



# Compassion Fatigue in Pediatric Nurses

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Compassion fatigue in nursing has been shown to impact the quality of patient care and employee satisfaction and engagement. The aims of this study were to determine the prevalence and severity of compassion fatigue among pediatric nurses and variations in prevalence based on respondent demographics using a cross-sectional survey design. Nurses under 40 years of age, with 6–10 years of experience and/or working in a medical–surgical unit had significantly lower compassion satisfaction and higher levels of burnout. Secondary traumatic stress from caring for children with severe illness or injury or end of life was a key contributor to compassion fatigue.

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CARING FOR CHILDREN who are sick or dying can be highly rewarding, and at the same time, emotionally exhausting or even traumatizing. Why is it that some nurses find satisfaction in caring for the sickest children for many years, while others experience chronic stress or burnout, become cynical or ineffective, or leave their positions? It is important for organizational leaders to understand what factors influence the pediatric nurse's ability to maintain compassion and professional commitment in the face of the helplessness, pain and sadness that they are likely to experience in caring for sick children and their families.

## Background

The term “compassion satisfaction” (CS) describes the satisfaction nurses feel when caring for others and feeling competent. According to Stamm (2010), CS is a measure of the positive aspects of altruism or caregiving, the experience of “feeling good that you can do something to help”. In

contrast, compassion fatigue (CF) is described as physical, emotional and spiritual depletion when caring for patients (Lombardo & Eyre, 2011). CF was first applied to nursing by Joinson (1992) to describe nurses' responses of either emotional distancing to turn off their own feelings, or feeling helpless and angry as they watch patients go through trauma or devastating illness. The emotional effect of being indirectly traumatized by helping others who have experienced primary traumatic stress is called secondary traumatic stress (STS) (Figley, 2002).

CF occurs when the amount of compassion expended by the staff member exceeds their ability to cope or recover (Coetzee & Klopper, 2010). CF can have an insidious onset with physical, social, emotional, spiritual and intellectual effects upon nurses, which can have a negative impact on patient and organizational outcomes. Left unmanaged, CF can lead to burnout.

Nurses who care for children are at risk of developing CF due to routine exposure to traumatic aspects of child illness or death, injury or medical treatment, as well as the families' emotional responses to the illness. In one study of 314 healthcare providers in a children's hospital, the level of CF

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was similar to that of a group of trauma workers, with 39% at moderately high to extremely high risk of CF and 21% at moderate to high risk of burnout (Robins, Meltzer, & Zelikovsky, 2009). In another study of 240 nurses in a pediatric hospital, nurses in the surgical unit, especially those with 5–9 years of experience, reported the highest burnout and lowest CS, while nurses in hematology–oncology reported the lowest burnout and the highest CS (Sekol & Kim, 2014). However, in a review of the literature, Zander, Hutton, and King (2010) found that the aspects that pediatric oncology nurses often define as “rewards of the job” can also be a source of tension, i.e. building close relationships with patients and families while using self-preservation strategies for effective coping.

CF poses a significant risk for long-term health consequences in nurses including numerous emotional health issues (Hamer, Endrighi, Venuraju, Lahiri, & Steptoe, 2012) such as anxiety, depression and post-traumatic stress disorder (PTSD) (Czaja, Moss, & Mealer, 2012; Figley, 1995;). Subsequent physical health issues may also develop, including lack of energy and being accident prone (Coetzee & Klopper, 2010), increased inflammatory process (Goldman-Mellor, Brydon, & Steptoe, 2010), hypertension and coronary artery disease (Hamer et al., 2012; Cora, Partinico, Munafo, & Palomba, 2012), diabetes (Heraclides, Chandola, Witte, & Brunner, 2009, Heraclides, Chandola, Witte, & Brunner, 2012), obesity (Berset, Semmer, Elfering, Jacobshagen, & Meier, 2011; Fernandez, Su, & Winters, & PC, Liang, 2010), and gastrointestinal disorders (Konturek, Brzozowski, and Konturek (2011).

CF can lead to numerous negative outcomes within a healthcare organization (Boyle, 2011; Lombardo & Eyre, 2011) such as nurse burnout (Maytum, Heiman, & Garwick, 2004; Meadors, Lamson, Swanson, White, & Sira, 2009), apathy, a desire to quit, decreased productivity and staff turnover. CF can also lead to ineffective or deficient patient care, callousness and indifference toward patients and co-workers (Coetzee & Klopper, 2010), medical errors, poor patient outcomes and low patient satisfaction (Kutney-Lee et al., 2009; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004).

The purposes of this study were to determine:

- 1) The prevalence and severity of CS and CF among pediatric nurses working with various subspecialty populations.
- 2) Variations in prevalence and severity of CS and CF based on respondent demographics
- 3) Sources of CF in pediatric nurses and methods used to address CF

## Methods

### Design and Procedures

This cross-sectional survey of pediatric registered nurses (RNs) was conducted in a five-hospital system which included an urban pediatric tertiary care teaching hospital. The study was approved by the University of Louisville institutional review board (IRB) and the target institutions.

Survey packets (cover sheet, survey) were placed on pediatric units in areas frequented by RNs such as break rooms and cyber labs. A container was available on each unit for placement of completed surveys for a 2-week period in March, 2014. In addition, Web-based surveys using SurveyMonkey® were available during the same 2-week period. The Web-based survey opened with a cover page explaining the study, followed by screens with the survey questions. Surveys took approximately 10 minutes to complete. RNs were informed of the study primarily via emails and flyers.

### Instruments

Participants completed the Professional Quality of Life Scale, Version 5 (ProQOL, V5) which assesses professional quality of life for those in the helping professions. Professional quality of life is a theoretical concept developed to analyze pathways of convergence between person environments (e.g. nurses), client environments (e.g. patients), and work environment (e.g. unit, hospital or system) (Stamm, 2010).

The ProQOL, V5 measures both CF and CS. CF includes both burnout and secondary traumatic stress (STS). Burnout can include feeling exhausted, frustrated, angry, or depressed. STS includes both direct trauma and secondary trauma from exposure to those who have directly experienced trauma. The ProQOL, V5 is a 30-item instrument assessing how often respondents experienced a particular situation in the workplace in the past 30 days. Each subscale includes 10 items that use a 5-point Likert type scale (1 = never, 5 = very often). Construct validity has been established. The Cronbach alpha reliabilities are: CS: .88; burnout: .75; and STS: .81. The items in each subscale are summed for a mean score. Higher scores on the CS indicate greater satisfaction in your ability to do your job. Higher scores on the burnout subscale indicate greater likelihood for burnout. Higher scores on the STS may indicate feeling overwhelmed with thoughts of the patients you have helped (Stamm, 2010). Demographic items concerning age, experience, work unit, position, education, race and ethnicity were gathered. In addition, two open ended questions asked respondents to describe a situation in which they experienced CF or burnout and the mechanisms used to deal with the situation (Yoder, 2010).

### Sample

Participants were RNs, at least 18 years old, and worked in a pediatric setting in the target healthcare system. Of the approximately 700 pediatric RNs that were employed in the system, 239 completed the survey for a 34% response rate. Most participants were over 40 years old (52%), female (98%), Caucasian (95%), staff nurses (83%), and had over 5 years of experience as an RN (74%) (Table 1). The majority had at least a baccalaureate degree (70%), and worked in critical care (36%), medical/surgical units (18%), or surgical services (14%).

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