The Effects of Compassion Fatigue on Burnout Among Inpatient Psychiatric and Intensive Care Unit Nurses

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REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Assistant Dean for MSN and DNP Studies, on behalf of the program; we verify that this is the final, approved version of the student's DNP Project including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Amita Madan Neidlinger, Student
Dr. Evelyn Parrish, Advisor
The Effects of Compassion Fatigue on Burnout Among Inpatient Psychiatric and Intensive Care Unit Nurses

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing Practice at the University of Kentucky

By

Amita Madan Neidlinger, BSN, RN

Lexington, KY

Fall 2019
Abstract

PURPOSE: This DNP project is relevant to nurses of the psychiatric and Intensive Care Unit (ICU) setting, as high stress environments may produce higher rates of compassion fatigue and burnout. Investigation of these areas may help illuminate unnecessary healthcare costs that are associated with these phenomena. This DNP project is important to the University of Kentucky’s healthcare system, its patients, and nurses. Increased absenteeism and increased medication errors are positively associated with the prevalence of compassion fatigue and burnout in nurses. Outcomes from this project will allow identification of unnecessary healthcare costs and encourage administrators to focus on reducing nurse compassion fatigue in order to promote safe, quality patient care and overall healthcare cost savings.

METHODS: A cross sectional analysis of an electronic survey administered to inpatient psychiatric nurses at Eastern State Hospital and Good Samaritan Hospital and ICU nurses from the University of Kentucky Chandler Hospital and University of Kentucky Children’s Hospital was performed. In addition, semi-structured interviews were implemented at the aforementioned locations to further enhance understanding of the concepts of compassion fatigue. Levels of compassion fatigue and burnout were analyzed using the Professional Quality of Life Scale (ProQOL). Interviews were evaluated using thematic analysis.

RESULTS: The sample was primarily female (90.5%), heterosexual (96.0%), less than 36 years of age (57.1%), had less than a post graduate degree (88.9%), were married or widowed (50.8%), and did not have children (63.5%). Most participants were bachelor’s prepared nurses (70.6%), worked in the ICU (77.7%), worked day shifts (53.2%), had worked greater than a year at their location (73.8%), and had practiced for greater than 1 year in their discipline (81.7%). There was a modest negative correlation between compassion satisfaction and burnout scores.
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Compassion satisfaction and burnout scores differed by work setting. However, no significant differences in compassion satisfaction or burnout scores were found between ICU and psychiatric nurses.

CONCLUSION: Although there were no significant differences in compassion satisfaction or burnout scores between ICU and inpatient psychiatric nurses; the work setting, population served, and type of shift worked had a negative impact on compassion satisfaction and burnout scores. Interviews provided a richer essence of the nursing perspective, indicating work engagement and staffing levels may be important factors that impact compassion fatigue and burnout.
Dedication

To my parents, Anita and Ashok Madan, I am sorry for my bratty ways and am grateful for your encouragement, love and guidance through life. To my brother, Alvin, I thank you for all the laughter, random conversations and most importantly your delicious baked goods.

To my dear husband Noah, I thank you for killing all the spiders, answering my unending hypothetical questions and most importantly, putting up with me for the last 8 years. I love you.

And to my daughter, Beatrix… your exuberant spirit, your thirst for life brightens the darkest of days.
Acknowledgements

I would like to first recognize the University of Kentucky, College of Nursing for the honor of bestowing me an educational opportunity at the first Doctor of Nursing Practice program in the United States. I must also acknowledge Dr. Sheila Melander for providing support and open communication. Thank you to Dr. Chizimuzo Okoli for not only supporting but also encouraging my interest in compassion fatigue. Your guidance and assistance helped to make this journey in scholarly research an adventure. I would also like to acknowledge Dr. Melanie Hardin-Pierce for support and flexibility throughout the capstone process. Finally, I would like to recognize my committee chair, advisor and mentor, Dr. Evelyn Parrish, who without her patience, kindness and understanding, would not have made this DNP project achievable.
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Introduction

Currently, in the United States, over 6 million individuals work in the healthcare field of which the largest proportion at 57%, or roughly 3.5 million, is comprised of registered nurses (BLS, 2016). Of the 3 million nurses, over 500,000 work in critical care (SCCM, 2017). As Baby Boomers age and healthcare needs grow, the demand for registered nurses accelerates (AACN, 2019). Although the number of registered nurses in the United States has considerably grown over the last decade, replacing nursing staff is no simple task. An increase of 3.7% in nursing enrollment over the past year is remarkable, however, not enough to meet the demands for nurses across the country (AACN, 2019).

Aiken and colleagues (2010) and Livanos (2018) reported that environments with higher nurse to patient ratios are associated with higher nurse burnout, nurse turnover, and increased patient mortality rates. There is a 23% increased risk of burnout and job dissatisfaction for each patient cared for by a nurse above the standard unit ratios (Aiken et al., 2002). Higher workloads potentiate a vicious cycle of burnout, increases in patient mortality rates, increases in overall healthcare costs, increases in job dissatisfaction, increases in nursing turnover and short staffed units which ultimately increases workload (AACN, 2019; Aiken et al., 2002; Aiken et al., 2010; Lee et al., 2017; Livanos, 2018).

An evaluation of the National Healthcare Retention and RN Staffing Report indicates that in the last 5 years, hospitals have relinquished over 85% of their employees (NSI, 2019). The national average nurse turnover rate for 2019 stands at roughly 19.1%, which equates to 573,000 registered nurses when considering the total nurse population (NSI, 2019). The cost to replace a nurse is estimated to be anywhere between $40,000 to upwards of $64,000 for critical care nurses; an amount that will cost hospitals $4.4 million to $6.9 million with an estimated
$328,400 added for each percent increase in nurse turnover (NSI; Thoma, Ganger, Peterson & Channell, 2017). Although the numbers are staggering, hospital administration does not appear to prioritize nursing needs, often placing them on the back burner and addressing concerns with governmental regulations and reimbursement, unpaid patient care and issues with clinical quality (Thoma, Ganger, Peterson & Channell, 2017).

**Background and Significance**

Nurses are the backbone of healthcare; they provide direct healthcare to the ever growing population, are the primary advocates for patients and drive an institution’s clinical quality and patient outcomes (ANA, 2019). Nolte, Downing, Temane, Hastyings-Tolsma (2017) reported burnout as a potential consequence of compassion fatigue as well as a counterpart to compassion fatigue. In 1995, Figley described the phenomenon of compassion fatigue as an experience resulting from caring for those in physical and/or emotional distress and often leading to a lack of self-care behavior on part of the caregiver (Lombardo & Eyre, 2011). Overlap exists between the concepts of burnout and compassion fatigue; however, Lombardo & Eyre (2011) describe burnout as a more evolving, progressive experience whereas compassion fatigue may occur more quickly, often triggered by patient care. In a sense, compassion satisfaction may be conceptualized as the ‘antithesis’ of compassion fatigue even though this term is not so well defined (Sacco & Copel, 2018; Stamm 2009). As of May 2019, the World Health Organization (WHO) has added burnout to the International Classification of Diseases (ICD-11), as a consequence to long term workplace stress. WHO recognizes burnout as a syndrome encompassing a lack of energy, pessimism towards anything work related and an overall reduction in work engagement (2019). Furthermore, high levels of burnout have been shown to
cause several health concerns such as physical ailments, psychological issues as well as substance abuse (CFAP, 2017; Hooper et al., 2010; Figley, 1995).

Currently there are no established guidelines to combat compassion fatigue and burnout, however, some literature discusses the concepts of self-care, mindfulness, positive affect and social support as conceivable tools to prevent compassion fatigue (Nolte et al., 2017; Mol et al., 2015; Figley, 1995; Radey & Figley, 2007). Additionally, the WHO recently established burnout as an ICD-11 item and are developing guidelines for a healthy work environment, which may potentially aid in decreasing the rates of compassion fatigue (2019). This DNP project will attempt to illuminate the detrimental costs of compassion fatigue on burnout among psychiatric nurses and ICU nurses.

**Objectives of the DNP Project**

The purpose of this DNP project was to evaluate how the prevalence of compassion fatigue affects levels of burnout among nurses in an ICU and psychiatric inpatient unit at University of Kentucky Chandler Hospital, University of Kentucky Children’s Hospital, Eastern State Hospital and Good Samaritan Hospital, respectively, in Lexington, KY. Because compassion fatigue is often measured by including burnout as a ‘sub-concept’ (Sacco & Copel, 2018; Stamm, 2009), it was important to understand how the opposite of compassion fatigue, that is, compassion satisfaction, was associated with burnout. Hence, the aims of this study were:

**Aim 1:** TO EXAMINE THE RELATIONSHIP BETWEEN COMPASSION SATISFACTION AND BURNOUT IN PSYCHIATRIC NURSES AND INTENSIVE CARE UNIT NURSES.

Questions that guided Aim 1:

1. What were the average compassion satisfaction scores among nurses?
2. What were the average burnout scores among nurses?

**Aim 2:** TO EXAMINE IF THE RELATIONSHIP BETWEEN COMPASSION SATISFACTION AND BURNOUT DIFFERS BY NURSING ROLE (PSYCHIATRIC INPATIENT VS. INTENSIVE CARE UNIT).

Questions that guided Aim 2:

1. Was there a relationship between compassion satisfaction and burnout?
2. Was there a difference between compassion satisfaction and/or burnout scores among psychiatric nurses and ICU nurses?
3. Was there a difference between compassion satisfaction and/or burnout scores by work setting?

**Theoretical Framework**

**Compassion Satisfaction – Compassion Fatigue Model**

In order to understand the context of compassion fatigue, compassion satisfaction and burnout, the theoretical model developed by Stamm (2009) was used to guide the DNP project. This model ultimately became the foundation for the Professional Quality of Life (ProQOL) scale and is now currently under the ownership of The Center for Victims of Torture (CVT) (2019). The theoretical process focuses on elements involved in the caring of others and illustrates how different environments, such as the workplace, patient/client setting, and an individual’s personal environment may positively or negatively impact compassion satisfaction and compassion fatigue (Stamm, 2010). Compassion satisfaction (CS) is essentially derived from the positive or “good” aspects one feels about their work. The opposing aspect, compassion fatigue (CF) incorporates two parts: burnout and secondary traumatic stress (STS) (Stamm, 2009; Stamm 2010; CVT, 2019). Symptoms such as physical or mental exhaustion, depression,
frustration, hopelessness, or anger are examples of burnout whereas secondary traumatic stress occurs from exposure to trauma directly from the patient or through the empathic process of caring for a patient (Figley, 1995; Stamm, 2010; Lombardo & Eyre, 2011; The Figley Institute, 2012; Lee & Kim, 2016; CFAP 2017; CVT, 2019; Zhang et al., 2019). (see Figure 1).

Figure 1: *Theoretical Model of Compassion Satisfaction & Compassion Fatigue.*

An online survey used for this study included all 30 questions from the ProQOL (see Appendix C) as well as questions regarding the experience of trauma. Similarly, nurse interviews examined the concepts of burnout, compassion fatigue and compassion satisfaction with open ended questions. Nurse responses were then evaluated for positive and negative factors, such as physical or mental exhaustion, work environment, and trauma as contributing factors for compassion satisfaction, compassion fatigue and burnout.
Review of Literature

In 1995, Figley described the phenomenon of compassion fatigue as an experience resulting from caring for those in physical and/or emotional distress and often leading to a lack of self-care behavior on part of the caregiver (Lombardo & Eyre, 2011). Overlap exists between the concepts of burnout (BO) and compassion fatigue (CF); however, authors Lombardo & Eyre (2011) describe burnout as a more evolving, progressive experience whereas compassion fatigue may occur more quickly and is often triggered by patient care. Meadors, Lamson and Swanson (2010) found an overlap between the concepts of secondary traumatic stress, post-traumatic stress disorder, burnout, compassion fatigue and compassion satisfaction when assessing providers in the pediatric and neonatal ICU as well as a general pediatric unit. The root of compassion fatigue is defined by depression, exhaustion, and frustration, which are concepts that overlap with burnout, as well as feelings of avoidance, fear, intrusion and hyper-vigilance, which are often terms associated with secondary traumatic stress (Mol, Kompanje, Benoit, Bakker, Nijkamp, 2015). Due to the overlap in concepts, some research uses the terms secondary traumatic stress or vicarious trauma interchangeably and often do not differentiate between the two (Mol et al., 2015).

More recently, the Figley Institute (2012) has differentiated the concepts of compassion fatigue, secondary traumatic stress and burnout. Compassion fatigue is defined as “emotional and physical exhaustion that can affect helping professionals and caregivers over time…” and “has been associated with…an increase in clinical errors, higher rates of depression and anxiety among helpers…” (The Figley Institute, 2012, p. 4). Secondary traumatic stress is distinguished from compassion fatigue as an experience where an individual is traumatized via indirect exposure (i.e. family, friends or professionally) (The Figley Institute, 2012). Lastly, burnout is
described as emotional and mental exhaustion that results over time from daily stress (Figley Institute, 2012). Although attempts have been made to differentiate these concepts, some research suggests otherwise, indicating burnout as a potential severe version of compassion fatigue or even a precursor to compassion fatigue (Mol et al., 2015). In a systematic review on compassion fatigue and burnout, 2 studies showed that compassion fatigue had a prevalence of 7 – 40% and 5 studies indicated a burnout prevalence of 0 – 70% in an ICU setting (Mol et al., 2015). Specific costs of compassion fatigue and burnout are unknown at this time; however, burnout has been associated with decreases in work engagement, nurse retention and increases in nurse absences (Hooper et al., 2010).

Lee and Kim (2016) reported that compassion satisfaction (CS) and secondary traumatic stress greatly impacted the levels of burnout among psychiatric nurses. Consequently, high levels of burnout have been shown to cause numerous health concerns such as physical ailments, psychological issues as well as substance abuse (CFAP, 2017; Hooper et al., 2010; Figley, 1995). Furthermore, burnout yields decreased nurse engagement, increased nurse absences and decreased nurse retention (Hooper et al., 2010). In a cross-sectional survey regarding safety culture in a neonatal intensive care unit (NICU), Profit and colleagues (2014) reported correlations between burnout and several factors. NICUs reporting higher levels of burnout correlated with lower percentages of job satisfaction as well as decreased perceptions of management and overall work environment (Profit et al., 2014). Mason and colleagues (2014) discovered correlations between work engagement and compassion satisfaction and fatigue. Work engagement was positively correlated to scores on the Professional Quality of Life Scale (ProQOL) but was negatively correlated with burnout scores (Mason et al., 2014).
To evaluate the phenomena of compassion fatigue, compassion satisfaction, and burnout, several tools have been used. The two most common tools used to assess burnout are the *Maslach Burnout Inventory* (MBI) and the *Burnout Measure (BM)*, with these tools being used in 90% and 5% of studies discussing burnout, respectively (Schaufeli et al., 2001). Internal consistency has been demonstrated for the BM tool, indicating a Cronbach’s alpha of greater than 0.90 (Scahufeli et al., 2001). The MBI has also been found to be a reliable and valid tool in assessing burnout among nurses (Pisanti, 2013). Conversely, the *Professional Quality of Life Scale* (ProQOL), is most commonly used to evaluate compassion fatigue, compassion satisfaction and burnout, representing the cumulative balance between the positive and negative aspects of caring for others (Stamm, 2010; Sacco, Ciurzynski, Harvey & Ingersoll, 2015). Internal consistency reliabilities for the ProQOL subscales were determined to be 0.72 – 0.82 (Bride, Radey & Figley, 2007).

Although there are no standardized guidelines to address compassion fatigue and/or burnout, researchers and institutions have attempted to abate these matters. An army medical center created a training program, the Care Provider Support Program (CPSP) for military and civilian nurses (Weidlich & Ugarriza, 2015). The program focused on self – awareness and how to best manage one’s energy. Education on stress, compassion fatigue, and resilience were the key elements of the program. A pilot study of the CPSP, using the ProQOL scale, resulted in lower levels of burnout and consequently reduced compassion fatigue (Weidlich & Ugarriza, 2015). Other suggestions to mitigate compassion fatigue included social and professional support, mindfulness, organizational support and education on compassion fatigue (Radey & Figley, 2007; Nolte et al., 2015; Sacco et al., 2015; Weidlich & Ugarriza, 2015).
Agency Description

This DNP project was conducted at the University of Kentucky Chandler Hospital, University of Kentucky Children’s Hospital, Eastern State Hospital, and Good Samaritan Hospital. The University of Kentucky Chandler Hospital (which includes UK Children’s Hospital) is a level 1 trauma center with 65 beds exclusively for the ICU. Founded in 1817, Eastern State Hospital is the second oldest psychiatric hospital in the United States with 239 beds. Good Samaritan Hospital is a local community hospital, first opened in 1888 and is now currently part of the UK Healthcare system as of 2007. All four institutions participated in the quantitative survey whereas only nurses from UK Chandler and Eastern State Hospital participated in the semi-structured interviews.

UK Healthcare takes pride in delivering advanced patient care through scholarly research, education and clinical quality to the people of Kentucky. This project is in congruence with UK Healthcare’s mission to provide top quality, evidence-based patient care. Examination of the phenomena of compassion fatigue and burnout may demonstrate triggers for clinical errors, increased absenteeism and nursing turnover. Key stakeholders of the UK Healthcare system include patients, registered nurses and the administration. Nurses are one of the most present healthcare providers in the system, driving the quality of an institution’s clinical outcomes. Ensuring the physical and mental health of these caregivers is necessary to achieve safe, quality patient care and thus keep overall healthcare costs from skyrocketing.

Project Design

Quantitative A cross-sectional analysis was performed using responses from an online Qualtrics survey, administered to nurses in inpatient psychiatric settings at Eastern State Hospital and Good Samaritan Behavioral Health Unit. Surveys were also administered to ICU nurses at
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the University of Kentucky Chandler Hospital and the University of Kentucky Children’s Hospital.

Qualitative To enhance the concepts of compassion fatigue, compassion satisfaction, and burnout, semi-structured interviews were performed on inpatient psychiatric nurses from Eastern State Hospital as well as ICU nurses from the University of Kentucky Chandler Hospital.

Project Methods

IRB Approval

Prior to initiating this DNP project, permission to administer surveys and information relating to the surveys in addition to conducting interviews was obtained from the University of Kentucky Institutional Review Board (IRB). An expedited review was requested due to the minimal risk to participants, the implementation of a survey as well as the data collection from voice recordings.

Sample Population

Quantitative Sample The sample consisted of 28 psychiatric nurses from Eastern State Hospital and Good Samaritan Behavioral Health in addition to 98 ICU nurses from the University of Kentucky Chandler Hospital and University of Kentucky Children’s Hospital combined. The inclusion criteria consisted of current employment on a full-time or part-time basis within the UK Healthcare enterprise, involvement in direct care to patients, and the age of 18 years or older. Exclusion criterion was representative of individuals who were unable to read or write in English.

Qualitative Sample The sample consisted of six psychiatric and three ICU nurses, from Eastern State Hospital and the University of Kentucky Chandler Hospital, respectively. Inclusion criteria for nurses consisted of 1) registered nurses who worked full time, and 2)
registered nurses who had worked for at least one year in their department. Exclusion criteria consisted of 1) part time nurses, 2) per diem nurses, 3) travel nurses, and 4) nurses with less than one year of experience in their department.

**Measures and Instruments**

**Demographics** Participants’ gender, age, sexual preference, undergraduate degree versus post graduate degree, marital status, presence of children, discipline, work setting, work shift, years of experience at specific location, years of experience in specified field, quality of sleep, average days exercised and whether the individual was diagnosed with a behavioral health issue were assessed on the survey. The semi-structured interviews focused on personal experiences and only indicated whether the participant was an ICU or psychiatric nurse.

**Compassion Satisfaction** The summation of joy and positivity one feels from helping others is the phenomena of compassion satisfaction (Stamm, 2010; Lombardo & Eyre, 2011, The Figley Institute, 2012; Mason et al., 2014; Sacco et al., 2015; CFAP, 2017; CVT, 2019). A total summary score of questions 3, 6, 12, 16, 18, 20, 22, 24, 27 and 30 on the ProQOL-5 (see appendix C) determines the degree of compassion satisfaction. Stamm (2009) reported compassion satisfaction scores to be an average of 50 (s.d. = 10) with an alpha reliability of 0.88. A total sum of 22 or less (score of 43 or less) indicated a low level of compassion satisfaction whereas sums of 42 or greater (score of 57 or greater) reflected a high level of compassion satisfaction (Stamm, 2009).

**Compassion Fatigue** This phenomenon encompasses the negative aspects of caring for others. Compassion fatigue is comprised of two parts; one regarding symptoms of burnout and the other is the experience of secondary traumatic stress (Stamm, 2010; Lombardo & Eyre, 2011, The Figley Institute, 2012; Mason et al., 2014; Sacco et al., 2015; CFAP, 2017; CVT, 2019).
**Burnout** The phenomenon of burnout is a gradual process, affecting job efficiency as well as producing feelings of exhaustion, depression, anger, frustration and hopelessness (Figley, 1995; Stamm, 2010; Lombardo & Eyre 2011; CFAP, 2017; CVT, 2019). Levels of burnout were measured using the ProQOL-5 (Stamm, 2009) by adding the scores from questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29. On this scale, 5 out the 10 questions were reverse coded (questions 1, 4, 15, 17, and 29). Stamm (2010) reported average burnout scores to be 50 (s.d. = 10) with an alpha reliability of 0.75. Sums of 22 or less (score of 43 or less) indicated a low level of burnout while sums of 42 or more (score of 57 or greater) indicated a high level of burnout (Stamm, 2009).

**Investigation of Nurse Experiences with Compassion Fatigue and Burnout** Semi-structured interviews were performed to better understand personal experiences of compassion fatigue and burnout. The interview consisted of the following questions:

1. Can you tell me about some incidences in the last year, when you experienced a difficult situation at work that caused you to call in on a subsequent day or days?
2. Can you give me some examples of when you have felt exhausted at work and/or at home as a result of work?
3. Could you describe situations when you have felt fully present and engaged at work? Could you describe situations when you have not felt fully present and engaged at work?
4. Can you describe what circumstances have led you to being rude or short with people at work or at home?
5. What situations or circumstance have made you feel detached from life?
6. With what areas (or aspects) of your job are you satisfied? With what areas (or aspects) of your job are you not satisfied?
7. Can you describe some of your experiences of being emotionally or personally affected by your patients or patient care?
8. How do you cope with the stresses of your work environment?
9. Can you describe an experience of having nightmares regarding work or a patient?

10. In your current job situation, can you describe how often you feel as if you are under an immense amount of pressure?

11. Can you describe any appetite or sleep changes that you can attribute to your job?

The questions were thoughtfully open-ended to permit the interviewees opportunity to express their narrative. To establish validity and trustworthiness of qualitative data, criterion from Lincoln & Guba (1985) was used. The criterion consisted of credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985). Credibility, which demonstrates how believable or conceivable the data is, was ascertained via triangulation and member checking. All interviewees were asked identical questions as well as to confirm their narrative.

Dependability was achieved through the University of Kentucky’s Institutional Review Board (IRB) and changes were not made to the project after IRB approval. Transferability, the means of generalizing data to another setting and time (Lincoln & Guba, 1985), was achieved by the use of thick descriptions or detailed overview of the project to support the evidence that the findings in this project were likely to be present in another setting. Lastly, confirmability was attained through an interview guide, which limited bias from the interviewer, as well as through keeping an audit trail, by providing detailed review of the measures taken to obtain the results.

DNP Project Procedures

Surveys Data was obtained from psychiatric nurses at ESH and the Good Samaritan Behavioral Health Unit as well as ICU nurses at UK via surveys that were designed to evaluate demographics, levels of compassion satisfaction and burnout. Surveys were administered from September 2018 to November 2018 electronically. All results were tabulated using SPSS version 4, and saved in a secure location at the University of Kentucky College of Nursing.
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**Interviews** Unit managers were contacted in February 2019 to forward an email briefly discussing the project, its goals and requirements to participate and how to contact the primary investigator (PI). As an incentive, registered nurses were offered a chance to participate in a drawing for a gift card if they completed the interview. A follow up email sent in March 2019, consisting of the aforementioned details, indicated further need for interviewees. Prospective participants were offered the option of completing the interview in person or over the phone. Prior to the interviews, a consent to participate in the study was obtained. All tape recordings were transcribed onto a word document and were saved in a secure location at the University of Kentucky College of Nursing.

**Data Analysis**

**Surveys** Descriptive statistics were used to characterize demographic data. Nominal and ordinal data were described using frequencies and percentages whereas interval/ratio data were described with means and standard deviations.

In order to analyze aim 1 of the project, the distributed survey incorporated the ProQOL-5 (Stamm, 2009), which measured levels of compassion satisfaction and burnout. For aim 1, the sample demographics were described using means with standard deviations for interval variables and frequencies with percentages for nominal variables. Descriptive statistics were used to describe scores on the ProQOL-5 (Stamm, 2009) using means with standard deviations.

To analyze aim 2 of the project, compassion satisfaction and burnout subscales from the ProQOL-5 (Stamm, 2009) were used. Levels of compassion satisfaction between inpatient psychiatric and ICU nurses was also evaluated. For aim 2, the relationship between ProQOL-5 (Stamm, 2009) compassion satisfaction and burnout scores were examined using Pearson correlations. Differences between psychiatric nurses and ICU nurses on ProQOL-5 (Stamm,
2009) compassion satisfaction and burnout scores were examined using independent sample t-tests. Differences between compassion satisfaction and burnout scores were examined using ANOVAs.

**Interviews** Audio files were transcribed verbatim and rigorously evaluated using the technique of Thematic Analysis, which consisted of extracting and analyzing emerging themes within the data (Braun & Clark, 2006; Lorelli, Nowell, Norris, White & Moules, 2017). According to Braun and Clark, there are six parts to thematic analysis; familiarization, coding, finding themes, evaluating themes, finalizing themes and writing. Once transcripts were reviewed for accuracy, the process of familiarization occurred by rereading each interview several times to appreciate the data. Key statements were initially highlighted in different colors to signify potential themes and/or issues and then compiled into a word document. Similar ideas were then grouped together, and recurring themes were identified. A thorough evaluation of the themes revealed no overlap, and all were supported by the data, subsequently permitting the themes to be finalized and presented in the DNP project.

**Results**

**Quantitative**

**Sample characteristics** As reflected in table 1, the sample was primarily female (90.5%), heterosexual (96.0%), less than 36 years of age (57.1%), had less than a post graduate degree (88.9%), were married or widowed (50.8%), and did not have children (63.5%). Most participants were bachelor’s prepared nurses (70.6%), worked in the ICU (77.7%), worked day shifts (53.2%), had worked greater than a year at their location (73.8%), and had practiced for greater than one year in their discipline (81.7%). On average participants rated a modest sleep quality ($m=5.6$, $sd=2.1$) and exercised for 2.7 ($s.d.=1.6$) days per week. A quarter of participants
also reported being diagnosed with a behavioral health problem (see Table 1). There was a modest negative correlation between compassion satisfaction and burnout scores ($r = -0.70$, $p < 0.0001$).

**Table 1: Sample Characteristics**

<table>
<thead>
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<th>%</th>
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<tbody>
<tr>
<td><strong>Male</strong></td>
<td>12</td>
<td>9.5%</td>
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<tr>
<td><strong>Female</strong></td>
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<td><strong>Age</strong></td>
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COMPASSION FATIGUE & BURNOUT

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<td>7 months to 1 year</td>
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<td>2 to 5 years</td>
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<td>Greater than 10 years</td>
<td>29</td>
<td>43</td>
<td>43.1</td>
<td>25.4</td>
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Average quality of Sleep (M, SD) 5.6 2.1
Average days exercised for 30mins or more per week (M,SD) 2.7 1.6
Ever diagnosed with a behavioral health problem 32 25.4

Compassion satisfaction scores and demographic variables Participants had average compassion satisfaction (m = 38.3, s.d. = 6.4) scores. There were significantly different compassion satisfaction scores by shift work (F = 3.2, p = .045) with day (m = 38.4, s.d. = 6.4) and night (m = 37.0, s.d. = 6.6) shift having lower scores than other (m = 41.7, s.d. = 4.0) shift. Furthermore, compassion satisfaction scores differed by population served (F = 12.9, p < .0001) with nurses serving adult populations (m = 36.6, s.d. = 6.5) having lower compassion satisfaction scores than those serving pediatric populations (m = 40.5, s.d. = 5.5). There were no other demographic differences in compassion satisfaction scores.

Differences in Compassion Satisfaction Scores between Intensive Care and Psychiatric Nurses There were no significant differences in compassion satisfaction scores between ICU and psychiatric nurses (m = 38.6, [s.d. = 6.1] vs. m = 37.3, [s.d. = 7.2], F = 0.9, p = .343). However, compassion satisfaction scores differed by work setting (F = 5.4, p = .002) with Good Samaritan Behavioral (m = 35.4, s.d. = 7.6) and UK Chandler ICU (m = 36.1, s.d. = 6.0) having lower scores than Eastern State Hospital (m = 39.1, s.d. = 6.6) and UK Children’s Hospital (m = 40.5, s.d. = 5.5) (see Figure 1).
Burnout scores and Demographic Variables Participants had low burnout (m = 24.4, s.d. = 6.4) scores. Scores on burnout for college graduates was significantly higher than for post graduates (m = 24.8, [s.d. = 6.4] vs. m = 21.2, [s.d. = 5.5], F = 3.9, p = .05). There were also significantly different burnout scores by shift work (F = 4.7, p = .011) with day (m = 25.3, s.d. = 6.5) and night (m = 24.5, s.d. = 5.9) shift having higher scores than other (m = 19.9, s.d. = 5.4) shift. Furthermore, burnout scores differed by population served (F = 17.0, p < .0001) with nurses serving adult populations (m = 26.3, s.d. = 6.6) having higher burnout scores than those serving pediatric populations (m = 21.9, s.d. = 5.2). Finally, burnout scores were higher among those who had a behavioral health diagnosis as compared to those who did not (m = 27.0, [s.d. = 5.5] vs. m = 23.5, [s.d. = 6.5], F = 7.5, p = .007). There were no other demographic differences in burnout scores.

Differences in Burnout Scores Between Intensive Care and Psychiatric Nurses

There were no significant differences in burnout scores between ICU and psychiatric nurses (m = 24.1, [s.d. = 6.2] vs. m = 25.5, [s.d. = 7.0], F = 1.1, p = .304). However, burnout scores significantly differed by work setting (F = 6.2, p = .001) with UK Chandler ICU (m = 26.9, s.d. =
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6.3) and Good Samaritan Behavioral (m = 26.4, s.d. = 6.0) having higher scores than Eastern State Hospital (m = 24.5, s.d. = 8.0) and UK Children’s Hospital (m = 21.9, s.d. = 5.2) (see Figure 2).

Figure 3: Differences in Burnout scores by work setting (F=6.2, p=.001)

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Mean (SD)</th>
</tr>
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<tbody>
<tr>
<td>UK Children's ICU</td>
<td>21.9 (10.0)</td>
</tr>
<tr>
<td>Eastern State Hospital</td>
<td>24.5 (10.0)</td>
</tr>
<tr>
<td>Samaritan Behavioral Health</td>
<td>26.4 (10.0)</td>
</tr>
<tr>
<td>Uk Chandler Intensive Care</td>
<td>26.9 (10.0)</td>
</tr>
</tbody>
</table>

Qualitative Exploration of Nurse Interviews

Semi-structured interviews facilitated a deeper understanding of nurse experiences within their respective units. All nine interviews of inpatient psychiatric and ICU nurses were transcribed and analyzed for key themes pertaining to compassion satisfaction, compassion fatigue and burnout. The themes were labelled as: negative factors, consequences of physical and/or mental exhaustion, and positive factors that helped to prevent burnout and compassion fatigue.

Negative factors contributing to burnout and compassion fatigue

Several nurses discussed the impact of specific patients on physical and mental health. With regard to feeling exhausted at work or at home as a result of work, a nurse from Eastern State Hospital stated:
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“…one patient would set the whole milieu out of whack and then that would trigger another one and so forth. And once it just starts snowballing…that can be a little overwhelming and pretty exhausting.”

Another nurse from the ESH stated:

“I worked on a unit that was specific for the violent, dangerous people. And I worked five days a week, eight hour shifts. So, working with those people day in and day out, I do recall actually one time coming in, getting report and then calling the shift coordinator saying, I've got to switch out with somebody because I cannot do this today.”

Being emotionally or personally affected by patients, an ICU nurse stated:

“…We’ve taken care of a patient that was severely injured in trauma and it’s just hard to see someone young go through such horrible things. Sometimes if I get invested in some of our pediatric patients…it’s really sad.”

Likewise, another ICU nurse stated:

“It sucks to see so many emotional things…like a person my age should not…anyone should not see these many people die in their life. Like, I’ve seen too many dead bodies. I’ve seen too many families suffer…When a patient passes away, they’re at peace…we’ve ended their suffering. But now you see the families just breakdown and suffer.”

In addition to issues with patients, nurses also mentioned staffing issues as a contributing factor in physical and mental exhaustion. A psychiatric nurse stated, “I don’t feel like they staff us, uh safely…They’re not very discriminating when they are hiring people for the tech positions.”

An ICU nurse stated:

“She’ll (manager) will pull staff from night shift to help out day shift and leave us with no one. So sometimes that can be a little burdensome, you know, frequently working understaffed…and you just feel like, gosh, I can’t wait to get outta here.”

Lastly, nurses felt a lack of support was another contributing factor towards symptoms of exhaustion. One nurse said, “They (management) say they are patient directed, patient care, all this whatever. But from what I’ve see, I really don’t feel that way sometimes.”
A psychiatric nurse said:

“The part that frustrates me, about my job, is when the people above you in the offices make decisions on your work. When administrative makes decision on how we are to do things or carry out things that don’t make any sense, because I feel like they’re detached from reality of what goes on the floor. So, they make our work harder.”

An ICU nurse felt unsupported and disengaged by the actions of her manager, stating:

“Sometimes when our manager just doesn’t keep us informed of anything and just throws extra responsibilities on us without telling us…that makes me not engage and be annoyed…When she makes us short staffed and doesn’t help us with things…that’s frustrating leave me not engaged (with work).”

**Consequences of physical and/or mental exhaustion** As a result of physical and mental exhaustion, a couple of nurses referred to a lack of work/life balance. One ICU nurse said, “It definitely carries over. You’re like extra tired and probably don’t do the things you would’ve done if you had more energy.” Another ICU nurse stated:

“…when I’m at home I have like no energy and no…like I’m so drained emotionally…I feel like I give so much at work and I just, I don’t have, I don’t give to myself at all. I don’t give time to myself to like decompress or any of that kind of stuff.”

Nurses also reported poor coping skills as a result of experiencing symptoms of burnout and compassion fatigue. One nurse stated, “…I was just so busy, and I was charge and doing all these things and I felt I couldn’t step away. I couldn’t take 10 minutes to put food in my mouth so then I binge eat because I’ve had a rough day.”

Additionally, some nurses reported feelings of detachment and avoidance behavior. An ICU nurse reported:

“…if I have like a really sad patient and a sad family…I know they’re going to die and I just like, I can’t emotionally be there. Like there’s sometimes where I’m completely tapped out and I feel so bad because most of the time, I feel like I do cry with the families and I do feel like so much of their pain along with them…And like it gets to a point where like sometimes I have nothing. I have nothing to give them and I feel really bad. Like I get really remorseful when I go home and I’m like I wasn’t really sympathetic as I felt I could have been. Like, it was a very sad situation, but I turned all my emotions off because I just couldn’t do it.”
Another nurse recognized their feelings of detachment and avoidance:

“…if I went in and I saw any type of, you know, traumatic thing going on, I didn’t want to be involved. Even if it wasn’t my patient, I would walk away ‘cause I just couldn’t handle it anymore. It was…it was too much. It was too exhausting seeing two kids, that were relatively young die. And then one of them is a coworker’s family member….It just took me over the edge and I knew it was an environment I had to get out of because you’re no good to the patients. And that’s when I recognized – I was like, I have compassion fatigue. Cause I can’t, you know, go into a room. Like, I became really numb. I just became blank faced. I’m just going through the motions…”

Positive factors helping to prevent burnout and compassion fatigue  Both inpatient psychiatric nurses and ICU nurses felt they were more engaged with work and more satisfied with their jobs when having control over their schedules, peer support, spirituality and the feeling they were making a difference. For example, when discussing how one coped with the stresses of the work environment, one nurse said, “I try to do my schedule. I try to work two days, off for three…and it gives me enough time to recharge my batteries in between.” Another reported peer support as an essential tool in coping with work stress:

“It helps to have good coworkers that I can vent to…you can talk about the situation with them, because they understand and go through the same things, that’s more valuable than anything.”

Another nurse stated the presence of good camaraderie allowed for one to feel more present and engaged with work:

“The best was when I would have a lot of nurses that had real good camaraderie and they worked together…they were more engaged in working and providing good care and they took pride in themselves and in the unit.”

Nurses also commented on how spirituality played a positive role in coping with work stress. One nurse said:

“…I pray a lot. I pray before I come to work. I pray days before I have to go back to work…I’m just using God as a source of strength because there are days I come in here and…I don’t think I could do this another day. And miraculously I’ll make it through another shift.”
Lastly, several nurses indicated a sense of reward, positivity and job satisfaction upon helping a patient. A nurse stated:

“I really like working with the patients; I find mental health to be super interesting…it can be really devastating to someone’s life if it’s not managed. If I have a patient who’s really struggling, if I can help them through that, it feels really good.”

Another nurse reported a good deal of job satisfaction on account of having a voice on the unit:

“…I do feel like I have a voice only because I am personally active in my council and two different councils. I feel like a lot of physicians have asked me to on their focus groups because they want my opinion. I feel like I can make a difference…I probably can’t make a difference to most of my patients’ lives because most of them are so sick…I can make a difference in care in general. To me that part is really rewarding.”

**Discussion**

The purpose of this DNP project was to evaluate the phenomena of compassion fatigue and burnout in the inpatient psychiatric and intensive care units and to ascertain whether relationships existed between these phenomena. As the complex demands of healthcare grow, the demand for registered nurses increases, however, the rate of nurse turnover does not budge. Increased nurse workloads contribute to the cycle of short staffed units, increases in patient mortality, job dissatisfaction, and burnout (AACN, 2019; Aiken et al., 2002; Aiken et al., 2010; Lee et al., 2017; Livanos, 2018). Investigating burnout and compassion fatigue is crucial to the future of nursing and safe, quality patient care.

A majority of the survey participants were female, under the age of 36, married or widowed and were bachelor’s degree prepared. Overall burnout scores, as measured from the ProQOL-5 (Stamm, 2009) were low, however, results indicated scores were higher for recent college graduates than post graduates. In addition, the data revealed burnout scores to be higher for nurses working with the adult population or those working day or night shift versus nurses who worked with the pediatric population or an ‘other’ shift. Likewise, compassion satisfaction
scores were lower for nurse working day or night shift as well as for those working with adults. The findings suggest novice nurses may be at a higher risk for burnout. First, this finding may be caused by a number of factors such as a lack of proper tools to manage the stresses of a nursing environment or lack of an appropriate support network to navigate difficulties on the job. Second, caring for of adult patients may be more physically and mentally demanding as compared to taking care of pediatric patients. Increased burnout for those working day or night shift may be due to increased demands by family members, fluctuating staff, or an inability to maintain a balance between home and work.

Although there were no statistically significant differences between burnout and compassion satisfaction scores among inpatient psychiatric and ICU nurses, a negative correlation was discovered between the two concepts. This finding is consistent with the literature (Zhang et al., 2018; Profit et al., 2014; Mason et al., 2014), that as compassion satisfaction increased, the level of burnout decreased. Moreover, compassion satisfaction scores were higher for nurses working at Eastern State Hospital and UK Children’s Hospital versus nurses working at Good Samaritan and UK Chandler Hospitals where burnout scores were significantly higher. Reasons for this finding may be due to other organizational or managerial differences, availability of resources, salary or individual preferences not examined in the project.

Implications for practice, education, policy and future research

Implications for practice and education Literature and findings from the DNP project indicate burnout and compassion fatigue as severe threats to nurse well-being, patient safety and rising healthcare costs. As discussed earlier, burnout has the potential to lead to a decrease in job engagement and less compassion satisfaction (Aiken et al., 2002; Hooper et al., 2010; Mason et
In this DNP project, nurses reported high acuity and low staffing numbers as issues contributing to feelings of physical and emotional exhaustion. Administrators should be compelled to further examine their organization’s nurse retention in relation to their morbidity/mortality rates and subsequent expenses. Administrators need to implement ways to reduce nurse stress such as improving nurse to patient ratios and providing education and resources on self-care (Aiken et al. 2002; Aiken et al., 2010; AACN, 2019; Hooper et al., 2010; Jones et al., 2007; Kurnat-Thoma et al., 2017; Lee et al., 2017; Mol et al., 2015; Nolte et al., 2017; Weidlich & Ugarriza, 2015; Zhang et al., 2017).

Research has indicated individuals who felt supported by their managers and organization were more likely to be engaged in their work (Hunsacker et al., 2015; Mason et al., 2014; Mol et al., 2015; Nolte et al., 2017; Profit et al., 2014). Literature has also indicated that education and focus on self-care activities has the potential to reduce burnout and, subsequently, compassion fatigue. Providing nurses with the resources to educate themselves on burnout and compassion fatigue as well as resources for self-care activities is a way for administration to provide and demonstrate support (Mol et al., 2015; Nolte et al., 2017; Weidlich & Ugarriza, 2015; Zhang et al., 2017). Education on preventing burnout and compassion fatigue should focus on stress management, signs and symptoms of compassion fatigue, one’s awareness of compassion fatigue, mindfulness and resilience in order for employees to succeed emotionally and physically at work (Weidlich & Urgarriza, 2015).

**Future Research** There continues to be an overlap of concepts regarding burnout, compassion fatigue, and secondary traumatic stress within the literature. Future research should explore the specific differences between secondary traumatic stress, compassion fatigue, and burnout.
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Potential contributing factors such as individual resilience, financial stressors, history of health problems not analyzed in this project are worthy of exploration in the future. Defining ways to manage burnout and compassion fatigue are essential for caregivers and thus further research should examine the impact of institutional employee wellness resources on levels of burnout and compassion fatigue.

Limitations

Although combining the results of a survey with the rich narratives from individual interviews provides a broader picture of burnout and compassion satisfaction, there were several limitations of the project. The survey sample size was generous, however, 77.7% were ICU nurses, demonstrating primarily the ICU experience. On the other hand, sample size for the interviews was limited (n = 9); more inpatient psychiatric nurses (n = 6) than ICU nurses participated in the interviews. The lack of balance between sample sizes may skew the results, consequently limiting a true understanding of differences between the inpatient psychiatric and ICU experiences as well as diminishing generalizability and transferability of findings.

Additionally, the PI is an employee of the University of Kentucky Chandler Hospital and has frequented some of the ICUs that were included in the DNP project. Participants may have recognized the PI by name or face and thus allowed for potential bias when interviewing in person. Peer debriefing and member checking were instituted to avoid presumptions and misconceptions.

Conclusion

Results indicated a negative relationship between burnout and compassion satisfaction. Both inpatient psychiatric and ICU nurses demonstrated that as their levels of burnout increased, compassion satisfaction levels dropped. The results also revealed the potential impact of factors
such as shift time and work setting on burnout and compassion satisfaction. It is not clear, however, why certain institutions presented lower compassion satisfaction scores than others. Extraneous variables like work culture, peer relationships and managerial differences are potential factors not accounted for in the project. Personal interviews granted a rich understanding not otherwise present with the survey, suggesting work engagement, staffing levels and peer support as factors influencing compassion satisfaction and compassion fatigue.

It is apparent that supporting nurses with adequate nurse to patient ratios as well as proper supplies and resources would not only benefit nurses but also patients as well as the healthcare organization (Aiken et al., 2002; Aiken et al., 2010; AACN, 2019; Jones et al., 2007; Kurnat-Thoma et al., 2017; Lee et al., 2017; Livanos, 2018; NSI, 2019). When administration choose to ignore the needs of their key employees, the vicious cycle of increased workloads, increased burnout, increased nurse turnover and increased rates of patient mortality may continue while causing healthcare expenditures to skyrocket. Considering the NSI’s 2019 report, if the current nurse turnover rate stands at roughly 19% per year and a hospital ICU unit employs a total of 30 nurses, the unit would demonstrate a loss of 6 nurses in a year. Over the course of 5 years, the unit would lose a total of 180 nurses, costing the hospital a minimum of $7,200,000 to replace and train new nurses for that specific unit alone (assuming it costs $40,000 to train 1 new nurse). This value alone does not include the specific cost of increases in patient mortality due to insufficient staffing and may very well be higher. It seems prudent to solicit healthcare organizations to provide vital resources for nurses to work safely and efficiently. As the backbone of healthcare, nurses need to have their physical and mental health prioritized; doing so may benefit patient care and overall healthcare expenditures.
Appendix A: Interview Questions

Interview Questions

1. Can you tell me about some incidences in the last year, when you experienced a difficult situation at work that caused you to call in on a subsequent day or days?

2. Can you give me some examples of when you have felt exhausted at work and/or at home as a result of work?

3. Could you describe situations when you have felt fully present and engaged at work? Could you describe situations when you have not felt fully present and engaged at work?

4. Can you describe what circumstances have led you to being rude or short with people at work or at home?

5. What situations or circumstance have made you feel detached from life?

6. With what areas (or aspects) of your job are you satisfied? With what areas (or aspects) of your job are you not satisfied?

7. Can you describe some of your experiences of being emotionally or personally affected by your patients or patient care?

8. How do you cope with the stresses of your work environment?

9. Can you describe an experience of having nightmares regarding work or a patient?

10. In your current job situation, can you describe how often you feel as if you are under an immense amount of pressure?

11. Can you describe any appetite or sleep changes that you can attribute to your job?
Appendix B: Informed Consent

Consent to Participate in a Research Study

KEY INFORMATION For The effects of compassion fatigue on burnout among inpatient psychiatric and intensive care unit nurses

You are being invited to take part in a research study about the potential effects of compassion fatigue on burnout in nurses. This page is to give you key information to help you decide whether to participate. Ask the research team questions. If you have questions later, the contact information for the research investigator in charge of the study is below.

WHAT IS THE PURPOSE, PROCEDURES, AND DURATION OF THIS STUDY?
By doing this study, we hope to learn if compassion fatigue has any effects on burnout among inpatient psychiatric and intensive care unit nurses. We hope to understand each nurse’s experience through semi-structured interviews that will take place over 2 months. Your participation in this research will last about 1 hour. Interviews will take place at the University of Kentucky, College of Nursing or will be teleconferenced via Skype or Google Chat. All interviews will be recorded using a digital audio recorder and will consist of the Principal Investigator asking open ended questions.

What are KEY reasons you might choose to volunteer for this study?
If you are a nurse in an intensive care unit you may be experiencing compassion fatigue and/or burnout. Investigation of high stress environments may help better understand the rates of compassion fatigue and burnout as well as illuminate potential unnecessary healthcare costs associated with these phenomena and reveal ways to reduce the occurrence of these phenomena among nurses.

What are Key reasons you might choose NOT to volunteer for this study?
Interview questions may potentially stir thoughts and feelings of uncomfortable situations at work that may be difficult to discuss.

DO YOU HAVE TO TAKE PART IN THE STUDY?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits, or rights you would normally have if you choose not to volunteer.

ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?
Exclusion criteria will consist of 1) part time nurses, 2) per diem nurses, 3) travel nurses, and 4) nurses who’ve worked less than 1 year in their department.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?
When we write about or share the results from the study, we will write about the combined information. We will keep your name and other identifying information private. All tape-
recorded interviews will be kept in a locked location and destroyed within 6 years of completing the study.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?
The person in charge of this study is Amita Neidlinger, *Principal Investigator, PI* of the University of Kentucky, Doctoral Nursing Student. If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study her contact information is: ama374@uky.edu or cell phone # (248) 890 – 3144.

If you have any questions, suggestions or concerns about your rights as a volunteer in this research, contact staff in the University of Kentucky (UK) Office of Research Integrity (ORI) between the business hours of 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.
**INFORMED CONSENT SIGNATURES**

This consent includes the following:
- Key Information Page
- Detailed Consent

You will receive a copy of this consent form after it has been signed.

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<tr>
<th>Signature of Principal Investigator or Sub/Co-Investigator</th>
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Appendix C: ProQOL Survey

Professional Quality of Life Scale (ProQOL)

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

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

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<tr>
<th>1=Never</th>
<th>2=Rarely</th>
<th>3=Sometimes</th>
<th>4=Often</th>
<th>5=Very Often</th>
</tr>
</thead>
</table>

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of others I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

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References


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