HEALTH POLICY AND SYSTEMS

Factors That Influence the Development of Compassion Fatigue, Burnout, and Compassion Satisfaction in Emergency Department Nurses

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Abstract

Purpose: The purpose of this study was twofold: (a) to determine the prevalence of compassion satisfaction, compassion fatigue, and burnout in emergency department nurses throughout the United States and (b) to examine which demographic and work-related components affect the development of compassion satisfaction, compassion fatigue, and burnout in this nursing specialty.

Design and Methods: This was a nonexperimental, descriptive, and predictive study using a self-administered survey. Survey packets including a demographic questionnaire and the Professional Quality of Life Scale version 5 (ProQOL 5) were mailed to 1,000 selected emergency nurses throughout the United States. The ProQOL 5 scale was used to measure the prevalence of compassion satisfaction, compassion fatigue, and burnout among emergency department nurses. Multiple regression using stepwise solution was employed to determine which variables of demographics and work-related characteristics predicted the prevalence of compassion satisfaction, compassion fatigue, and burnout. The α level was set at .05 for statistical significance.

Findings: The results revealed overall low to average levels of compassion fatigue and burnout and generally average to high levels of compassion satisfaction among this group of emergency department nurses. The low level of manager support was a significant predictor of higher levels of burnout and compassion fatigue among emergency department nurses, while a high level of manager support contributed to a higher level of compassion satisfaction.

Conclusions: The results may serve to help distinguish elements in emergency department nurses' work and life that are related to compassion satisfaction and may identify factors associated with higher levels of compassion fatigue and burnout.

Clinical Relevance: Improving recognition and awareness of compassion satisfaction, compassion fatigue, and burnout among emergency department nurses may prevent emotional exhaustion and help identify interventions that will help nurses remain empathetic and compassionate professionals.

The profession of emergency nursing is physically and emotionally demanding. Complex patient loads, long shifts, demanding physicians, a fast-paced environment, and working in an emotionally and physically challenging area can cause stress for emergency department (ED) nurses (Healy & Tyrrell, 2011; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Von Rueden et al., 2010). Compassion fatigue (CF) and burnout are

conditions that can become overwhelming burdens on nurses and can cause physical, mental, and emotional health difficulties (Potter, 2006). CF is a negative consequence of working with traumatized individuals (Figley, 1995). Moreover, CF has been described as emotional, physical, and spiritual exhaustion from witnessing and absorbing the problems and suffering of others (Peery, 2010; Sabo, 2011). Equally as troubling is burnout, which differs from CF in that it is associated with feelings of hopelessness and apathy and creates an inability to perform one's job duties effectively (Stamm, 2010). Burnout manifests similarly to CF, but is not typically linked to empathy. Instead, it is a gradual worsening of feelings of frustration with career responsibilities (Maslach, Jackson, & Leiter, 1996). Both CF and burnout may cause a nurse to become ineffective, depressed, apathetic, and detached (Boyle, 2011). Long-term results of both CF and burnout include low morale in the workplace, absenteeism, nurse turnover, and apathy (Jones & Gates, 2007; Portnoy, 2011). All of these consequences have a negative impact on patient care. Moreover, high levels of nurse burnout are linked to patient dissatisfaction (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Consequently, it is imperative that CF and burnout be recognized and addressed. By studying the impact of CF and burnout on ED nurses, researchers may bring to the attention of managers, healthcare leaders, and nurses themselves the reality of this phenomenon and aid in the comprehension of its negative influence.

Additionally, the complexity of patient care is climbing, resources are decreasing, and insurance reimbursement is being linked to patient satisfaction (Medicare, 2013). It is more important now, perhaps more than at any other time in health care, to understand the prevalence and predictors of CF and burnout, but also compassion satisfaction (CS), in ED nurses. By understanding factors that influence both positive and negative aspects of nurses' work, perhaps levels of awareness will be raised and nurses may maintain caring relationships and positive attitudes. Moreover, few studies were conducted to explore factors that influence the prevalence of CF and burnout on ED nurses (Dominguez-Gomez & Rutledge, 2009; Hooper et al., 2010). Thus, the purpose of this study was to determine the prevalence of CS, CF, and burnout in ED nurses throughout the United States and to determine which demographic and work-related components affect the development of CS, CF, and burnout in this nursing specialty.

Based on the purpose of the study, the research questions were: (a) What is the prevalence of CS, CF, and burnout among ED nurses? (b) What demographic characteristics such as age and gender are associated with the prevalence of CS, CF, and burnout among ED nurses?

(c) What work-related characteristics such as educational level, years in nursing, shift length, years worked in the ED, hours worked per week, and having adequate manager support are significantly associated with the prevalence of CS, CF, and burnout among ED nurses? And (d) To what extent do the variables of demographics and work-related characteristics predict the prevalence of developing CS, CF, and burnout among ED nurses, respectively?

Literature Review

The term compassion fatigue was first introduced by Joinson in 1992. She described CF as nurses losing their ability to nurture. CF has been defined as the negative consequences of working with a significant number of traumatized individuals in combination with a strong, personal, empathic orientation. Figley (1995), a noted early researcher on CF, commented that those who are in a caring profession have an enormous capacity for feeling and expressing empathy and tend to be more at risk for CF. Humans, by nature, are wired for empathy, and therefore, caregiving can take a toll both emotionally and physically (Flarity, 2011). The stress resulting from helping a traumatized or suffering person may result in CF, which develops as a self-protection measure (Figley, 1995).

While CF is caused by empathy, burnout is associated with environmental factors such as high patient acuity, overcrowding, and problems with administration (Flarity, Gentry, & Mesnikoff, 2013). Burnout is a condition often associated with feelings of hopelessness and inability to perform job duties effectively (Stamm, 2010). Burnout and CF are often linked and closely mimic one another. CF is often described as a type of burnout (Portnoy, 2011). A principal difference between burnout and CF is that burnout typically exhibits a gradual onset while CF may occur suddenly. Although measuring negative aspects of a nurse's job is important, it is equally valuable to determine what makes a nurse feel happy. CS is the positive aspect of helping others. It is the satisfaction achieved with one's work by helping others and being able to do one's job well (Stamm, 2010). Many nurses chose their profession specifically to help others.

CF and burnout may have severe professional consequences in addition to affecting a nurse's personal well-being. CF and burnout affect nurse retention, patient safety, and patient satisfaction (Burtson & Stichler, 2010; Potter et al., 2010). Hospitals are expected not only to provide positive outcomes for patients, but make them happy while providing quality care. A relatively new performance measure for hospitals is patient satisfaction.

Since 2007, the passage of health reform legislation has increased focus on the importance of the patient experience (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). Therefore, Medicare reimbursements to hospitals are now partially based on patient satisfaction measurements. Thirty percent of the incentive payments provided by Medicare to hospitals is based on approval scores of satisfaction (Medicare, 2013).

Nurses who are experiencing CF and burnout are too exhausted to provide levels of care that help patients feel satisfied (Boyle, 2011; McHugh et al., 2011). As aforementioned, CS is the positive aspect of helping others (Stamm, 2010). Many nurses choose this profession because they experience fulfillment in helping others. Thus, understanding the factors that contribute to CF and burnout may help ED nurses maintain their ability to experience work fulfillment and contribute to patient satisfaction.

Empirical Studies Related to the Study Problem

The need to identify the level of CF in ED nurses was clear throughout the literature review. The conclusions in most research reviewed portrayed high levels of CF in healthcare workers and indicated the need for further research regarding CF and burnout among ED nurses. To the researchers' knowledge, there have been only two quantitative studies precisely targeting CF in ED nurses (Dominguez-Gomez & Rutledge, 2009; Hooper et al., 2010). Both studies had a limitation of a small sample size and studied CF in ED nurses in two specific geographical locations: a hospital in the Southeast United States, and three hospitals in California, respectively.

Hooper et al. (2010) compared levels of CS, CF, and burnout among ED, intensive care unit, oncology, and nephrology nurses. The Professional Quality of Life (ProQOL) scale was used to examine a difference in the level of CF and burnout in nurses working in these different specialty units. Although this exploratory, cross-sectional study did not show a significantly statistical difference in CF levels of the nurses among those specialty units, it did attest that ED nurses were at risk for less CS compared to the other types of nurses. This study also revealed a greater risk for burnout in ED nurses and a greater risk for CF in oncology nurses.

Dominguez-Gomez and Rutledge's (2009) study focused on measuring the level of CF in ED nurses using the Secondary Traumatic Stress tool. It was the first quantitative exploration of CF in ED nurses. The findings of the study demonstrated high levels of CF among the ED nurse respondents. High levels of CF in nurses may affect patient care and contribute to burnout. The study suggested further research aims at increasing the awareness of this phenomenon, as well as a recommendation for managers and organizations to be more aware of the problems of CF and burnout and to support nurses, and, when appropriate, urge them to seek counseling (Dominguez-Gomez & Rutledge, 2009).

Understandably, EDs are often considered to be a stressful work environment. Multiple studies have revealed that workplace violence, death or resuscitations of patients, caring for trauma victims, and stressful events that occur frequently in this setting contribute to increased stress in ED workers (Healy & Tyrrell, 2011; Von Rueden et al., 2010). ED nurses must deal with unpredictable events, which may include death, violence, and overcrowding. However, little evidence has emerged to identify factors that are associated with ED nurses' demographics and work-related characteristics contributing to their CF, CS, and burnout levels. Identifying factors that may predict CF and burnout, as well as recognizing factors that improve satisfaction at work, may be useful in retaining ED nurses and developing strategies to support them to provide excellent care without compromising their own health and happiness.

Conceptual Framework

A number of theoretical frameworks were applied to guide studies related to CS, CF, and burnout, such as Maslow's theory of hierarchy of needs and Watson's theory of human caring (Burtson & Stichler, 2010). A most significant theoretical model developed by Figley (2002) was the stress-process framework. This model was developed based on factors that contribute to CF. Figley discovered that CF develops as a result of a caregiver's exposure to his or her patients' experiences joined with his or her natural empathy. Later on, Stamm (2010) applied the CS-CF model to the development of the ProQOL scale. The CS-CF model illustrates a theoretical path analysis of positive outcomes (CS) and negative outcomes (CF) of helping those who have experienced traumatic stress.

Based on Stamm's (2010) theoretical path analysis diagram, a conceptual framework related to CS, CF, and burnout among ED nurses was developed to guide this study. The researchers believe that individual and organizational characteristics may contribute to and have an influence on the development of CS, CF, and burnout. Several variables were identified according to literature reviews. The demographic independent variables were age and gender. The work-related independent variables were level of education, years in profession, hours of work per week, length of shift, years as an ED nurse, and manager support. The dependent variables included CS, CF, and burnout.

Methods

Sample and Population

This cross-sectional study used a nonexperimental, descriptive, and predictive design. The target population for this study was registered nurses (RNs) who worked in EDs throughout the United States. The inclusion criteria for participation were: (a) work at least 8 hr per week in the ED, (b) interact directly with ED patients at least 8 hr per week, and (c) have at least 1 year of experience in the ED. The rationale for including a minimum of at least 1 year of experience in the ED and working at least 8 hr per week was the consideration of having experience and exposure frequently enough to traumatic events that contribute to the development of CF and burnout. According to a list of ED nurse members with mailing addresses throughout the United States provided by the Emergency Nurses Association (ENA), a purposive sampling was used to recruit the total 1,000 ED nurses in this study.

Data Collection Procedure

Approval from the institutional review board of the university was obtained prior to any data collection. The survey packet, including a letter of explanation, an informed consent letter, a copy of the demographic questionnaire, and a copy of the ProQOL version 5 (ProQOL 5) scale, was mailed to each potential participant. The participants returned the surveys to the researchers in a provided self-addressed stamped envelope. In order to maximize the response rate, two follow-up postcard reminders were sent to all 1,000 potential participants at 2-week and 6-week intervals, respectively, from the original survey mailing date. The researchers took every precaution possible to protect the anonymity and privacy of the individuals. The survey was answered anonymously and kept confidential in reporting the results of the study by removing identifying information. To protect confidentiality, all data were numerically coded and accessible only by the researchers.

Instrumentation

The survey used in this study included the ProQOL 5 scale and a set of demographic questions developed by the researchers. The demographic questions included information about the ED nurses' education level, years in nursing profession, typical shift length, age, etc. The ProQOL is a 30-item self-report survey that includes three subscales: CS, CF, and burnout (Figley & Stamm, 1996). Testing for convergent and discriminant validity have demonstrated that each scale measures different constructs (Stamm, 2010). Each subscale is distinct, and the results of each subscale cannot be combined to give a single significant score. Stamm (2010) reported psychometric properties with an α reliability ranging from .84 to .90 on the three subscales. The interscale correlations showed 2% shared variance ($r = -.23$; co-$\sigma = 5\%$; $N = 1,187$) with CF and 5% shared variance ($r = -0.14$; co-$\sigma = 2\%$; $N = 1,187$) with burnout. Each subscale has 10 question items and uses a 5-point Likert scale scoring from $1 = never$ to $5 = very\ often$ (Stamm, 2010). Stamm (2010) has previously established the construct validity and reliability of the ProQOL. The scores of the ProQOL for each subscale were totaled using Stamm's validated levels: a CS score of 22 or less denotes low levels of CS, a score of 23–41 indicates average levels, and 42 and above suggests high levels of CS. For CF and burnout, a score of 22 or less indicates low levels, 23–41 indicates average levels, and a score of 42 and higher reveals high levels of CF and burnout.

The ProQOL tool was first developed in 1995 and has been used, revised, and updated over time. The ProQOL 5 was used to examine the prevalence of CS, CF, and burnout among ED nurses in this study. Cronbach's α coefficients of internal consistency reliability of the ProQOL 5 for this study were .96 for the total scale, .92 for the CS subscale, .79 for the CF subscale, and .82 for the burnout subscale.

Data Analysis

All of the data were entered into and analyzed by the Statistical Package for the Social Science (SPSS) for Windows, version 21.0 (SPSS Inc., Chicago, IL, USA). Item means, standard deviations, medians, and percentages of the descriptive statistics were computed for the level of CS, CF, and burnout. A series of Pearson r correlation, t test, and one-way analysis of variance (ANOVA) were used to examine the associations between demographics, work-related characteristics, and the level of CS, CF, and burnout. The α level was set at .05 for statistical significance.

Multiple regression was employed to determine which variables of demographics and work-related characteristics contributed to the variation of the level of CS, CF, and burnout. Using seven selected independent variables to run a multiple regression, this study needed a minimum sample size of 153 subjects to achieve 95% power and a medium effect size (.15) at $\alpha = .05$.

Results

Demographic Characteristics

Of the 1,000 surveys mailed to ED nurses nationwide, 284 were returned, representing a 28% response rate. Because six participants worked fewer than 8 hr

per week, their results were removed from data analysis, leaving the total sample number at 278. The participants of the study were primarily women ($n = 243$, 87.4%), White ($n = 248$, 89.2%), and married ($n = 190$, 68.3%). The mean age was 44 years ($SD = 11.47$; range = 24–74 years). Years working as a nurse ranged from 1 to 48 ($M = 17.58$; $SD = 12.67$). The mean length of years working in the ED was 13.01 ($SD = 9.89$; range = 1–40). The participants' educational background varied from diploma ($n = 86$, 30.9%) to MSN/doctoral degree ($n = 55$, 19.8%), with the largest number holding a bachelor's degree ($n = 137$, 49.3%). Most of the participants worked 12-hr shifts ($n = 213$, 77.2%).

Prevalence of CS, CF, and Burnout

Research question 1 was "What is the prevalence of CS, CF, and burnout among ED nurses?" Descriptive statistics were used to calculate means, standard deviations, and percentages for CS, CF, and burnout. The mean scores for the level of CS, CF, and burnout among ED nurses were 39.77 ($SD = 6.32$), 21.57 ($SD = 5.44$), and 23.66 ($SD = 5.87$), respectively. According to Stamm's (2010) interpretation, 56.8% of the ED nurses fell into the average level of CS (score of 23–41), 65.9% of the ED nurses were in the low level of CF (score of 22 or less), and 54.1% of the ED nurses were in the average level of burnout (score of 23–41).

Associations Between Demographics, CS, CF, and Burnout

Research question 2 was "What demographic characteristics such as age and gender are associated with the prevalence of CS, CF, and burnout among ED nurses?" The Pearson r correlation and t test were used to examine the prevalence of CS, CF, and burnout related to the demographic variables of age and gender. The results showed that the older the nurse was at the time of taking the survey, the higher the level of CS ($r = .260$, $p = .001$). The younger the nurse was at the time of taking the survey, the higher the burnout score ($r = -.191$, $p = .002$) and the CF score ($r = -.134$, $p = .027$). While comparing the difference in the level of CS, CF, and burnout between male and female nurses, no statistical significance was found.

Associations Between Work-Related Characteristics, CS, CF, and Burnout

The Pearson r correlation, t test, and one-way ANOVA were used to answer research question 3, "What work-related characteristics such as educational level,

years in nursing, shift length, years worked in the ED, hours worked per week, and having adequate manager support are significantly associated with the prevalence of CS, CF, and burnout among ED nurses?" Scheffe post-hoc comparisons were used to compare if significant differences were found in the groups. It was discovered that the CS level among nurses who held graduate and doctorate degrees was higher than among nurses with diploma or ADN and BSN degrees ($F = 5.48$, $p = .005$). Moreover, those who had master's or doctorate degrees had significantly lower burnout levels than did nurses who held the other degrees ($F = 4.92$, $p = .008$). No significant differences in CF between educational backgrounds were identified in this study.

The relationship between years as a nurse, years as a nurse working in the ED, average hours worked per week, and level of CS, CF, and burnout was computed using Pearson's bivariate correlations, respectively. The result indicated that the more years a nurse has practiced, the higher the level of CS ($r = .269$, $p = .001$) and the lower the level of burnout ($r = -.182$, $p = .003$). There was no statistically significant relationship between years that a nurse has practiced and CF level. Additionally, the more years that nurses worked in the ED, the higher the level of CS ($r = .264$, $p = .001$) and the lower the level of burnout ($r = -.183$, $p = .003$) they had. There was no significant relationship between years a nurse worked in the ED and level of CF. Also, no significant relationships between average hours that ED nurses worked per week and level of CS, CF, and burnout were identified.

While comparing the difference in the level of CS, CF, and burnout between length of shifts and the support of managers, respectively, t tests were computed to find that nurses who worked 8- to 10-hr shifts had a higher level of CS ($t = 2.47$, $p = .014$) and a lower level of burnout ($t = -3.34$, $p = .001$) than did nurses who worked 12-hr and "other" shifts, respectively. No significant difference in CF was found between nurses who worked 8- to 10-hr shifts and those who worked 12-hr and other shifts. Regarding the support received from the manager, nurses who perceived receiving support from the manager had a higher level of CS ($t = 3.99$, $p = .001$) and a lower level of CF ($t = -2.89$, $p = .005$) and burnout ($t = -5.64$, $p = .001$).

Factors for Predicting the Level of CS, CF, and Burnout

In order to identify which significant variables of demographics and work-related characteristics can predict the level of CS, CF, and burnout, multiple regression was employed for research question 4. Seven significant variables of demographics and work-related

Table 1. Summary of Multiple Regression for Predicting the Compassion Satisfaction, Compassion Fatigue, and Burnout in Emergency Department nurses ($N = 237$)

Block[a]	Dependent variable/ variable entered	Adjusted R^2	R square change	F	Standardized coefficient β	t
	Compassion satisfaction					
1	Age	.040	.044		.239	3.90**
2	Manager support	.122	.085	17.36**	.292	4.77**
	Compassion fatigue					
1	Age	.006	.011		−.126	−1.96
2	Manager support	.055	.053	7.76**	−.230	−3.59**
	Burnout					
1	Age	.013	.017		−.166	−2.74*
2	Manager support	.148	.138	21.26**	−.373	−6.15**

[a] Stepwise solution was used.

*$p < .05$; **$p < .01$.

characteristics identified from research questions 2 and 3 were entered into the regression equation using the stepwise solution. As shown in **Table 1**, age ($\beta = .239$, $p < .01$) and manager support ($\beta = .292$, $p < .01$) significantly and positively predicted the level of CS, whereas only manager support ($\beta = −.230$, $p < .01$) significantly and negatively predicted the level of CF. In addition, age ($\beta = −.166$, $p < .05$) and manager support ($\beta = −.373$, $p < .01$) significantly and negatively predicted the level of burnout. Apparently, manager support was the major predictor contributing to the level of CS (8.5%, adjusted $R^2 = .122$, $F = 17.36$, $p < .01$), CF (5.3%, adjusted $R^2 = .055$, $F = 7.76$, $p < .01$), and burnout (13.8%, adjusted $R^2 = .148$, $F = 21.26$, $p < .01$).

Discussion

Level of CS, CF, and Burnout

In this study, the results indicated a low to average level of CF and burnout among ED nurses, which is not consistent with the results of the two previous studies (Dominguez-Gomez & Rutledge, 2009; Hooper et al., 2010) related to ED nurses who perceived significantly higher levels of these two negative aspects. Due to this study's participants being members of the ED professional organization, perhaps they were more involved and invested in their careers than the non-ENA counterparts.

Compassion satisfaction occurs when the care provider feels a sense of connection with his or her patients and feels a sense of achievement in his or her work (Stamm et al., 2010). The positive aspect of caring for others and providing support for those in need may outweigh the difficulties of the job. Although the CS level among ED nurses was average in this study, the possible reason might be that this group's nurses were more senior and encompassed a more confident outlook of CS toward the

positive aspects of nursing. Low levels of CS are a known factor in nursing turnover in the ED (Sawatzky & Enns, 2012). Not only should the nursing profession pursue the likely causes of CF, but it must further investigate the factors that contribute to CS in ED nurses.

Demographic-Related Characteristics and CS, CF, and Burnout

CF is less prevalent with increasing age and working experience (Hill & Stephens, 2003). Correspondingly, this current study demonstrated that older nurses had higher CS scores, as well as lower CF and burnout levels. Specific challenges are present for new, younger nurses. Not only are they inexperienced and challenged to learn new information daily, but they must also maintain their stride in a busy work environment where speed and skill are critical. The ED leadership and experienced senior nurses must provide a supportive and collaborative environment for newer nurses. Perhaps a formal mentoring program would be helpful to pair a new ED nurse with a more established nurse.

Work-Related Characteristics and CS, CF, and Burnout

Crucial factors that surfaced in this study as significant elements in ED nurses who exhibited higher CS levels and lower burnout levels included increased years in the profession, more years in the ED, a higher level of educational background, shorter shift length, and adequate manager support at work. The above-mentioned findings are consistent with previous research in which the influence of a positive work environment and more working experience leads to more satisfied nurses (Friedrich, Prasun, Henderson, & Taft, 2011; Hoar, 2011; Li, Early,

Mahrer, Klaristenfeld, & Gold, 2014; Torangeau, Cummings, Cranley, Ferron, & Harvey, 2010). The more attentive and involved ED managers are, the higher the CS scores of their nurses. Healthy, happy work environments that include manager support, shared decision making, and recognizing nurses' contributions to practice are precisely associated with increased nurse retention, reduced staff turnover, and increased job satisfaction (American Organization of Nurse Executives, 2003; Leiter & Laschinger, 2006).

Factors for Predicting the Level of CS, CF, and Burnout

This study identified specific demographic and work-related characteristics that influence a nurse's level of happiness and satisfaction, as well as CF and burnout at work. A critical modifiable feature related to predict the level of CS, CF, and burnout was manager support. While influences such as age are not changeable, the nursing leaders might acknowledge that younger nurses may be at risk for developing burnout and CF at work.

A key concern is that EDs are becoming increasingly busier and more stressful. Between 1997 and 2007, total annual visits to U.S. EDs increased from an estimated 94.9 million to an estimated 116.8 million (Tang, Stein, Hsia, Maselli, & Gonzales, 2010). According to the Agency for Healthcare Research and Quality, ED visits in the United States are outpacing the growth of the general population. In 2011, there were more than 131 million total ED visits in the United States (Weiss, Wier, Stocks, & Blanchard, 2014). Certainly, these statistics are going to make an ED nurse's job more challenging. The prevalence of CF and burnout will most likely continue to grow unless further strategies and solutions are made available to decrease the severity. Compassion fatigue and burnout may have severe professional consequences, such as affecting the ability to care for others (Boyle, 2011; Sabo, 2011; Wisniewski, 2011) and affecting nurse retention, patient safety, and patient satisfaction (Burtson & Stichler, 2010; Hooper et al., 2010; Potter et al., 2010).

A positive, supportive manager is more likely to have nurses who have high levels of CS, as well as lower levels of burnout. Nurse leaders must become cognizant of nurses who are at higher risk for CF and burnout and have a positive relationship with them in order to appropriately counsel and communicate with them. These leaders are crucial in the successful development of strong, positive, professional practice environments (Laposa, Alden, & Fullerton, 2003). By building a supportive environment, perhaps the early recognition of CF and burnout in ED nurses and providing adequate manager support may aid in the retention of knowledgeable, caring, experienced nurses.

Limitations and Recommendations

One limitation of this study was a small sample size with a low response rate. To reach more subjects, a mailed survey was utilized. However, out of 1,000 surveys mailed to ENA members, only 284 were returned. A disadvantage of a mailed survey is that prospective subjects may not feel the topic is pertinent to them and they may not participate. Another shortcoming of sending the survey to ENA members is that the results may not be generalizable to all ED nurses. Not all ED nurses belong to this professional organization; involvement and membership is voluntary. A second limitation is that the prevalence of CS, CF, and burnout was measured at a single point in time, and it is possible that an individual's assessment of his or her perceptions changes over time due to individual work-related conditions (Stamm, 2010). Moreover, ED nurses' perceptions of CS, CF, and burnout are subjective, and their perceptions may be affected by variables that were not examined in this study.

Further research could lead to the development of programs that help ED nurses manage the strain of caring for difficult patients. Additional exploration may be directed toward examining coping strategies that may prevent the development of CF and burnout. Future research concentrating on a more detailed view of the finding that older and more experienced nurses had higher levels of CS would be very beneficial for the nursing profession. It may be possible that more experienced nurses could be the key in assisting newer, younger nurses to find strategies that can improve their quality of life at work and perhaps prevent burnout and CF.

Conclusions

Overall results of this study revealed average to low levels of CF and burnout and average to high levels of CS among this group of ED nurses. Demographic and work-related characteristics, such as age, educational background, and years as a nurse, influenced the prevalence of CS, CF, and burnout among ED nurses. A key predictor, manager support, predicted the CS, CF, and burnout in this study. An increased awareness of CF and burnout may aid in improved ED nurse job satisfaction, and therefore, increased quality patient care. It is imperative that the nursing profession address support, strategies, and solutions that may facilitate a higher level of work satisfaction among ED nurses.

Clinical Resources

- Professional quality of life information, including compassion fatigue/burnout;
- Professional Quality of Life Scale self-test: www. proqol.org
- Information for caregivers: www.compassion-fatigue.org
- Information and articles for post-traumatic stress syndrome survivors and their caregivers: www.giftfromwithin.org

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