Creating Healthy Work Environments 2019

Relationships Among Self-Care, Compassion Satisfaction, and Compassion Fatigue of Nurses in Community Hospitals

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When nurses do not practice self-care; they risk the achievement of compassion satisfaction and increase their potential for compassion fatigue. According to the American Nurses’ Association Code of Ethics Provision 5.2, “Compassion fatigue affects a nurse’s professional performance and personal life. "Nurses owe the same duty to self as to others and should practice the same health promotion and maintenance behaviors that they teach their patients (ANA Code of Ethics, 2015). In 2005, the World Health Organization (WHO) acknowledged the significance of assessing and improving individuals’ quality of life. An occupational hazard of nursing is that providing empathic care to patients may result in the development of compassion fatigue (Todaro-Franceschi, 2013). It is vital that nurses become knowledgeable about compassion fatigue symptoms in order to develop a personal plan of care to help them achieve a healthy work-life balance (Lombardo & Eyre, 2011).

The Theory of Human Caring (Watson, 2010) provides the overarching framework for the integration of the following middle range theories in the study: Nola J. Pender’s Health Promotion Theory (Pender, 2011) and Stamm’s Professional Quality of Life Framework (Stamm, 2010). Watson (2010) explains that nurses must practice self-care when caring for others to prevent compassion fatigue.

Although the need for self-care is expressed in the literature, the majority of the articles pertaining to self-care were patient-focused rather than nurse-focused. Knowledge regarding compassion fatigue in nursing continues to grow, but the lack of research to support the theory of compassion fatigue is limited (Lamke, 2014; Houck, 2014; Mason et al., 2014; Neville & Cole, 2013; Potter, Deshields, & Rodriguez, 2013). No research has been conducted to examine the relationship of self-care with compassion satisfaction and compassion fatigue of nurses employed in a variety of clinical areas. This study examined the relationships among self-care, compassion satisfaction, and compassion fatigue of nurses in community hospitals in the Southeastern United States.

Self-care (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) was measured by the Health Promoting Lifestyle Profile-II (HPLP-II). Compassion satisfaction and compassion fatigue was measured by the Professional Quality of Life (ProQOL-5) scale.

Approximately 340 nurses (RNs or LPNs) were eligible to participate in the study. A pre-analysis screening to maximize insight into the data, examine for skewness, missing values, and outliers was performed. The survey was available for a three month period of time via an electronic portal on the intranet at each of the clinical facilities.

The final sample consisted of 75 nurses who completed the survey and met the inclusion criteria. An a priori power analysis indicated the sample size needed to achieve a significance level of .05, a power of .80, and a medium effect size of 0.13 was 76 participants. The actual sample size of 75 participants was sufficient to meet the power requirements for the study.

Statistical analysis of descriptive statistics was completed by examining frequencies and means. Data was then analyzed using single linear regression for each of the outcome variables: compassion satisfaction, compassion fatigue/burnout, and compassion fatigue/secondary traumatic stress. The outcomes were analyzed with each of the self-care subscales and the total score to examine R value and significance. Multiple linear regression was used for the variables that were significant during the single linear regression analysis to evaluate the outcome against the main independent variable. Demographic
variables that were significant with the multiple linear regression were analyzed using t-tests and ANOVA.

The mean age of the respondents was 41.57 years with a range of 23 to 68 years. The majority of the respondents were female (n= 61, 81%). Approximately half of the respondents have dependents (n=35, 46.67%). Most of the respondents were not a primary caregiver for someone else (n = 60, 80%). Some of the respondents have a chronic health condition (n=21, 28%). Most of the respondents that participated in the study had not received any professional development education about compassion fatigue (n = 67, 89%). The most frequently observed category of assigned clinical area was Critical & Emergency Care (n = 24, 32%), but there were also respondents from Long-Term Acute Care, Medical, Maternal Child, Perioperative, and other work areas. The majority of the respondents had worked in their clinical area 5 years or less (n = 36, 48%). Over half of the respondents had a Diploma or Associate Degree (n = 46, 61%). The most frequently observed category for description of shift worked was Days (n = 40, 53%) and most of the respondents worked 12 hours or more for their shift (n = 51, 68%). Overtime of 12 hours or greater was a common response (n = 46, 61%). Most of the respondents did not have another job (n = 19, 25%). Respondents reported that they did have absences in the past year (n = 41, 55%). Over half of the respondents admitted that they have worked sick in the past year (n = 47, 63%).

The Health-Promoting Lifestyle Profile II (HPLP-II) was used in this study to measure the self-care behaviors of nurses: health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. The participants’ mean subscale scores were 1.60 to 3.81 with a total mean score of 2.44 (SD = 0.43, Min = 1.60, Max = 3.81), slightly below the midpoint. Higher scores indicate a healthier lifestyle.

Health responsibility had an average of 2.30 (SD = 0.53, Min = 1.11, Max = 4.00). Physical activity had an average of 2.16 (SD = 0.63, Min = 1.12, Max = 3.88). Nutrition had an average of 2.27 (SD = 0.45, Min = 1.33, Max = 3.56). Spiritual growth had an average of 2.78 (SD = 0.53, Min = 1.78, Max = 4.00). The observations for interpersonal relations had an average of 2.81 (SD = 0.54, Min = 1.89, Max = 4.00). Stress management had an average of 2.30 (SD = 0.46, Min = 1.12, Max = 3.75).

The Professional Quality of Life Scale (ProQOL-5) was used to measure compassion satisfaction, compassion fatigue / burnout, and compassion fatigue/STS in nurses. The subscale t-scores for the ProQOL-5 could range from 10 to 90 with a midpoint of 50. Higher scores indicate greater compassion satisfaction, burnout, and secondary traumatic stress. Compassion satisfaction had an average of 35.10 (SD = 5.79, Min = 24.00, Max = 50.00). The observations for Compassion Fatigue Burnout had an average of 25.87 (SD = 5.09, Min = 11.00, Max = 37.00). The observations for Compassion Fatigue STS had an average of 25.03 (SD = 5.43, Min = 13.00, Max = 37.00).

Multiple Linear Regression for demographic, self-care, compassion satisfaction, compassion fatigue/burnout, and compassion fatigue/secondary traumatic stress variables were analyzed to determine further significance. For compassion satisfaction, the only one of the independent variables that was significant was spiritual growth, p less than .001. For compassion fatigue/burnout, the only one of the independent variable’s that was significant was health responsibility, p = .021. For compassion fatigue/secondary traumatic stress, the only one of the independent variable’s that was significant was critical and emergency care nurses, p = .023.

The failure to practice self-care can contribute to risks for a multitude of health problems (Neville & Cole, 2013). Barriers need to be overcome to ensure that nurses are able to lead change in order to respond effectively to rapidly changing health care settings and an evolving health care system (Institute of Medicine, 2010). The overarching goals of Healthy People 2020 focus on the achievement of high-quality lives for all groups that are free of preventable disease, disability, injury, and premature death through the promotion of healthy behaviors (Health and Human Services, 2010).
Being there for patients physically, emotionally, mentally, and spiritually means that nurses also need to be there for ourselves as well. Self-care has the potential to help nurses face the challenges of the professional with the acquisition of compassion satisfaction and the prevention of compassion fatigue.

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**Keywords:**
Caring, Compassion Fatigue and Self-Care

**References:**


Neville, K., & Cole, D. A. (2013). The Relationships Among Health Promotion Behaviors, Compassion Fatigue, Burnout, and Compassion Satisfaction in Nurses Practicing in a Community Medical Center. *Journal of Nursing Administration, 43*(6), 348-354 347p. doi:10.1097/NNA.0b013e3182942c23


**Abstract Summary:**
Seventy-five nurses participated in a descriptive, non-experimental, correlational, cross-sectional study via an electronic portal. Statistically significant relationships were identified among self-care, compassion satisfaction, and compassion fatigue of nurses at community hospitals in the Southeastern United States.

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e) Compassion Fatigue significance.

III. Conclusion

A. Significance.

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Author Summary: Katherine Rigdon is a PhD in Nursing candidate at University of Mississippi Medical Center in Jackson, Mississippi. The focus of her doctoral research is the science of caring, compassion satisfaction, compassion fatigue, and self-care behaviors of nurses in community hospitals. This work has the potential to reveal understanding about the significance of nurses caring for themselves and patient outcomes. She has presented her work at state, regional, and international meetings.