work environment and recommend reforms that address the interrelated concerns of environment status, education, nursing staff ratios, and recurrent training. Lin and Liang (2007) indicated that confusion on the specific roles and competencies of nurses, staff ratio issues, and lack of nurse empowerment create weaknesses that result in safety risks and these interconnected issues must be addressed systemically to impact the nursing care system. They also suggested that nurse dissatisfaction with the workplace has been directly related to having significant negative implications for patient safety.

Lin and Liang (2007) highlighted concerns with the work environment and satisfaction and safety for nurses by providing evidence-based information related to each. They reported that in 2003, the National Academies News confirmed registered nurses, licensed practical nurses, and nursing assistants constituted greater than half of all healthcare providers, and the Institute of Medicine (IOM) reported that, “the work environment for nurses needs to be substantially transformed to better protect patients from healthcare errors” (Lin & Liang, 2007, p 21). They also discussed an online study conducted by the American Nurses Association in 2001 collecting information about the feelings of nurses about their work environment, and indicated that the merging theme was a decrease in nurse satisfaction and patient safety, with declining work satisfaction being associated with an increase in stress. Nurses reported being exhausted and job stress being a top health and safety concern (Lin & Liang, 2007). In addition, Lin and

Liang (2007) provided data on the direct relationship between the level of nurse staffing and its effect on patient safety, outcomes, and the satisfaction of the nursing professional in the hospital, which suggested that “each additional patient per nurse was associated with a 7% increase in both patient mortality and deaths following complications and a 23% increase in nurse burnout (Lin & Liang, 2007). They also provided information that in 2003 the IOM Committee released a report that indicated that the current healthcare environment is leading to patient harm and nurse burnout (Lin & Liang, 2007, p 22). Lin and Liang (2007) highlighted the use of the military model, utilized by the United States Army, United States Navy, and United States Air Force to confirm clear roles, and ensure competencies are well defined and known by all members of the healthcare team. They believe this action may lead to a distinct understanding of the competencies of the nurse, improve satisfaction, and promote nurse satisfaction.

Lin and Liang (2007) concluded that for years the nursing profession has been challenged with the multifaceted problem of a poor working environment and the risk of patient safety. They indicated that work environment issues are associated with the status of nurses, and by empowering nurses and providing them with valuable, practical recurrent skills’ training and problem-solving power, nurses will obtain the respect, autonomy, and professional status and skills to lead in the effort to promote patient safety (Lin & Liang, 2007). A strength of the work included a thorough search of the literature to provide details and examples centered around the interconnection between the nursing work environment, patient safety and nurse satisfaction.

Literature Related to Theoretical Perspective

The Neuman Systems Model (NSM) is a theory referred to for a wholistic approach to nursing practice, in that it “fits well with the wholistic concept of optimizing a dynamic, yet stable interrelationship of mind, body, and spirit of the client in a constant changing environment and society (Neuman, 1989, p 10). The NSM implies there is a constant exchange of energy, moving an individual either toward or away from stability while interacting with the environment (Neuman, 1989). Neuman (1989) states:

The consideration of the environment is crucial, since health and wellness vary as to the needs, predisposition, perception, and goals of all identifiable systems; environment is that viable arena that has relevance to the life space of the system, including a created environment. (p 12)

Nurses are constantly adjusting to their surrounding environment, which the literature has proven to be stressful; therefore, the NSM approach to nursing is potentially beneficial to the nursing practice.

Neuman and Reed (2007) and other authors collaborated for a question and answer session and contributed ideas in a column to discuss the NSM perspective on nursing in 2050. Neuman and Reed (2007) mentioned that the notion of wholeness, the goal of optimal health and primary prevention to maintain wellness and popular thinking in the literature helped catapult the NSM to being accepted in the nursing profession; and “the model is on the forefront of what is being proposed in medicine” (Neuman & Reed, 2007, p 112). Information in the column points out that current literature shows that the ideas of the NSM continue to be relevant, and it enables other cultures to inference to their specific healthcare situations. Several organizations “claim that the breadth of the

model plus the specificity of the process of delivering nursing care are helpful to nurses by unifying their approach to implementation” (Neuman & Reed, 2007, p 112).

The question and answer session consisted of three questions. The first question asked was, “how do you see the values and beliefs of your theory emerging through new conceptualizations that are relevant to the health and quality of life of persons in 2050?” (Neuman & Reed, 2007, p 112). Neuman and Reed (2007) provided an exhaustive response including:

The Neuman nursing process is designed to implement the model through use of the theoretical concepts and scientific processes. [It] acts as a comprehensive wholistic care guide for 21st century intervention, nursing research, education, practice, and administration to include interdisciplinary sharing and cultural care efficacy. The wholistic Neuman perspective will remain adaptive and relevant to changing healthcare needs up to and including the year 2050. Since 1970, the model has both preceded and followed the increasing trend toward wholistic systemic thinking. Its social utility will remain high. (p 112)

The second question addressed how conceptualizations would be expressed in the health and quality of life of persons in 2050. Providing a thorough response, Neuman and Reed (2007) pointed out that knowledge put to use in 2050 would need to be organized to offer comprehensive practice that allows for evaluation and clarification of evidence. The third question addressed what is needed to lead to the organization and evaluation of knowledge in nursing practice in 2050. Neuman and Reed (2007) responded with a list of seven “requirements for the 21st century professional care-giving” (p 112). The column concluded by highlighting the importance of using systems that will adapt to

future changes, and a systems care approach that will meet the pertinent planning and implementation needs to serve one client as a system or many. The system should be adaptable to a wide range of care programming needs (Neuman & Reed, 2007). The strength of this column was referring to the literature's use of the NSM to confirm validity and reliability. Another strength was one of the authors was the creator of the model being addressed.

The cross-sectional study by Günüsen, Üstün, and Erdem (2014) examined the extent to which the relationship between work stress and emotional exhaustion is mediated by nurses' internal locus of control (ILOC). They indicated that the number of studies available on this subject is limited, and with the studies available it was suggestive that there was a positive correlation between work stress and emotional exhaustion. Results of the study suggested that the locus of control (LOC) affects how one can cope with a stressful situation, with the internal locus of control being significantly associated with emotional exhaustion with the effects of the work environment. Günüsen et al. (2014) suggested individuals may be inclined to view their work environment positively or negatively, depending if their locus of control is internal or external. Günüsen et al. (2014) link emotional exhaustion and work stress to the Neuman Systems Model (NSM). Günüsen et al. (2014) pointed out if work stressors in the environment are not buffered by the flexible line of defense they may invade the normal line of defense, and nurses attempt to cope with ongoing stress by utilizing their line of resistance. If this coping mechanism is successful, burnout does not occur; however, if lines of resistance are weak or stressors are strong, burnout ultimately occurs. The study brings light to the fact that there are other studies centered on nurse burnout

and work stress; however, the number of studies investigating the relation between work stress, emotional exhaustion, and ILOC are very few.

Participants of the study included nurses working in a university hospital in Izmir, Turkey, working 12-hour shifts for 180 hours a month and providing care for an average of 15 to 20 patients per shift. All nurses ($N = 730$) were invited to participate in this study, with 347 nurses returning the completed questionnaire. Total participation rate for the study was 47.5% (Günüsen et al., 2014). The study utilized three separate instruments to measure the Locus of Control: (1) ILOC, (2) emotional exhaustion, and (3) level of work stress. The Locus of Control Scale, used to measure ILOC, is a valid and reliable ($\alpha = .83$) 5-point Likert scale. The Maslach Burnout Inventory, used to measure emotional exhaustion, is a reliable ($\alpha = .82$) 5-point Likert scale. The Work-Related Strain Inventory, used to determine the level of work stress, is a 4-point Likert scale with a reliability of $\alpha = .78$ (Günüsen et al., 2014).

Results revealed all nurses were female, the mean age was 32.55 years, and the average length of their clinical experience was 9.89 years. Most of the responders had obtained a bachelor's degree in nursing (74.4%). Most of the participants worked in the departments of surgery (38.9%) and internal medicine (32.9%). All three variables, ILOC, emotional exhaustion, and work stress had satisfactory reliabilities with Cronbach's alpha coefficients of $\alpha = .70$ or higher (Günüsen et al., 2014). The study's findings provided support that work stress would be associated with emotional exhaustion, and also ILOC mediated the relation between work stress and emotional exhaustion with a decrease by 3% (Günüsen et al., 2014). In this study based on Neuman Systems Model, the presence of work stress is assumed to mean a break in the normal

line of defense, lines of resistance is expected to be active (ILOC), and emotional exhaustion is not expected to develop (core response) (Günüsen et al., 2014). According to Günüsen et al., (2014), Neuman's assumptions were confirmed in this study. Strengths of this study included the study being centered upon a nursing theory and including ethical consideration. A weakness of the study was no limitations were included.

Marsh, Beard, and Adams (1999) conducted a non-randomized study to investigate the mediational effect of spiritual well-being and hardiness on job stress and burnout among nurses. They suggested that research has described both social support and hardiness to serve as mediators for both job stress and burnout, and research supports that burnout in nurses due to job stress has been reduced by hardiness. Marsh et al. (1999) mentioned that spirituality offers optimism in "healing the environment" (p 13), especially the workplace. Betty Neuman, through the Neuman Systems Model (NSM), added the spiritual component to her model and it serves as one of the theoretical frameworks for this study, along with Selye's Theory of Stress (Marsh et al., 1999). Marsh et al. (1999) reported that to date, the literature does not provide examination of the effects of spiritual well-being as a mediator for job stress and burnout.

The study's sample consisted of 208 registered nurses, with 187 from the state of Texas and 19 from other states. The company Nurseweek, Inc. provided a simple, random sample of 700 registered nurses from Texas. Questionnaires were mailed. One hundred and fifty-three were completed, with a useable questionnaire return rate of 22%. An additional convenience sample of 55 individual nurses also completed the questionnaire, with 36 being from Texas and 19 outside of Texas. One hundred forty-five (69.7%) of the study's nurses were white, married females with a mean age of 43.6

years. Slightly over one-fourth (27.9%) of the nurses were employed full-time as staff nurses in a critical care area of an urban hospital and had less than a Bachelor of Science Degree in Nursing (Marsh et al., 1999). The overall health status of the nurses was excellent, and 183 (88%) believed they had a personal relationship with God. Attending religious services was important to a majority of the nurses, and the largest group of respondents attended religious services once weekly (37%) (Marsh et al., 1999). The survey for this study included four measures: (1) the Stress Diagnostic Survey, (2) the Journees Audiovisuelles Rurales et Environnementales de Lema (JAREL) Spiritual Well-Being Scale, (3) the Personal Views Survey, and (4) the Maslach Burnout Inventory. The Stress Diagnostic Survey was used to measure job stress, the JAREL Spiritual Well-Being Scale was used to measure spiritual well-being, the Personal Views Survey was used to measure hardiness, and the Maslach Burnout Inventory was used to obtain data on burnout. There are reports of validity and reliability for each instrument (Marsh et al., 1999).

Results of the study indicated that job stress has a direct positive effect on burnout, demonstrated by both Selye's Stress Theory and Neuman Systems' Model explaining that a potential stressor can result in a negative outcome within an individual. Results also indicated spiritual well-being has a direct negative effect on burnout, with the hypothesis for this concept being derived from the NSM where Neuman portrays the total person as consisting of the mind, body and spirit. Results of the study further indicated spiritual well-being has a direct positive effect on hardiness, with the hypothesis for this concept being derived from the NSM which highlights the higher the spiritual well-being of nurses, the more hardiness the nurse possesses when encountering

job stress. Results also indicated hardiness has a direct negative effect on burnout among nurses, as well as spiritual well-being operating through hardiness has an indirect negative effect on burnout among nurses (Marsh et al., 1999). In conclusion, during the investigation of the study, no other research study was found that directly tested the relationship of spiritual well-being and burnout. In general, the study supported the importance of spiritual well-being as directly and indirectly reducing burnout (Marsh et al., 1999). Strengths of the study included providing ethical considerations with approval from the review board and ensuring the use of informed consent, providing definition of terms, and also providing recommendations.

Summary of Review of Literature

Literature review revealed there were many studies addressing the presence of compassion fatigue, burnout, and work stress for nurses; however, most studies take place in an in-patient hospital acute care setting. This literature search revealed a paucity of studies of compassion fatigue amongst nurses in the private practice setting. This literature review portrayed the use of the Neuman Systems Model (NSM) to address burnout and emotional exhaustion, two subscales of compassion fatigue.

CHAPTER III

Methodology

The purpose of this study was to assess nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. Compassion fatigue may affect many areas of the nurse's daily practice. The aim of this study was to investigate nurses who are working in the private practice setting perception of compassion

Study Design

This quantitative study was conducted using a non-randomized convenience sample. The study consisted of gathering data from participants in order to assess nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. A total of 43 nurses at a private practice, consisting of clinical and triage Licensed Practical Nurses (LPNs) and clinical Registered Nurses (RNs), were asked to complete a confidential online survey. Approval was granted by the university Institutional Review Board (IRB) and the private practice where the data was collected.

Setting and Sample

The study was conducted at a private neurology practice. The researcher used a convenience sample by way of an online invitation for the nurses to complete the Professional Quality of Life (ProQOL V5) Elements Theory and Measurement, Version 5 questionnaire. A total of 43 nurses, consisting of clinical and triage LPNs and RNs were invited to participate in this study. Participants of the study included clinical and triage nurses who were employed at the private practice. The clinical and triage nurses worked as part of the facility's care team which includes nurses, providers, support staff, and leadership. Direct care nurses were selected as participants due to their role in the

organization's daily operation and setting. Nurses who were not involved in direct patient care were not included in the study.

Design for Data Collection

This study was conducted by the researcher sending a link via email that contained the Professional Quality of Life (ProQOL V5) Elements Theory and Measurement, Version 5 questionnaire to the Chief Nursing Officer (CNO) to distribute via email to the sample of nurses. The CNO invited the nurses to participate in the study and informed the sample of nurses that participation is strictly voluntary and confidential. The participating nurses had one week to complete the online 30 question 5-point Likert scale questionnaire entitled, "Professional Quality of Life Scale (ProQOL V5), Version 5". After the completion time frame ended, the researcher reviewed the data received and entered the completed data into the IBM® Statistical Package for Social Sciences® (SPSS), Version 22 statistics software for analysis. The SPSS software can handle large amounts of data and is able to perform various types of analysis ("Introduction to SPSS," n.d.); therefore, this was the best choice for data analysis.

Measurement Method

The questionnaire used for this study was from the Professional Quality of Life (ProQOL V5) Elements Theory and Measurement, an international data bank dedicated to the development of the theory of Compassion Satisfaction and Compassion Fatigue ("Professional Quality of Life Elements Theory and Measurement," 2017). The quality an individual may feel in relation to the work they provide as a helper is considered their professional quality of life, and both the positive and negative facets of their work has an influence on their quality of life (Stamm, 2010). The ProQOL V5 questionnaire was part

of over 200 published papers and more than 100,000 electronic publications. Also, of the numerous published research papers on compassion fatigue, secondary traumatic stress and vicarious traumatization, nearly half have used ProQOL V5 or one of the earlier versions. There was a good construct validity for the ProQOL V5 questionnaire (Stamm, 2010).

Data Collection Procedure

Following IRB approval, a link to the Professional Quality of Life (ProQOL V5) Elements Theory and Measurement, questionnaire was sent via email from the researcher to the CNO to distribute via email to the sample of nurses. The email also included the informed consent via an attachment for each nurse to review prior to proceeding with the questionnaire. Participation was voluntary. The questionnaire consisted of 30 questions assessing the nurse's experiences, both positive and negative, as a helper in the past 30 days of their nursing practice. The questionnaire was retrieved through a protected link in each participating nurse's email via AllCounted, a secure website used to conduct surveys and confidentially display results. Each participating nurse's completed questionnaire was submitted to the researcher via AllCounted's secure system. The researcher analyzed the data received and a total aggregate score was calculated using the SPSS statistics software.

Protection of Human Subjects

The study was approved by the university's Institutional Review Board (IRB) and the private practice where the data was collected before proceeding to ensure the participant's rights were not violated and ethical practices were utilized. The sample of nurses' participating in the study was voluntary and an informed consent was presented

to each nurse before completing the online questionnaire. Nurses' participation were confidential and anonymous, with no personal identifying information collected.

Data Analysis

Data collected via the completed online questionnaire was entered into SPSS statistics software by the researcher. Utilizing SPSS, the researcher determined the mean, standard deviation, and distribution for the two subscales of compassion fatigue: burnout and secondary traumatic stress. The subscale compassion satisfaction was excluded from the study due to the study's purpose being to investigate the prevalence of compassion fatigue in the private practice setting. A one sample t-test was conducted to compare the mean scores of the two subscales to that of the ProQOL manual's mean of 50, based on previous research, and to analyze significance related to the presence of compassion fatigue in the private practice setting.

CHAPTER IV

Results

The purpose of this study was to assess nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. Current literature provides information on the topic of compassion fatigue in an in-patient setting, and there is limited material about compassion fatigue in the private practice setting. Compassion fatigue may affect many areas of the nurse's daily practice. The aim of this study was to investigate nurses who are working in the private practice setting perception of compassion fatigue. Data collected during this study was entered into IBM® Statistical Package for Social Sciences® (SPSS), Version 22, by the researcher for the purpose of analyzing the data.

Sample Characteristics

A non-randomized convenience sample of 43 nurses at a private practice, consisting of direct care nurses, were asked to complete a confidential online questionnaire. Of the 43 nurses at the private practice, 16 nurses participated. One nurse did not fully complete the questionnaire by not providing a response to all questions; therefore, the incomplete data was excluded from the study.

Major Findings

The researcher used SPSS to evaluate data attained from the fifteen completed online questionnaires. Ten questions related to the subscale compassion satisfaction were excluded, as this subscale does not measure compassion fatigue. Of the remaining 20 questions, 10 related to burnout and the other 10 were related to secondary traumatic stress, which are the subscales which make up compassion fatigue (Stamm, 2010). Of

the 10 questions associated with burnout, five were reverse scored as suggested in The Precise ProQOL Manual (Stamm, 2010). Next, the sum of the burnout and secondary traumatic stress subscales were calculated using SPSS by summing the Likert-scale responses of each participant for each subscale. Then, raw scores were converted to t-scores to determine the mean scores for each subscale. The Precise ProQOL Manual's Table for Determining ProQOL T-Score from Raw Scores was utilized to enter listed t-score values from the table into SPSS. The calculated sum of each subscale for each participant in SPSS was used as the raw score to locate the correct t-score from the ProQOL manual table (Stamm, 2010). This transfer of values from the subscales for each participant in SPSS to the ProQOL manual table as raw scores and then back into SPSS as the converted t-scores from the ProQOL manual table, allowed a conversion of the researcher's data to be comparable to the ProQOL manual's mean scores. A one sample t-test was conducted to compare the ProQOL manual's mean for the two subscales, burnout ($M = 50$) and secondary traumatic stress ($M = 50$), to the study's mean for the two subscales, burnout ($M = 48.27$) and secondary traumatic stress ($M = 47.00$) (Stamm, 2010). Refer to Table 1 for the descriptive statistics of the mean scores on both subscales.

Table 1

Mean Scores of Burnout and Secondary Traumatic Stress

	N	Mean	Std. Deviation	Std. Error Mean
Burnout	15	48.27	6.724	1.736
Secondary Traumatic Stress	15	47.00	8.552	2.208

Results of the one sample t-test indicated there was minimal difference between the responses to the questions about burnout ($M = 48.27$, $SD = 6.724$, $p = .335$) and secondary traumatic stress ($M = 47.00$, $SD = 8.552$, $p = .196$) when compared to previous responses from the ProQOL V5 questionnaire measuring compassion fatigue ($M = 50$, $SD = 10$) (Stamm, 2010). These results suggested that although compassion fatigue, consisting of the subscales burnout and secondary traumatic stress, was present in the private practice setting, there was minimal difference in the prevalence of compassion fatigue in the private practice setting compared to other healthcare settings.

Summary

The data gathered for this study included 15 voluntarily completed questionnaires. The questionnaire included three subscales: (1) compassion satisfaction, (2) burnout, and (3) secondary traumatic stress; however, only the subscales burnout and secondary traumatic stress were the focus of the study due to being directly connected with compassion fatigue (Stamm, 2010). The results of this study suggested there was little difference in the prevalence of compassion fatigue in the private practice setting compared with other healthcare settings.

CHAPTER V

Discussion

The purpose of this study was to assess the nurses' perception of the presence of compassion fatigue for nurses in the private practice setting. The role of nurses in healthcare is vital to the care team, as well as the patient, and the nurse's key position is that of a liaison. Understanding how a nurse's stress level impacts their job function, as well as their quality of life is necessary to maintain healthy nurses and safe patients. The aim of this study was to investigate nurses who are working in the private practice setting perception of compassion fatigue

Implication of Findings

Findings from this study suggested there was minimal difference in the prevalence of compassion fatigue in the private practice setting compared with other healthcare settings. Burnout is one of the elements of compassion fatigue and usually has a gradual onset due to feeling one is not making a difference for patients. Burnout typically is linked with a high work load and non-supportive work environment (Stamm, 2010). Higher scores on the "Professional Quality of Life Scale (ProQOL V5)" questionnaire means an individual is at a higher risk of burnout (Stamm, 2010, p 17). The average score for burnout on the "Professional Quality of Life Scale (ProQOL V5)" questionnaire is 50 (SD = 10). If an individual scores less than 18, they more likely hold positive feelings about their ability to be effective in their work; however, if an individual's score is above 57, they feel ineffective at their work (Stamm, 2010, p 17). Secondary Traumatic Stress is the other component of compassion fatigue, and is related to being secondarily exposed to traumatically stressful situations, which includes being

exposed to other's traumatic events. Secondary traumatic stress is more of a rapid onset and is linked to a particular situation (Stamm, 2010). The "Professional Quality of Life Scale (ProQOL V5)" questionnaire average score for secondary traumatic stress is 50 (SD = 10). On the ProQOL V5 questionnaire, about 25% of people score below 43 and about 25% of people score above 57. A score above 57 suggests the need to consider what could be frightening at work, and an indication of need for further examination (Stamm, 2010, p 17).

Indicated in this study was the use of the "Professional Quality of Life Scale (ProQOL V5)" questionnaire in non-private practice settings. The literature portrays results of compassion fatigue subscales, burnout and secondary traumatic stress, were represented as either being in close proximity to the average score of 50 or having higher scores than the average for both subscales. Although there was mention of a "lower percentage or means on burnout, compassion fatigue or secondary and post-traumatic stress in the ICU compared to other wards" (van Mol et al., 2015, p 13), most studies showed higher means for compassion fatigue. The findings from this study were synonymous with other studies in the literature, in that the mean scores for the subscales of compassion fatigue were closely related when compared with the average scores according to the measurement tool utilized in the particular study.

Application to Theoretical Framework

The theoretical framework for this study was the Neuman Systems Model (NSM), which is derived from:

Chardin's philosophical beliefs about the wholeness of life, Marxist philosophical views of the oneness of man and nature, Gestalt and field theories

of the interaction between person and environment, general system theory of the nature of living open systems, Putt's ideas of entropy and evolution in systems, Selye's conceptualization of stress, and Caplan's formulation of levels of prevention. (Neuman, 1989, p 67)

NSM was appropriate for this study in that it brings attention to the important role the environment plays as a stressor. Nurses may experience stress with almost every patient and family interaction due to the responsibility of advocating, educating, providing competent and quality care, and the accountability to patient safety. Compassion fatigue could potentially affect the nurse's personal and professional quality of life, which in turn could affect the patient's quality of life. Findings of this study were congruent with the NSM and indicated that nurses in the private practice setting experience about average levels of compassion fatigue. Therefore, results from this study suggested that compassion fatigue exists in the private practice setting and should be addressed. According to Leineweber et al. (2014), "the nurse work environment dynamics are related to nurses' burnout experiences" (p 2). The NSM includes the concept that an individual's energy is directly related to their environment (Neuman, 1989).

Limitations

Limitations of this study consisted of a small sample size of 15 participants. A larger sample size would offer a broader range of analysis to consider and a better representation of the population. Also, the sample was obtained from a convenience sample, which although is easier to access, may not be representative of the entire population. No demographics were collected during the study, which did not allow for comparison of demographics with other studies. Also, research was conducted at a

private neurology practice and may not be a strong indicator of the environment of other private practice settings.

Implications for Nursing

Nurse managers work closely with staff nurses and can impact the daily flow of the healthcare setting. Compassion fatigue can affect not only the nurse, but everyone the nurse comes in contact with, including the environment. It is significant for nurse managers to wholly grasp the concept of compassion fatigue, understand its subscales, how to identify the signs and symptoms associated with each, and which interventions to implement. Providing attention to the subject of compassion fatigue improves healthcare as a whole, and allows appropriate interventions to take place for the nurse and patient.

Recommendations

Recommended is the assessment of all nursing staff at the healthcare facility for signs and symptoms associated with burnout and secondary traumatic stress, which formulate compassion fatigue. The assessment should incorporate the use of a valid and reliable measurement tool to ensure accuracy of results. After results have been finalized, the recommendation is to begin implementing interventions to address compassion fatigue. The nurse manager could advocate for the nursing staff to establish wellness programs and serve as facilitators for stress reduction techniques to utilize during the work day. These interventions could allow nurses time away from factors that contribute to fatigue and stress, and help nurses balance their energy and decompress, which may lead to decreased compassion fatigue.

Conclusion

Most of the current literature regarding compassion fatigue is based in acute care settings. The researcher chose to investigate the presence of compassion fatigue in the private practice setting. The study was based on the Neuman Systems Model (NSM), which implies the exchange of energy, which is either moving an individual toward or away from stability (Neuman, 1989). The study's results indicated the presence of compassion fatigue in the private practice setting; however, there was a slight difference in the prevalence of compassion fatigue in the private practice setting when compared to other healthcare settings. To assist with the presence of compassion fatigue, it is essential for nurse managers and leaders to understand that compassion fatigue exists, how to assess for compassion fatigue, and ways to implement interventions to address it.

References

- Allen, D., Weinhold, M., Miller, J., Joswiak, M. E., Bursiek, A., Rubin, A....Grubbs, P. (2015). Nurses as champions for patient safety and interdisciplinary problem solving. *Medsurg Nursing, 24*(2), 107-110.
- Bao, S., & Taliaferro, D. (2015). Compassion fatigue and psychological capital in nurses working in acute care settings. *International Journal for Human Caring, 19*(2), 35-40.
- Billeter-Koponen, S., & Frede, L. (2005). Long-term stress, burnout and patient-nurse relations: Qualitative interview study about nurses' experiences. *Nordic College of Caring Sciences, 19*, 20-27.
- Boyle, D. A. (2011). Countering compassion fatigue: A requisite nursing agenda. *OJIN: The Online Journal of Issues in Nursing: A Scholarly Journal of the American Nurses Association, 16* (1), 1-13. doi: 10.3912/OJIN.Vol16No01Man02
- Fradelos, E., Mpelegrinos, S., Mparo, C., Vassilopoulo, C., Argyrou, P., Tsironi, M., ...Theofilou, P. (2014). Burnout syndrome impacts on quality of life in nursing professionals: The contribution of perceived social support. *Progress in Health Sciences. 4*(1), 102-109.
- Gandi, J. C., Wai, P. S., Karick, H., & Dagona, Z. K. (2011). The role of stress and level of burnout in job performance among nurses. *Mental Health in Family Medicine, 8*, 181-194.

- Günügen, N. P., Üstün, B., & Erdem, S. (2014). Work stress and emotional exhaustion in nurses: The mediating role of internal locus of control. *Research and Theory for Nursing Practice: An International Journal*, 28(3), 260-268. doi:10.1891/1541-6577.28.3.260
- Henson, J. S. (2017). When compassion is lost. *MedSurg Nursing*, 26(2), 139-142.
- Introduction to SPSS. (n.d.) Retrieved from <http://www.uvm.edu/~dhowell/fundamentals7/SPSSManual/SPSSLongerManual/SPSSChapter1.pdf>.
- Lee, J. S., & Akhtar, S. (2011). Effects of the workplace social context and job content on nurse burnout. *Human Resource Management*, 50(2), 227-245.
- Leineweber, C., Westerlund, H., Chungkham, H. S., Lindqvist, R., Runesdotter, S., & Tishelman, C. (2014). Nurses' practice environment and work-family conflict in relation to burn out: A multilevel modelling approach. *PLoS ONE*, 9(5), 1-9. doi:http://dx.doi.org. ezproxygardner-webb.edu/10.1371/journal.pone.0096991
- Lin, L., & Liang, B. A. (2007). Addressing the nursing work environment to promote patient safety. *Nursing Forum*, 42(1), 20-30. doi:10.1111/j.1744-6198.2007.00062.x
- Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *OJIN: The Online Journal of Issues in Nursing: A Scholarly Journal of the American Nurses Association*, 16 (1), 1D – 8D.
- Marsh, V., Beard, M. T., & Adams, B. N. (1999). Job stress and burnout: The mediational effect of spiritual well-being and hardiness among nurses. *Journal of Theory Construction and Testing*, 3(1), 13-19.

- Neuman, B. (1989). *The Neuman Systems Model*. East Norwalk, Connecticut: Appleton & Lange A Publishing Division of Prentice Hall.
- Neuman, B., & Reed, K. S. (2007). A Neuman systems model perspective on nursing in 2050. *Nursing Science Quarterly*, 20(2), 111-113.
doi:10.1177/0894318407299847
- Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L., & Olsen, S. (2010). Compassion fatigue & burnout: Prevalence among oncology nurses. *Clinical Journal of Oncology Nursing*, 14(5), E56-62.
- Professional Quality of Life Elements Theory and Measurement. (2017). Retrieved from http://www.proqol.org/Home_Page.php.
- Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse*, 35(4), 32-42. doi:10.4037/ccn2015392
- Smith, M. C., & Parker, M. E. (2015). *Nursing theories and nursing practice*. Philadelphia, PA: F.A. Davis Company.
- Stamm, B. H. (2010). The concise ProQOL manual, 2nd Ed. Pocatello. Retrieved from <http://www.proqol.org>.
- Stewart, W., & Terry, L. (2014). Reducing burnout in nurses and care workers in secure settings. *Nursing Standard*, 28(34), 37-45. doi:10.7748/ns2014.04.28.34.37.e8111
- van Mol, M. C., Kompanje E. J., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: A systematic review. *PLoS ONE*, 10(8), 1-22. doi:10.1371/journal.pone.0136955