



A survey of compassion satisfaction, burnout and compassion fatigue in nurses practicing in three oncology departments in Durban, South Africa

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ABSTRACT

Purpose: Prolonged and continual contact with grief and recurrent deaths, observing patients undergoing unrelenting medication therapies which could prove unsuccessful, and a constant atmosphere of hopelessness put the oncology nurse at high risk of developing compassion fatigue and burnout. This study conducted a survey of compassion satisfaction, burnout and compassion fatigue in nurses practicing in three oncology departments in Durban, South Africa.

Method: A quantitative non-experimental descriptive survey using purposive sampling.

Results: Results revealed that 55% (n = 83) of participants had high compassion satisfaction, 61% (n = 83) had average burnout and 75% (n = 83) had average compassion fatigue. Only three participants scored high risk for compassion fatigue.

Conclusions: The results from this study are in contrast to previous international and national studies where compassion fatigue and burnout were reported at high-risk levels. This study revealed average to high levels of compassion satisfaction.

1. Introduction

Caring for oncology patients may well be a source of both personal fulfilment and intellectual stimulation for healthcare professionals but it can also exact a toll on their physical and emotional health (Medland, Howard-Ruben, & Whitaker, 2004). The physical and emotional demands of the patient–nurse relationship and of the oncology unit, together with daily challenges of nursing oncology patients, generate significant stress in oncology nurses (Gillespie, 2013; Potter et al., 2012). Enduring and repeated patient losses, as experienced by oncology healthcare workers, coupled with caring both for patients with life-threatening illnesses and for bereaved families, can predispose to psychological stress (Gillespie, 2013; Medland et al., 2004).

Oncology nurses are involved in nursing cancer patients through the full protracted, extensive and traumatic continuum of cancer diagnosis, treatment regimens and difficult management of intractable pain that the patients often suffer. Oncology patients begin their journey in the acute setting, but, depending on the progress of the cancer, may subsequently progress to the chronic and palliative setting. Should cancer reoccur or present with life-threatening conditions, the patient will be referred back to the acute setting, and should the cancer metastasize and the prognosis become terminal, the patient will be referred to the palliative setting. Exposure to this continuum is likely to cause both

acute and chronic stress for oncology nurses.

Compassion satisfaction is about obtaining fulfilment from caring by overcoming the adverse emotional exposures encountered in the work environment (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), and competent and compassionate oncology nurses can reportedly avoid compassion fatigue by establishing meaningful memories (Potter et al., 2012). It is indeed possible for some healthcare professionals to sustain their caring capability regardless of increased workload pressure, exposure to traumatic events and multiple stressors (Gillespie, 2013; Hooper et al., 2010).

Burnout happens when an individual is gradually trapped in a situation of mental, emotional or physical fatigue, possibly resulting from long-term job stresses when unable to manage the work environment (Demirci et al., 2010; Potter et al., 2012). Nursing cancer patients may give rise to substantial work stress, leading to emotional exhaustion and lack of personal accomplishment. Burnout causal factors such as these are in turn associated with patient dissatisfaction and ultimately with adverse health outcomes for the healthcare professionals (Hooper et al., 2010).

In healthcare professionals working in the clinical setting, compassion fatigue commonly occurs because of prolonged exposure to patients' anguish and hardships (Adams, Figley, & Boscarino, 2008). Adverse effects of compassion fatigue can include increase in staff

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turnover and absenteeism, deterioration in quality inpatient care, and diminished patient satisfaction and patient safety (Boyle, 2011). Compassion fatigue can also cause healthcare professionals to leave the profession and it has a significant effect on the personal life of the healthcare professional (Boyle, 2011).

Unresolved compassion fatigue can lead to physical and emotional exhaustion and impair performance and patient care (Hooper et al., 2010). Potter et al. (2012) state that nurses working in oncology at the beginning of their careers with little experience are more likely to experience burnout and compassion fatigue compared with oncology nurses with good oncology experience who exhibit compassion satisfaction.

In Africa, cancer is rated as a low priority, and globally only 5% of resources are dedicated to cancer in developing countries (Moten, Schafer, & Ferrari, 2014). Because of financial constraints, the survival rate for cancer patients in Africa is much lower than in high-income developed countries (Stefan, 2015). South Africa is further burdened by the increase in patients' suffering from HIV-related cancers such as Kaposi's sarcoma (Stefan, 2015). Increased number of cancer patients and survivors, coupled with increase in HIV-related cancers, raises the demand for healthcare resources such as drugs, radiotherapy, hospitals, hospices, oncologists and oncology nurses and further burdens already overwhelmed oncology healthcare workers. Treatment regimens also differ for each type of cancer, adding to the pressure to provide competent, empathetic and up-to-date nursing care (Van Rooyen, le Roux, & Kotze, 2008).

Literature shows that compassion fatigue in oncology healthcare professionals reduces quality of nursing care, heightens absenteeism and weakens retention of staff (Gillespie, 2013; Potter et al., 2012). In South Africa, where the still-developing healthcare system caters for multicultural clients with severe constraints in staff, equipment and financial resources, it is thus all the more important to investigate the issue of compassion fatigue. As Knobloch (2010) has noted, nurses in South Africa have to contend with "unbearable workloads, poor working conditions [and] lack of resources," putting severe pressure on their physical and psychosocial well-being.

2. Purpose

This study was conducted to survey compassion fatigue, burnout and compassion satisfaction in three settings. It was the first part of a larger study to develop an in-facility intervention to manage compassion fatigue in oncology nurses and was important to establish baseline data.

3. Methods

3.1. Study design, sample and data collection

A quantitative, non-experimental and descriptive survey of compassion satisfaction, burnout and compassion fatigue was conducted with nurses practicing in three urban oncology settings in Durban, KwaZulu-Natal, South Africa. The settings included a nongovernmental organisation (NGO) hospice, oncology clinics (in a state hospital) and oncology wards (in state and private hospitals).

Site One was an NGO hospice giving palliative care to patients whose condition was deemed terminal. Patients could either receive care at home by registered nurses from the home-based programme or be admitted to the hospice inpatient unit.

Site Two was a state institution. In the oncology clinic, patients were seen on an outpatient basis, receiving chemotherapy and/or radiation therapy. In addition, the institution had five inpatient wards for oncology patients, to which patients were admitted overnight or for longer, receiving chemotherapy and/or radiation and palliative care and undergoing medical and surgical procedures related to the cancer diagnosis. All wards and clinic were used in the study.

Site Three was a private institution for patients with private health insurance. This site had two oncology wards consisting of an acute unit and a step-down/palliative unit. The oncology wards admitted patients receiving chemotherapy and/or radiation and palliative care. Both wards were used in this study.

The three settings were chosen as representative of the full, protracted continuum of care for the oncology patient, from diagnosis, through the various cancer treatment regimens, to palliative care, in private, state and NGO institutions in Durban.

The study population was all South African Nursing Council qualified nurses (registered nurses having completed a four-year diploma or degree course and enrolled nurses having completed a two-year certificate course) in the oncology wards or clinics at the three settings, who had been working for a minimum of six months in an in-facility oncology ward or clinic in Durban. Registered and enrolled nurses who had been working for less than six months in an oncology ward/ clinic were excluded from the study.

Data was collected over four months from October 2016 to January 2017. The researcher liaised with management of the institution at the three sites for permission to access the oncology nurses. With permission from the unit managers, the researcher then approached nurses who worked in the units to request their participation in the research. Willing participants provided written consent and were then given a questionnaire to complete. Nurses completed the questionnaires while on duty, in a separate room and with the researcher waiting in attendance. Questionnaires took approximately 15–20 min to complete and all completed questionnaires were then placed in a sealed envelope and returned to the researcher. Questionnaires were completed in English.

3.2. Instrument

Section A of the questionnaire collected demographic data of the participants. Section B comprised a Professional Quality of Life Scale (ProQOL-V) self-test. The instrument incorporates three sub-scales: compassion satisfaction, burnout and compassion fatigue. Each subscale has 10 questions, with a 5-point Likert scale ranging from 1 (Never) to 5 (Very often). ProQOL-V asks the participants to reflect on how frequently they experienced situations in their current work setting over the last 30 days (Stamm, 2005).

For all scales, a low-risk cut-off score was set at total sum of 22 or less, between 23 and 41 for average risk, and 42 or more for high risk. These cut-off values were based on the reported scores in the ProQOL Manual (Stamm, 2005). Cronbach's alpha reliabilities for the three scales previously established are: compassion fatigue alpha = 0.80, burnout alpha = 0.72 and compassion satisfaction alpha = 0.89 (Stamm, 2005). ProQOL-V has been reported in over 200 peer-reviewed national and international articles, thereby indicating well-established construct validity, and is available on open source (Stamm, 2005).

3.3. Data analysis

With the assistance of a statistician, descriptive and inferential statistics were used. Means and standard deviation were calculated for the subscale scores for compassion satisfaction, burnout and compassion fatigue. Subgroup comparisons of categorical data were then made, using Fisher's exact test, and Kruskal-Wallis equality-of-populations rank test was used to compare the mean ProQOL-V scores in the three settings. Data were analysed using Stata v13 statistical software. A *p*-value of < .05 was considered statistically significant.

3.4. Ethical considerations

Ethical approval to carry out this study was obtained from the university where the researcher is a student (reference number: BF140/14), from both hospitals (public and private), from the Department of Health and from Hospice Palliative Care Association of South Africa.

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