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Compassion fatigue in the perioperative environment

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Compassion fatigue (CF) is an important issue for nursing professionals today because 'caring and compassion, which provide nurses with satisfaction and fulfilment in patient care, can contribute to the exhaustion of those emotions and lead to compassion fatigue'.

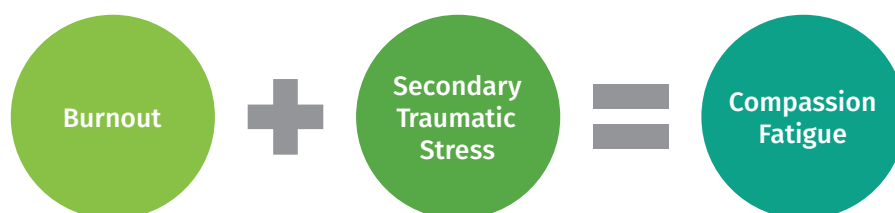
CF can impact negatively not only on the professional performance of the nurse² but in broader terms of workplace stability³ including staff retention and turnover⁴, absenteeism due to sickness, low morale⁴, psychological injury claims⁵ and even patient outcomes³. It can impact personally on nurses' quality of life⁶ including their health³. Left untreated, CF can lead to compromised patient care, as nurses may become desensitised toward future patient suffering⁶.

CF is considered to be the 'cost of caring'³, and is defined as 'the convergence of secondary traumatic stress and cumulative burnout; a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment'⁵. The term was originally used by Joinson¹ in a study investigating burnout in emergency nurses who lost 'the ability to nurture'³ and became tired, depressed, angry, ineffective, apathetic and detached³. Charles Figley later adopted the term in

his study of psychotherapists who became distressed by caring for clients who had experienced trauma³. He claimed CF has the same symptoms as a secondary traumatic stress reaction – a construct of Post-Traumatic Stress Disorder¹.

Today, CF is defined as the cumulative effects of both burnout, and secondary traumatic stress^{1,4,5,7}. It is interesting to note that burnout is associated with many professions while CF, although it has many similarities with burnout⁸, is generally agreed to belong to the caring professions³.

Burnout is 'a progressively worsening condition whereby one has difficulties performing his or her job effectively due to feelings of hopelessness and a non-supportive environment'⁶. It can also refer to a 'lack of interest in work, exhaustion, and the physical and emotional collapse that evolves over time in response to a period of high workload³. Environmental stressors⁸ may include a disproportionately great workload¹, poor workplace culture, or inadequate staffing¹. Emotional exhaustion² is another causative agent, which, in the professional environment may stem from feelings of 'frustration and powerlessness'. Evidence of burnout may include a detached demeanour, more frequent mistakes and cynicism⁹.



Secondary traumatic stress arises from nursing patients who have experienced suffering². Caring for a traumatised patient is an inherent part of the nurses role and could be described as an occupational hazard². Much of the current professional literature is based on nurses in the emergency, oncology, or intensive care areas. However, this author believes that perioperative nurses experience secondary traumatic stress too, particularly in the Post Anaesthetic Care Unit (PACU), where all patients have undergone a surgical trauma. Regardless of the nature of the surgery performed or the causative agent, surgery may bring emotional, physical and psychological distress. It is important to remember that 'exposure to patients experiencing trauma or distress can negatively impact professional's mental and physical health, safety and wellbeing, as well as that of their families, the people they care for, and their employing organisations⁵.

The risk factors inherent to CF amongst nurses in today's literature are transferrable to the perioperative environment.

Patient-related stressors³ may include factors such as recurrent exposure to patient distress and trauma³, patient death and unexpected outcomes¹. Cocker and Joss further state⁵ that caring for patients where treatment is futile, or who have life-threatening conditions, may trigger CF, as may caring for 'difficult' patients while fulfilling the moral obligations of the nursing role³.

Practice related stressors³ include factors such as intensifying workloads⁵ and physically and emotionally draining work⁵, long shifts and inadequate rest time between shifts⁵, inadequate staffing levels¹, and limited resources and equipment³. These stressors may also stem from management – poor support⁵, quality of interpersonal relationships³, and a lack of meaningful recognition⁵.

In addition, unique environmental stressors in the perioperative environment exist. These may include 'the need to work quickly, to face higher medical dispute risks, to work uncertain shifts, to handle precision instruments, and to master complex techniques'¹⁰, as well as instrument processing issues, low morale and

staff shortages'¹⁰. Theatre nurses also have a uniquely potentially hostile environment, and may be exposed to or experience different forms of bullying compared to non-perioperative colleagues¹⁰.

Perhaps not surprisingly, the ability to use empathy in nursing is considered a risk factor in developing CF⁵. However, this is contentious, as no research has been completed linking nurses who self-describe as 'very compassionate' with increased levels of CF³. It is also interesting to note that multiple research cites contradictions in prevalence – some state that nurses with three or fewer years' experience are most at risk¹ as are those who are younger⁷, while other state that as experience grows, so does the likelihood of CF². With the ageing workforce, and the increasing demand for surgery as our population also ages, CF is an issue that must be explored.

The signs and symptoms of CF are many (see Table 1).

Compassion satisfaction (CS) 'is the ability to receive gratification, joy and a sense of purpose derived from providing care'⁸. It is imperative that the positives of CS outweigh the

Table 1: Signs and symptoms of compassion fatigue

Physical	Behavioural	Psychological	Spiritual
- physical exhaustion and fatigue³ - impaired ability to care for patients³ - insomnia³ - compromised immunity³ - somatisation³ - headaches and stomachaches^{1,3} - sleep disturbance^{1,3}	- negative coping behaviours e.g. drug and alcohol abuse^{3,5} - increased absenteeism^{3,5} - altered personal relationships³ - avoidance of patients³ - compromised patient care⁸ and diminished performance³	- anger⁵ - irritability⁵ - a lessened sense of enjoyment in work⁵ - impaired ability to make decisions^{3,5,8} - emotional exhaustion³ - resentment³ - diminished professional satisfaction³ - depression¹	- reduced ability to feel sympathy and empathy^{3,5} - moral distress^{1,3} - decreased spiritual wellbeing^{1,3} - errors in judgement³

negatives of CF in order to achieve not only good quality professional life for individual nurses, but also for the broader nursing community. Poor quality of professional life (that is, low CS and high CF) 'has strong links to a decline in patient care'⁶. Much research has been done for non-perioperative specialties, some of which translates across all acute care nursing⁵; however, the exploration carried out by this author has found that there is a dearth of research on the effectiveness of interventions to reduce CF in nurses in general – let alone in the perioperative environment.

Much of the current literature concurs that the risks of occupational exposure are difficult to limit or change⁵. Therefore, one solution to combatting and preventing CF must be based upon strategies to promote resilience in individual nurses, and promote effective coping tactics^{5,9}. Much research proves a strong correlation between the burnout aspect of CF, and lack of resilience^{9,11}.

In 2016, Cocker and Joss⁵ published a systematic review of interventions to reduce CF. Perhaps not surprisingly, they found that music therapy interventions, social activities and even a grief ritual to farewell dead patients were all ineffective in decreasing the symptoms of CF. Mindfulness and meditation showed a decrease in burnout⁵. Other strategies such as promoting self-care (good nutrition, exercise, relaxation activities³), and employee wellness programs³ (mentorship, chaplaincy and role modelling³) have been documented, but have little evidence of conclusive efficacy^{3,5}. 'The most promising trend was for the effectiveness of interventions involving an element focused on teaching and/or bolstering resilience leading to an improved CS'⁵.

Education programs in the acute care setting have been successful

in improving self-coping skills such as resilience¹, however this, like much of the current literature, is broad and not readily adaptable to other specialty areas. Multiple variants also exist, and therefore are not replicated consistently in other studies.

It remains contentious that perioperative nurses have the ability to receive so little 'in house' education as a group, as compared to our non-perioperative colleagues who have double staffing time at shift changeover. This ward double staffing period is traditionally used for in-servicing, whereas the perioperative Nurse Unit Manager (NUM) faces a more difficult challenge of maintaining a balance between network requirements to fulfill surgical lists and adequate time for whole group education. It is an unenviable position to negotiate a late start to the theatre list on a regular basis. So, with networks providing so little time for ongoing education of experienced perioperative nurses, where can a resilience program fit in? It requires a NUM to have good insight into this issue and prioritise it as a learning essential for staff.

NUMs can play a vital role in the prevention and management of CF, and promotion of CS. Research shows that even addressing the issue of CF can 'result in energised moments and feelings of contribution which is beneficial for both the nurse as well as the hospital system'². Addressing CF provides the opportunity for nurses to reconnect to their original passion to enter into the profession as well as align with an organisation's values and mission². Furthermore, strategies such as simply being aware of the signs of CF⁸ (absenteeism, decreased productivity or more frequent errors¹²), and prioritising breaks during busy lists⁸, can be of benefit. The NUM also needs to lead a healthy

work environment¹, which can be supplemented by debrief.

Debrief (as defined as 'meaningful reflection')¹² has 'shown to decrease professional stress and improve concentration, morale and work engagement'. After a traumatic event, it can also decrease the likelihood of suffering from secondary trauma⁸. Debrief, lead professionally, can facilitate the understanding of 'emotions and experiences, and develop knowledge that can be used in subsequent situations. Debriefs promote individual learning, through groups sharing and bonding, which are beneficial in combatting compassion fatigue'¹².

This investigation has also highlighted that receiving meaningful recognition aided high job satisfaction and low CF¹. Indeed, research shows that meaningful recognition was 'a significant predictor of decreased burnout and increased CS'⁷. It is rare that staff in the perioperative environment receive recognition in the form of verbal thanks, cards or chocolate as our ward-based colleagues enjoy, and, given the effect of anaesthesia and the nature of our work, this type of recognition is not expected. However, networks, via the NUM, could remedy this deficit. Initiatives such as 'star of the week' may work towards an improved working environment, increased involvement and satisfaction as staff are able to nominate colleagues for all manner of awards. These do not need to be expensive – a certificate and a round of applause can be restorative and provide an immediate increase in CS. Additionally, research revealed that even the act of being nominated was a significant predictor of those nurses that have lower CF and higher CS⁷.

Much research has been done into the cause, effect and mitigating factors for CF in nurses, particularly in specialties such as emergency, ICU

and palliative care. However research also shows that the results cannot be translated into all specialties⁵. This author has been unable to ascertain with solid evidence whether today's theatre nurse is more or less prone to CF than our acute and critical care colleagues, nor the specific reasons why nurses are drawn to theatre and if these factors are a protective measure. Empathy as a contributing or protective factor is also under-researched in the perioperative arena. There is much exploration required in order to not only raise awareness of this issue, but to decrease the occurrence of compassion fatigue, manage the consequences, and improve the compassion satisfaction of future perioperative nurses in our unique and concealed environment.

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