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Compassion Satisfaction, Burnout, and Intent to Stay Among Nurse Leaders

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Walden University
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Abstract

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MSN, East Carolina University, 2013

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Dissertation Submitted in Partial Fulfillment

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Abstract

Nurses in leadership roles have a substantial influence on the quality of the work environment and on safety, quality, and patient outcomes. However, compassion satisfaction (CS) and burnout (BO) have historically been understudied, and evidence is lacking regarding the existence of a relationship between CS, BO, and intent to stay among nurse leaders. The purpose of this cross-sectional descriptive study, guided by Stamm's theory of CS and compassion fatigue (CF), was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders. An anonymous online survey was conducted using the Professional Quality of Life Scale to measure CS and BO and the Intentions to Stay Scale to measure intent to stay. Ninety-nine members of the American Organization for Nursing Leadership responded to the survey. Multiple linear regression revealed a strong negative relationship between CS and BO and a statistically significant relationship between BO and intent to stay. Future research should focus on the examination of CS and BO in the nurse leader population, which may contribute to positive social change by influencing team members, strengthening the healthcare organization, and contributing to retention of nurses and nurse leaders.

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Dedication

I would like to dedicate this dissertation to all those who have supported me throughout my doctoral journey. To my family, friends, former students, and colleagues, thank you for your understanding and encouragement. To my mother, Jean Settlemyre Tashman, a trailblazing nurse leader in her own right, who set the standards high by developing a corporate college for healthcare leaders in California in the early 1980s, then convincing leaders such as Dr. Peter Drucker, Dr. Warren Bennis, Dr. Terrence Deal, and Dr. Peter Koestenbaum to lecture there.

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To Dr. Beth Hudnall Stamm, Dr. Jacqueline Mayfield, and Dr. Milton Mayfield, thank you all for your support and interest in my research topic and for granting me permissions to use your instrumentation scales regarding professional quality of life and intent to stay in my research.

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Chapter 1: Introduction to the Study

Compassion is an essential concept in the nursing profession, yet nurses are not fully educated on this concept (Ledoux, 2015). Ledoux (2015) posited that compassion provides nurses with the strength to act, increases resilience, and sustains them instead of rendering them vulnerable. However, there is a missing link in the scope and understanding of compassion in nursing, ranging from compassion satisfaction to compassion fatigue (Ledoux, 2015). As such, nursing lacks a clear understanding of the role compassion might play in turnover or intent to stay across the profession. Compassion satisfaction (CS) is defined as a positive (or resilient) outcome, while compassion fatigue (CF) is defined as a negative outcome of prolonged contact with adversity (Stamm, 2009).

A recent Press Ganey report noted nurses in leadership roles have a substantial influence on the quality of the work environment and on safety, quality, and patient outcomes (Worth 2017). Ledesma (2014) observed a direct relationship between stress associated with a leader's job and the ability to maintain resilience. Clinicians and nurse leaders are exposed to traumatic situations or critical incidents in which the immediate and/or delayed stress of these exposures can impact ability to function, overall wellness, and intent to stay (Griner, Shirk, Brown, & Hain, 2017; Johari, Yean, Adnan, Yahya, & Ahmad, 2012). Thieman (2018) suggested that nurse leaders, often torn between the needs of administration and those of their staff, experience stress, burnout, and health issues at rates equal to the individuals they manage. The potential positive social change implications of the current study stem from the examination of CS and CF in the nurse

leader population, which may positively influence team members, strengthen the organization, and contribute to retention of nurses and nurse leaders (Thacker, Haas Stavarski, Brancato, Flay, & Greenwald., 2016).

Background

Researchers have evaluated CS and CF among direct care providers in various nursing specialties (Abendroth & Flannery, 2006; Adriaenssens, DeGucht, & Maes, 2015; Cho & Jung, 2014; Meyer, Li, Klaristenfeld, & Gold, 2015; Sacco, Ciurzynski, Harvey, & Ingersoll, 2015; Stamm, 2009). Abendroth and Flannery (2006) found that 78% of hospice nurses in their study were at moderate to high risk for CF, and 26% were in the high-risk category. Key determinants of CF risk in the hospice nurses studied included trauma, anxiety, life demands, and excessive empathy, which lead to blurred professional boundaries (Abendroth & Flannery, 2006). Part of CF is burnout. Burnout (BO) is defined as one of the elements of CF associated with feelings of hopelessness, which may include difficulty in dealing with work or difficulty in doing one's job effectively (Stamm, 2010). Negative feelings associated with BO usually have gradual onset and can reflect the feeling that one's efforts make no difference, or they may be associated with a very high workload or a nonsupportive work environment (Stamm, 2010). Adriaenssens et al. (2015) found that BO rates in emergency nurses were high, citing job demands, job control, social support, exposure to traumatic events, and organizational variables such as personnel and material resources, procedures, policies, and organizational culture and reward as determinants of BO. Cho and Jung (2014) found that 72% of the participants in their study of oncology nurses reported a moderate to high

level of CF, and empathy was positively correlated with CF while resilience and self-care were negatively correlated with CF, including both BO and secondary traumatic stress (STS). STS is the second element of CF, defined by Stamm (2010) as secondary exposure to extremely stressful events. For example, nurses may repeatedly hear stories about traumatic events experienced by those they care for. According to Stamm, the symptoms associated with STS are usually rapid in onset, associated with a particular event, and may include fear, difficulty sleeping, intrusive images, or avoiding situations that remind one of the event. Jackson, Firtko, and Edenborough (2007) defined resilience as the ability of an individual to positively adjust to adversity and posited that resilience could be applied to building personal strengths in nurses. Salloum, Kondrat, Johnco, and Olson (2015) defined self-care as being aware of one's own emotional experience in response to adversity and planning and engaging in positive coping strategies. Meyer et al. (2015) found that stress exposure significantly predicted lower CS and more BO in pediatric novice nurses. Furthermore, Sacco et al. (2015) reported that significant differences in CS and CF among critical care nurses were related to gender, age, educational level, unit, acuity, change in nursing management, and major systems change.

Studies have been conducted to assist nurse leaders with recognizing, understanding, and predicting CS and CF among direct care staff (Potter, Deshields, & Rodriquez, 2013; Slatten, Carson, & Carson, 2011; Zeidner & Hadar, 2014). Potter et al. (2013) initially evaluated CF in oncology staff, which led to the implementation of a resiliency program for oncology registered nurses (RNs) and ultimately to the implementation of a hospital-wide resiliency program that was designed to help

healthcare professionals understand CF, recognize the physical, mental, and emotional effects of stress, and adopt resiliency strategies for oncology RNs and ultimately to the implementation of a hospital-wide resiliency program. Slatten et al. (2011) posited that managers could mitigate issues related to CF with interventions such as patient reassignments, formal mentoring programs, employee training, and a compassionate organizational culture. Zeidner and Hadar (2014) found that individual differences in CS in healthcare professionals were significantly predicted by emotional competencies, positive affect, and problem-focused coping. These studies primarily focused on assisting with the maintenance of a healthy workforce. Other researchers examined nurse leader retention and turnover and employee intention to stay (Johari et al., 2012; Jones, Havens, & Thompson, 2008). Johari et al. (2012) examined human resource management practices and intent to stay and found that compensation and benefits promoted intent to stay more than training and development, career development, and performance appraisal. Jones et al. (2008) posited that chief nurse officer (CNO) turnover is an issue that requires attention and recommended developing strategies and policies aimed at the recruitment and retention of CNOs. Kelly and Adams (2018) described the uniqueness of BO for the role of the nurse leader and explored the idea of engagement, satisfaction, and joy in the workplace. However, a gap exists in the literature regarding the prevalence of and relationship between CS and BO (an element of CF) and intent to stay among nurse leaders. Reducing CF may increase nurse leaders' intent to stay by helping them become healthier, happier, and more resilient (Roberts & Strauss, 2015).

Problem Statement

Warshawsky and Havens (2014) reported on the growing concern regarding nurse leader dissatisfaction, intent to leave, and turnover among nurse managers working in United States hospitals. Nurse leaders included were those who served in formal leadership positions. Role responsibilities and increased job demands such as accountability for both clinical and patient satisfaction outcomes, providing safe, engaging, positive work environments for the staff, fostering relationships with interdisciplinary leaders throughout the organization, and promoting physician engagement, combined with limited authority to make decisions affecting operations in their respective areas, can undermine authority and lead to disengagement, BO, and nurse leader turnover (Nelson, 2017; Wong & Spence Laschinger, 2015). A recent Press Ganey report noted that nurse leaders have substantial influence on the quality of the work environment and on safety, quality, and patient outcomes (Worth, 2017). In addition, Ledesma (2014) discovered a "direct relationship between the stress of the leader's job and his or her ability to maintain resilience in the face of prolonged contact with adversity" (p. 1). Moreover, Wei, Sewell, Woody, and Rose (2018) conducted a systematic review of 54 research articles from 2005 through 2017 to ascertain the state of the science of nurse work environments in the United States. Wei et al. posited that nurse leaders are "anchors for nurses" (p. 298) and suggested that effective nurse leaders need to be inspirational, proactive instead of reactive, and lead with a vision. The results of the systematic review suggested that a positive organizational culture, rich in caring at both "micro and macro levels" is the underpinning for a healthy work environment (Wei et al.,

2018, p. 298). Nurse leaders play an important role in organizational culture and the work environment. In the ever-changing healthcare environment, retention of caring and compassionate, experienced nurse leaders is highly valued (Boyle, 2015). CS, CF, and BO have historically been understudied, underrecognized, and undertreated (Boyle, 2015), and evidence is lacking regarding the existence of a relationship between CS, BO, and intent to stay among the nurse leader population.

Purpose of the Study

The purpose of this study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders. I used a quantitative approach with a cross-sectional survey design using the Professional Quality of Life Scale (ProQOL) developed by Stamm (2009) to measure CS and BO and the Intentions to Stay Scale developed by Mayfield and Mayfield (2007) to measure intent to stay. In this descriptive study, the predictor variables were CS and BO. Intent to stay was the outcome variable.

Research Question and Hypotheses

Research Question: What is the relationship between CS and BO and intent to stay in nurse leaders?

$H_0$1: There is no relationship between CS and BO and intent to stay in nurse leaders.

H_a1: There is a relationship between CS and BO and intent to stay in nurse leaders.

I used a quantitative approach with a cross-sectional survey design using the ProQOL developed by Stamm (2009) to ascertain the prevalence of CS and BO and the

Intentions to Stay Scale developed by Mayfield and Mayfield (2007) to ascertain intent to stay within the nurse leader population. The ProQOL measures three separate constructs: CS, BO, and STS. STS is the element of CF associated with work-related secondary exposure to others' traumatically stressful events (Stamm, 2010). Nurse leaders are more likely to experience the BO element of CF as most nurse leaders in formal leadership positions are not involved in direct patient care. The ProQOL CS and CF Version 5 (Stamm, 2009) consists of 30 items scored using a Likert scale ranging from 1 (*never*) to 5 (*very often*). Each item addresses the individual completing the survey and their current work situation during the preceding 30 days (Stamm, 2009). The Intentions to Stay Scale is a 7-item, 5-point Likert scale ranging from1 (*strongly disagree*) to 5 (*strongly agree*) used to elicit positive or negative reactions to the intent to stay (Mayfield & Mayfield, 2007). The survey was electronically distributed to members of the American Organization of Nurse Executives (AONE), an organization whose 9,700 members serve at every level of nursing leadership (AONE, n.d.) using a web-based service. Demographic data were also obtained, including gender, age group, race, years at current employer, years in the field, and years in leadership.

Theoretical Framework

The theoretical basis for this study was Stamm's (2009) theory of CS and CF. Increasing importance has been placed on resiliency and transforming negative into positive outcomes and emotions (Stamm, 2010).

Stamm (2010) posited that CS involves the positive aspects of helping others, and CF involves the negative aspects of helping others. Research conducted on CS and CF

since the mid-1990s has led to a refined understanding of the theory of CS and CF via a data driven theoretical model (Stamm, 2009).

CF is comprised of two elements: BO and STS (Stamm, 2009). BO is gradual in onset and associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively (Stamm, 2009). These negative feelings may be a result of feeling one's work efforts make no difference, or they can be associated with an extremely high workload or a nonsupportive work environment (Stamm, 2009).

STS is usually rapid in onset and associated with a specific event (Stamm, 2009). STS is associated with work-related secondary exposure to extremely stressful or traumatic events (Stamm, 2009). Repeatedly hearing others' stories about the traumatic things that happen to them is considered vicarious (secondary) traumatization (Stamm, 2009). However, if an individual's work puts them directly in the path of danger, this is primary exposure (Stamm, 2009). The symptoms of STS include being afraid, having difficulty sleeping, having images of the upsetting event resurface in one's mind, or avoiding things that remind one of the event (Stamm, 2009).

Individuals who derive pleasure from being able to do their work well may feel as though it is a pleasure to help others through their work and may feel positively about colleagues or their own ability to contribute to the work setting or even the greater good of society (Stamm, 2009). These individuals score higher on the CS scale portion of the ProQOL (Stamm, 2009). More detail is provided on Stamm's (2009) theory of CS and CF in Chapter 2.

Nature of the Study

I used a quantitative approach with a cross-sectional survey design using the ProQOL developed by Stamm (2009) and the Intentions to Stay Scale developed by Mayfield and Mayfield (2007). A survey design affords a quantitative description of trends of a population obtained from a sample of that population (Creswell, 2014). The purpose of using a survey design in this study was to generalize from a sample (members of the AONE) to a population (nurse leaders in the United States) so that inferences could be made about the prevalence of CS, BO, and intent to stay among nurse leaders in the United States (see Creswell, 2014). This electronically delivered survey design was preferable as it is economical, with a rapid turnaround expected in data collection (see Creswell, 2014). The survey was cross-sectional as all data were collected at one point in time (see Creswell, 2014).

The ProQOL measures three concepts: CS, BO, and STS. Both BO and STS are elements of CF. BO scores can reflect current mood and vary day-to-day. STS scores are more cumulative than BO scores. This study focused only on CS and BO scores as the predictor variables. Intent to stay, the outcome variable, was measured using the Intentions to Stay Scale developed by Mayfield and Mayfield (2007).

The ProQOL is a 30-item instrument, scored using a 5-point Likert scale from *never* to *very often*. Construct validity for the instrument is well established in over 200 published papers (Stamm, 2010). Alpha reliabilities range from 71% to 89%, and convergent and discriminant validity ranges from 14% to 23% (Stamm, 2010). The Intentions to Stay Scale is a 7-item instrument, also scored using a 5-point Likert scale

from *strongly disagree* to *strongly agree*, to elicit positive or negative reactions to the intent to stay (Mayfield & Mayfield, 2007). Three of the statements reflect positive intention. Four of the statements reflect negative intention. Cronbach's reliability for the negative responses is alpha = 0.77, and for the positive responses is alpha = 0.66. In analyzing the data, I used descriptive statistics and logistic regression.

Definitions

The operational definitions for my study are the following:

Burnout (BO): One of the elements of CF associated with feelings of hopelessness, difficulty in dealing with work, or difficulty in doing one's job effectively (Stamm, 2010). Negative feelings associated with BO are usually of gradual onset and can reflect the feeling that one's efforts make no difference, or they may be associated with a very high workload or a nonsupportive work environment (Stamm, 2010).

Compassion fatigue (CF): A negative outcome of prolonged contact with adversity. As members of a caring profession, nurses are at "particular risk of experiencing compassion fatigue" (Mendes, 2014, p. 1146). CF is comprised of two elements: (a) BO, as evidenced by exhaustion, frustration, anger, and depression; or (b) STS, as evidenced by a negative feeling driven by fear and work-related trauma (Stamm, 2010).

Compassion satisfaction (CS): A positive (or resilient) outcome. The pleasure one derives from being able to do one's work well (Stamm, 2010). For example, one may feel positively about one's colleagues or one's ability to contribute to the work setting or the greater good of society (Stamm, 2010).

Intent to stay: A positive aspect that causes employees to be willing to remain in their current position and organization (Johari et al., 2012; Youcef, Ahmed, & Ahmed, 2016).

Key environments: The work environment; the client or person helped environment; and the personal environment (Stamm, 2010). The *work environment* is defined as the actual work situation (Stamm, 2010). The *client or person helped environment* is defined as the environment of the individual for whom one is providing care or assistance, including direct reports (Stamm, 2010). The *personal environment* is defined as that environment which individuals bring to the workplace (Stamm, 2010).

Nurse leader: A nurse who is less task-oriented, less hands-on, and more focused on setting standards, spearheading transformation, and inspiring and influencing teams (Williamson, 2017). The nurse leader is charged with fulfilling the organization's mission, vision, and strategic long-range plans (Williamson, 2017). The nurse leader role includes policy setting, overseeing quality measures, dealing with regulatory compliance, and responsibility and accountability for the overall quality of patient care, patient and staff satisfaction, and organizational outcomes (Williamson, 2017).

Resilience: The ability of an individual to positively adjust to adversity (Jackson et al., 2007).

Secondary traumatic stress (STS): The element of CF associated with work-related secondary exposure to others' traumatically stressful events (Stamm, 2010). Symptoms associated with STS are usually rapid in onset, associated with a particular

event, and may include fear, difficulty sleeping, intrusive images, or avoiding situations that remind one of the event (Stamm, 2010).

Assumptions

There were two assumptions for my study: (a) Nurse leaders desire CS and pleasure from being able to do their work well, potentially reducing BO and (b) nurse leaders desire to avoid CF and BO to stay in their jobs and be effective.

Scope and Delimitations

My study was a quantitative, nonexperimental correlational design. I chose this design because correlational research can be used to determine prevalence and relationships among variables and to predict events from current data and knowledge (see Curtis, Comiskey, & Dempsey, 2016). I considered a qualitative design; however, research design must be evaluated to identify the most efficient method (McCusker & Gunaydin, 2015). In the current study, a quantitative, nonexperimental, correlational design was the most efficient method.

I chose the ProQOL (Stamm, 2009) as the instrument for this study to measure CS and CF. The ProQOL instrument has established validity and reliability. There is good construct validity with more than 200 published research papers on CS and CF using the ProQOL (Stamm, 2010). I chose the ProQOL because it is a well-established, easily accessible, fee free, valid, and reliable tool. I considered using other tools such as the Occupational Fatigue Exhaustion Recovery scale (Winwood, Winefield, Dawson, & Lushington, 2005). However, the Occupational Fatigue Exhaustion Recovery scale did not measure the satisfaction (or positive) effects of stress. Responses from participants

may not reflect reasons for staying or leaving, and intent to stay or leave correlations cannot infer causality.

The scope of the population of my study included members of AONE, an organization that includes representation of nurse leaders at every level of nursing leadership (AONE, n.d.), and excluded all other nurses who were not members of AONE, regardless of their role. As such, generalizability may have been limited due to these boundaries.

Several theoretical frameworks that focus on motivational factors were considered related to CS and BO, including Maslow's hierarchy of needs, Watson's theory of human caring, and Figley's stress-process framework (Hunsaker, Chen, Maughan, & Heaston, 2015). However, Stamm's (2010) CS-CF model best illustrates a theoretical path analysis of positive outcomes (CS) and negative outcomes (CF) associated with helping others.

Limitations

Limitations of this study may be associated with the quantitative cross-sectional survey design that includes participant history, professional experience, and instrumentation (see Creswell, 2014). The web-based delivery of the survey provided anonymity for participants, increasing the likelihood of a desire to participate and thereby the provision of reliable answers (see Stamm, 2010). However, survey designs are time limited in that participants must sacrifice the time needed to participate in the survey, and a closing date must be established when the survey is no longer available.

Cross-sectional designs may have limited findings as results may be influenced by the participant's experience immediately prior to completing the questionnaire or the type

of day the participant is having (Fahey & Glasofer, 2016). In addition, selection bias was a limitation to this study related to convenience sampling as participants were not recruited in a random manner. Limited generalizability may be attributed to limiting the survey to members of the AONE.

Nonresponse bias may prove to be a limitation of this study. Nonrespondents may differ from respondents regarding the study variables (Davern, 2013). Uncaptured information about nonrespondents may differ from information obtained from respondents. As such, nonresponse bias was reported as a possible limitation of the study findings.

Significance

This research fills a gap in understanding by focusing specifically on the prevalence of CS and BO among nurse leaders and their intent to stay. This project was unique because it addressed an underresearched area involving the nursing profession. Appropriate management of CF, including BO, requires acknowledgment of its existence in a proactive manner (Mooney et al., 2017). Leaders who understand their context, their environment, and their relationships are more likely to embrace their own weaknesses (Friedlander, 2017). Nurse leaders set the tone for their respective workplaces (Worth, 2017). Once a nurse leader recognizes the existence of (or potential for) CF or BO in themselves, it becomes their responsibility to come up with a plan and find resources to mitigate the sequelae (Mendes, 2014). Building positive emotions and fostering positive social change can change the way nurse leaders approach and view the environment, helping them become healthier, happier, and more resilient, thereby helping employees

and teams become more productive and engaged (Roberts & Strauss, 2015). The potential positive social change implications of the current study stem from the examination of CS and CF in the nurse leader population, which may positively influence team members, strengthen the organization, and contribute to retention of nurses and nurse leaders (see Thacker et al., 2016).

Summary

The purpose of this quantitative, nonexperimental study was to determine if there was a relationship among CS, BO, and intent to stay among nurse leaders. Existing research has been conducted primarily focusing on assisting nurse leaders in the maintenance of a healthy workforce by evaluating CS and CF among direct care providers in various nursing specialties (Abendroth & Flannery, 2006; Adriaenssens et al., 2015; Cho & Jung, 2014; Meyer et al., 2015; Sacco et al., 2015) and understanding and predicting CS and CF within the ranks (Potter et al., 2013; Slatten et al., 2011; Zeidner & Hadar, 2014). Other research addressed nurse leader retention and turnover and employee intent to stay (Johari et al., 2012; Jones et al., 2008). Further studies suggested that expanded role responsibilities, increased job demands, and limited authority to make decisions can lead to disengagement, BO, and nurse leader turnover (Nelson, 2017, Wong & Spence Laschinger, 2015). Research focusing on the prevalence of CS and BO among nurse leaders and their intent to stay in their current employment situation on a long-term basis is needed to illuminate the need for recruitment, retention, and succession planning in the nurse leader population (Richards, 2014; Steege, Pinekenstein, Knudsen, & Rainbow, 2017). Chapter 2 provides more detailed information

regarding the literature search process, an exhaustive review of the current and historical literature, the theoretical foundation for the study, and a concise summary of the findings.

Chapter 2: Literature Review

Nurse leaders play an important role in organizational culture and the work environment. In the ever-changing healthcare environment, retention of caring, compassionate, experienced nurse leaders is highly valued (Boyle, 2015). CS, CF, and BO have historically been understudied, underrecognized, and undertreated (Boyle, 2015), and evidence is lacking regarding the existence of a relationship between CS and BO and intent to stay among the nurse leader population. The purpose of this study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders.

The current literature focuses on assisting nurse leaders in maintaining a healthy workforce via evaluation of CS and CF among direct care providers in diverse nursing specialties (Abendroth & Flannery, 2006; Adriaenssens et al., 2015; Cho & Jung, 2014; Meyer et al., 2015; Sacco et al., 2015), understanding and predicting CS and CF within the ranks (Potter et al., 2013; Slatten et al., 2011; Zeidner & Hadar, 2014), examining nurse leader retention and turnover and employee intent to stay (Johari et al., 2012; Jones et al., 2008), and suggesting that expanded role responsibilities, increased job demands, and limited authority may lead to disengagement, BO, and nurse leader turnover (Nelson, 2017, Wong & Spence Laschinger, 2015), while nurse leaders who perceive their supervisors as demonstrating greater resonant leadership practices by inspiring others to reach their own potential, working collaboratively, and encouraging employee investment were more likely to intend to stay in their current employment situations (Hewko, Brown, Fraser, Wong, & Cummings, 2015). Research focusing on the prevalence of CS and BO

among nurse leaders and their intent to stay in their current employment situation on a long-term basis is needed to illuminate the need for recruitment, retention, and succession planning in the nurse leader population (Richards, 2014; Steege et al., 2017).

This chapter focuses on the literature search strategy I used, including the databases and search engines used, the key search terms, the scope of the literature review, detailed information pertaining to the theoretical foundation of the study, an exhaustive review of the literature related to key variables and concepts, and summary and conclusions.

Literature Search Strategy

I conducted a literature review by extensively searching multiple databases in nursing, health sciences, leadership, psychology, and business management. Databases searched included Sage Journals, ScienceDirect, CINAHL, MEDLINE, Ovid Nursing Journals, ProQuest Nursing, EBSCO, PsychINFO, and Google Scholar. Key words used included: compassion, compassion satisfaction, compassion fatigue, burnout, intent to stay, resilience, professional quality of life scale, nurse leaders, and nursing leadership. Each of the key words was used independently and in combination. The most common combinations of search terms were *compassion satisfaction, burnout, and nurse leaders*, *resilience and nursing leadership*, and *intent to stay and nurse leaders*. The search included 2009 through 2019. The purpose of searching for articles within a 10-year time span was to locate sentinel work related to the chosen theory. The searches within the past 5 (current) years sought to gain insight into the contemporary impact of the concepts and variables of Stamm's theory and intent to stay among nurse leaders. Thousands of

professional articles resulted from the search. As such, filtering was used to focus on the key concepts.

Theoretical Foundation

Nurse leaders who feel satisfied with their work feel fully engaged, energized, and gain satisfaction from their work (Sheppard, 2015). Conversely, the loss of work-related satisfaction, when the job brings more distress than satisfaction, is considered CF (Stamm, 2010). Widespread use of a conceptual model of CS and CF, called the ProQOL, was developed by Stamm and Figley (2009), and later modified by Stamm (2010). The conceptual model of CS and CF includes an instrument that bears the same name (ProQOL). Across healthcare professions, Stamm's (2010) ProQOL has been the most frequently used conceptual model to quantify and describe CS and CF (Sheppard, 2015).

In Stamm and Figley's (2009) conceptual model, STS and BO together contribute to increased risk for CF, with CF manifested by negative physical and mental well-being (Sheppard, 2015). BO is a negative emotional reaction to external stressors that originate within an individual's work environment (Sheppard, 2015). According to Maslach and Leiter (2008), feeling unfairly treated or overlooked, or incivility by a supervisor may precipitate BO. STS is defined as the negative emotions and behaviors that result from exposure to another person's traumatic experience and does not result from the work environment but from an individual's sense of caring and emotional investment (Stamm, 2010). By contrast, CS is conceptualized as the sense of pleasure associated with doing a job well (Stamm, 2010). Researchers from many caring professions have reported CS

may modify BO or STS (Sheppard, 2015). The illustration of Stamm's (2009) theoretical model of CS and CF is presented in Figure 1.

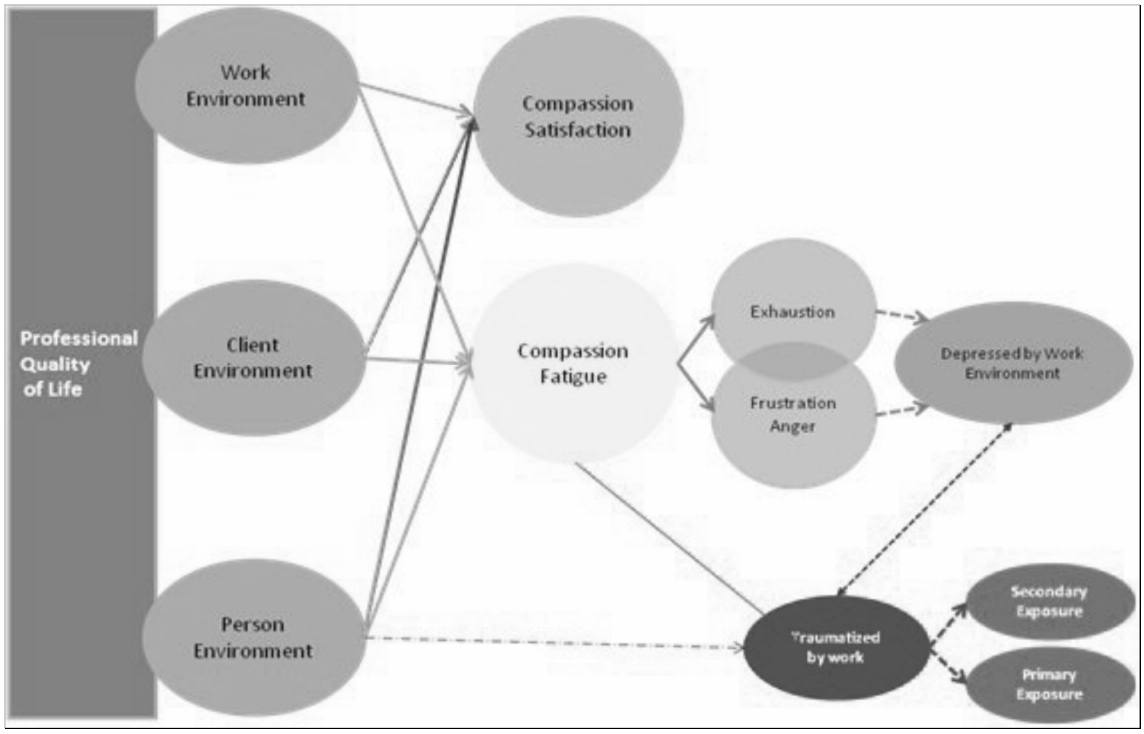

Figure 1. Theoretical model of CS and CF.

Literature Review Related to Key Variables and Concepts

Burnout and Compassion Fatigue

BO among nurses, described as being associated with workplace stressors such as leader unresponsiveness, lack of camaraderie and teamwork, staffing shortages, working long hours, intense workloads, conflicts with other nurses and healthcare providers, and time pressures differs from CF among nurses, described as emanating from the stress nurses experience related to relationships with patients and their families (Boyle, 2015). A recent systematic review of studies measuring BO in healthcare settings revealed that more errors were significantly associated with health practitioner BO (Hall, Johnson,

Watt, Tsipa, & O'Connor, 2016). BO may manifest differently in nurse leaders (Kelly & Adams, 2018).

An unhealthy relationship with stress may develop if a nurse leader believes they must always take on the burdens of their departments, never decline projects or requests, or always appear to be constantly working for their departments (Kelly & Adams, 2018). This behavior reflects poor role modeling to the staff (Kelly & Adams, 2018). As a leader, BO may manifest from organizational stress, personnel issues, improper work-life balance, lack of boundaries, and technology overload (Kelly & Adams, 2018). Fatigue and BO in nurse leaders can impact their performance, work-life balance, and turnover intention (Steege et al., 2017; Warshawsky & Havens, 2014). Demand for an individual's time and energy has increasingly exceeded individuals' capacities in a leaner, highly competitive, postrecession workforce, and both personal and professional BO have become prevalent (Young, Duff, & Stanney, 2016). Many studies on BO focus on its causes and associated factors, prevalence rates, and prevention programs in individuals without discussing or analyzing the concept of BO as a societal aspect (Heinemann & Heinemann, 2017; Slatten et al., 2011; Thieman, 2018; Young et al., 2016).

Although nurse leaders work to foster joy and engagement in the work environment for others, it is imperative that nurse leaders recognize and foster their own joy and engagement to prevent BO (Kelly & Adams, 2018). BO poses the risk of failing to retain current leaders, thereby creating a lack of role modeling and exemplars and ultimately decreasing the number of qualified future leaders (Kelly & Adams, 2018).

Compassion and Compassion Satisfaction

Although compassion is considered a core attribute of nursing, limited literature exists on the attributes, antecedents and effects, measurements of the presence and prevalence of compassion, or the expected nursing practices related to compassion (Ledoux, 2015). Understood as a motivation to act, to alleviate the suffering of others, to nurture and to be moved towards social justice, compassion resonates with the ideal of nursing and is inextricably linked to professional practice (Ledoux, 2015). Caring can be viewed by nurse leaders as a natural compassionate response to working with others (Dyess, Prestia, & Smith, 2015). As a leader, compassion may be derived from mentoring, being a supportive leader, or making large-scale change (Kelly & Adams, 2018). Sacco et al. (2015) suggested that units with stable leadership structures exhibited environments that were more supportive of CS. In a recent exploration of CS, BO, and CF in a large regional healthcare system in western North Carolina, CS was more predominant than BO in nurse leader participants (DePaola, Guyette, & Hooper, 2018). As a result of the limited number of studies examining CS in the nurse leader population, further research is needed.

Intent to Stay

Youcef et al. (2016) suggested that intent to stay is a positive aspect that prompts individuals to be willing to work and to remain within an organization. Johari et al. (2012) defined intent to stay as an individual's intention to remain in the present employment relationship with the current employer on a long-term basis. Although job satisfaction, retention, and intent to stay among staff nurses have been well researched,

few researchers have explored these same concepts among the nurse leader population (Warshawsky & Havens, 2014). Hewko, Brown, Fraser, Wong, and Cummings (2014) found that nurse leaders intending to stay reported that their workplaces were significantly empowering. In addition, those same leaders reported significantly greater professional efficacy and were more satisfied with their jobs (Hewko et al., 2014). Due to the limited number of published studies, additional research is needed to understand nurse leader job satisfaction and intent to stay.

Nurse Leaders

Nursing is a call to leadership (Williamson, 2017). Upper level nurse leaders are less task oriented than nurse managers (Williamson, 2017). They are more focused on setting standards, spearheading transformation, and inspiring and influencing their teams (Williamson, 2017). Nurse leaders are charged with fulfilling the organization's mission, vision, and outcomes (Williamson, 2017). Both direct care staff and nurse managers look to nurse leaders for their knowledge, experience, and vision (Williamson, 2017). The role of the nurse leader is expansive as it touches the entire organization (Williamson, 2017). Findings from multiple studies in a recent systematic review indicated nurse leadership as a significant component of healthy work environments and a substantial determinant of nurse retention and patient quality of care (Wei et al., 2018).

Leadership has been defined as behaviors and ways of being that inspire a positive, enduring impact on those whose lives are influenced by the leader's presence (Pipe, FitzPatrick, Doucette, Cotton, & Arnow, 2016). According to Pipe et al. (2016), excellent leaders follow their inner compass to inspire, coach, and guide others with

compassion, clarity, and purpose. As such, nurse leaders are positioned to create effective systems and process changes across the healthcare continuum (Pipe et al., 2016).

Resilience

Resilience has been defined as the ability to return to a state of normalcy or to recover from adversity or trauma and remain focused and optimistic about the future (Turner, 2014). Jackson, Firtko, and Edenborough (2007) defined resilience as "the ability of an individual to positively adjust to adversity" (p. 1). Bernard (2019) posited, "resilience consistently appears as the core ingredient of clinician well-being and professional joy" (p. 43). Ledesma (2015) defined resilience as the ability to come back or recover from adversity, frustration, and misfortune and described it as an essential characteristic of effective leaders, noting a direct relationship between the leader's stresses and his or her ability to maintain resilience in the face of prolonged contact with adversity. Dyess, Prestia, and Smith (2015) posited that caring and resilience are intertwined and could be the undergirding concepts necessary for nurse leader success. To ensure caring and resilience are actualized, nurse leaders must practice self-care, accountability, and reflection (Dyess, Prestia, & Smith, 2015). From their research, DePaola, Guyette, and Hooper (2018) developed a hierarchy suggesting professional resilience occurs with transformational leadership and a positive organizational culture/workplace environment as shown in Figure 2.

Figure 2. Hierarchy of professional resilience.

Resilience has been researched extensively on the staff nurse, but literature related to nurse leader resilience is sparse. Due to the lack of focus on resilience in this population of the nursing profession, and given the relationship between resilience and professional joy (Bernard, 2019), this study aspired to add to the body of knowledge by evaluating resilience as it may relate to CS, BO, and intent to stay among nurse leaders. Stamm's (2009) *Theoretical Model of CS and CF* clearly illustrates work, client, and person environments directly contribute to both CS and BO (Figure 1).

Summary and Conclusions

Across healthcare professions, Stamm's (2010) ProQOL has been the most frequently utilized conceptual model used to quantify and describe CS, CF, and BO. The bulk of current literature related to CS, CF, and BO in the nursing profession focuses on assisting nurse leaders in the maintenance of a healthy workforce via evaluation of these constructs among direct care providers by understanding and predicting CS, CF, and BO in diverse nursing specialty areas. One recent exploratory study of CS, CF, and BO in a

large regional healthcare system in the southeastern United States revealed CS was more prevalent than BO in nurse leader participants while nurses from the healthcare system as a whole were at the national mean on CS, CF, and BO (DePaola, Guyette, & Hooper, 2018). Many studies on CS and BO focus on causes, associated factors, prevalence rates, and prevention programs. However, few studies involving these constructs include the nurse leader population. In addition, although job satisfaction, retention, resilience, and intent to stay among staff nurses have been well researched, few researchers have explored these same concepts among the nurse leader population. No studies were uncovered that investigated all three variables of CS, BO, and intent to stay specifically among nurse leaders.

The literature review I conducted revealed a gap as it pertains to CS and BO and intent to stay among nurse leaders, due to the lack of focus on this population in the nursing profession. The intent of this study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders using a quantitative approach with a correlational, cross-sectional survey design. In reviewing the literature, I did not find studies on the relationship between CS and BO and intent to stay among nurse leaders. The study of the existence or absence of a relationship between CS and BO and intent to stay among nurse leaders is significant for adding to the body of knowledge by illuminating factors that may affect nurse leader retention, recruitment, and succession planning.

Chapter 3 provides the research plan and design for gathering pertinent information about nurse leaders' intent to stay and the prevalence of CS and BO in the

nurse leader population. The gap in the knowledge regarding the existence of a relationship between CS and BO and intent to stay in the nurse leader population was evident in the literature, and the chosen design for research was in alignment with similar studies that evaluated direct care nurses' intent to stay and the prevalence of CS, CF, and BO. Through this descriptive, correlational quantitative study, the existence or absence of a relationship between CS and BO and intent to stay among nurse leaders was evaluated.

Chapter 3: Research Method

The role of the nurse leader is expansive and touches the entire organization (Williamson, 2017). Nurse leadership is a significant component of healthy work environments and a substantial determinant of nurse retention and patient quality of care (Wei et al., 2018). As such, retention of caring, compassionate, experienced nurse leaders is highly valued (Boyle, 2015). The purpose of this study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders.

In Chapter 3, I cover the research design and rationale for my study, the target population, the sampling procedures used, the sampling design, participation, data collection, instrumentation, data analysis, potential threats to validity, and ethical considerations for the study and its participants.

Research Design and Rationale

Due to the nature of the topic, the associated variables, and the impact of nurse leaders across entire organizations on safety, quality, and nurse retention, a descriptive, nonexperimental survey method was used to explore the absence or presence of a relationship between CS and BO and intent to stay among nurse leaders. CS and BO were the independent variables. Intent to stay was the dependent variable. I conducted a descriptive, correlational design to evaluate the relationships between variables without manipulating any of the factors.

RQ: What is the relationship between CS and BO and intent to stay in nurse leaders?

$H_0$1: There is no relationship between CS and BO and intent to stay in nurse leaders.

H_a1: There is a relationship between CS and BO and intent to stay in nurse leaders.

The self-administered web-based questionnaire (online survey) afforded anonymity for the participants. The study was conducted as an anonymous online survey that required the intended target population to take the time to complete the questionnaire. Self-administered web-based questionnaires tend to provide respondents with a greater sense of privacy (Cox, 2016). Data collected through many commercial web-based survey hosts, such as Survey Monkey, can be exported directly into statistical software programs, thereby eliminating time spent on manual data entry (Cox, 2016). However, the targeted population must possess competence in the use of and have access to the Internet and email (Cox, 2016).

Time constraints depended upon the length of time required to contact the target population via the online platform. The questionnaire was available for a limited window of time to minimize maturation effects of the study and the participants (see Edmonds & Kennedy, 2017). Another time constraint involved the time required for data testing and analysis. Once data testing was completed, time was required to accurately interpret the results into meaningful information that added to knowledge on the topic (see Burkeholder, Cox, & Crawford, 2016).

The research design was aligned with other studies in the field of nursing. Edmonds and Kennedy (2017) suggested that cross-sectional designs are useful as the

data collection occurs at one specific point in time. This approach allowed for a larger sample size of participants in a shorter timeframe (see Cox, 2016). Further, statistical analysis can reveal the existence or absence and strength of any relationships between the variables (Edmonds & Kennedy, 2017). Basic descriptive statistical analyses were used to summarize the data (see Edmonds & Kennedy, 2017). The analysis of information supports the advancement of knowledge on the topic of nurse leaders' intent to stay by exploring the extent to which CS or BO has or does not have on nurse leaders' intent to stay in their current position.

Methodology

To carry out the study, the target population was explicitly and clearly identified, the sampling method and sample size were determined, inclusionary or exclusionary criteria were pinpointed, and appropriate statistical tests were selected to analyze the data.

Population

The target population consisted of nurses who served in formal leadership positions within the United States. The chosen population included nurses who are less task-oriented, less hands-on, and more focused on setting standards, spearheading transformation, and inspiring and influencing teams (see Williamson, 2017). The target population for this study originally consisted of members of the AONE, a professional organization whose 9,700 members serve at every stage of nursing leadership (AONE, n.d.). However, in April 2019 during the annual meeting, AONE announced the name of the organization would change to the American Organization for Nursing Leadership

(AONL), effective May 2019, to better reflect that the organization serves nurse leaders at all stages of their careers and across the care continuum (Thew, 2019).

Sampling and Sampling Procedures

The sample of participants came from nurse leaders within the United States who were members of the AONL. The target population estimated by AONL was 9,700. This target group was chosen as the National Database of Nursing Quality Indicators does not provide information regarding the number of nurses holding formal leadership positions despite multiple nursing surveys conducted annually.

I obtained my sample from the AONL, which is a professional organization whose 9,700 members serve at every stage of nursing leadership (AONE, n.d.). As a member of AONL, I contacted the organization and requested information regarding application for and access to the organization's membership. To obtain access to the members of AONL, I completed an application for access to the membership through the organization's electronic newsletter and submitted a one-time fee of $250.00 (see Appendix A). Access afforded submission of the study survey to AONL's online periodical for the length of data collection needed. Access to AONL's electronic format was preferable over the organization's mailing list to ensure the most efficacious completion and number of participants as the mailing list did not include email addresses and would involve addressing and mailing thousands of envelopes. The application process included the fee, Walden's IRB approval (#02-13-20-0596016), and an executive summary outlining the proposed study including the survey, participant informed consent, and research participation agreement.

To participate in my study, the individual must have the following:

1. Been in at least one formal nursing leadership position (either currently or in the last 3 years), such as CNO, vice president of nursing, or director of nursing, for at least 1 year.
2. Reported to a senior administrative officer, such as a chief executive officer.
3. Supervised at least one department no smaller than 15 full time employees (FTEs).
4. Earned a minimum of a Bachelor of Science in Nursing or equivalent time (diploma) with registered nurse (RN) licensure.
5. Been employed in a formal nursing leadership position in a facility with a bed size of no less than 20 beds.
6. Spent less than 50% of position in direct patient care.

The sampling design was convenience sampling of individuals who were members of the AONL (see Edmonds & Kennedy, 2017; Frankfort-Nachmias & Leon-Guerrero, 2015). Conducting the survey through the professional organization that included the target population in its membership yielded enough responses to complete the data analysis. Although response rates for the survey approach are usually low, a 15% to 20% return rate (Edmonds & Kennedy, 2017) on 9,700 members would yield 1,455 to 1,940 responses. I used convenience sampling as members of the target population were readily available due to my personal connection with the professional organization (see Edmonds & Kennedy, 2017). Nonprobability convenience sampling provided a greater opportunity of reaching the targeted population and obtaining adequate numbers of

participants for meaningful and significant statistical data (see Edmonds & Kennedy, 2017). This study involved two independent variables and one dependent variable. The measurement level for both the independent variables and the dependent variable was continuous/interval. Therefore, I used multiple regression to analyze the data.

G*Power (see Faul, Erdfelder, Lang, & Buchner, 2007), a flexible statistical power analysis program, was used to calculate the required sample size based on multiple regression. The resultant calculations performed using G*Power yielded a sample size of 55 (power = 0.8, medium effect, two tailed, alpha = .05).

Multiple regression was used to evaluate the data for predictability between the variables. The independent variables were studied using a 5-point Likert scale with a range of 1 (*never*) to 5 (*very often*). The dependent variable was also studied using a 5-point Likert scale with a range of 1 (*strongly disagree*) to 5 (*strongly agree*). As such, all variables were measured consistently using continuous intervals, ensuring equally dispersed differences of the aspects of the variables.

Multiple regression was used to describe the relationship between the response variable (intent to stay) and the two independent (predictor) variables (CS and BO). Per the calculations performed via G*Power, an estimated sample size of 55 was needed (two-tailed; medium effect; alpha = .05, power = 0.80). If the sample size had been too small, the odds of prediction of outcomes could have resulted in false predictions (see Edmonds & Kennedy, 2017).

Participation and Data Collection

Participation and data collection were conducted through the professional organization of the AONL and was voluntary. Participants were recruited through AONL's online electronic newsletter. Recruitment was carried out through an advertisement for the study (see Appendix B) seeking volunteers, which included a link to the survey via Survey Monkey®. Participation was encouraged to help further the knowledge base of both the nursing profession and nursing leadership. No monetary or similar form of compensation was offered.

If individuals decided to participate, an informed electronic statement outlining the intent of the study minimizing risk to the participant and ensuring anonymity was provided. Opening statements for the survey included the type of data that were to be collected, including demographic information. In the survey platform, participants were asked to read the opening statements and were provided the opportunity to agree or disagree with continuing to the survey. Agreeing constituted the subject's informed consent, which was assumed if the subject continued to the survey.

Along with the targeted data gleaned from the instrumentation for the study, the following demographic data were collected: the length of time the participant had been in the current formal leadership position, age, gender, reporting structure to a senior executive, bed size of the facility, percentage of time spent in direct patient care, professional degree(s), state of employment, number of FTEs, and length of time in the nursing profession (see Appendix C). Once the participant completed the anonymous online survey, they were thanked and reminded of the intent of the study, the privacy

feature provided by Survey Monkey, and my intent to publish my dissertation. No follow-up with participants postsurvey was planned. However, my email was provided if participants desired to contact me separately.

Data were collected anonymously through an online platform (Survey Monkey®). Participants had the choice to not take part after the disclosure and informed consent. Only data collected from individuals who agreed to continue to the survey were used. No personal identifying information was requested. Only my name and contact information were provided to the participants at the end of the survey if they wished to communicate after the study was concluded. If a participant did not complete the full survey, their data was evaluated for impact on study results and was excluded as missing data.

Data were stored electronically on a secured external device and secure cloud storage. I stored data on a thumb drive Cention ® and external hard drive, to which only I had access. All data storage was password protected. My committee chair had access to the data upon request. All raw data collected remained in the possession of the researcher. Data will be maintained for 5 years as required by the Walden IRB.

Instrumentation

Two instruments were used for data collection on the variables of CS, BO, and intent to stay. The operational definitions of each of the variables are as follows:

1. *BO*– Stamm (2010) defined BO as one of the elements of CF associated with feelings of hopelessness, difficulty in dealing with work, or in doing one's job effectively. BO was measured using Stamm's (2010) Professional Quality of Life (ProQOL) Scale (see Appendix D). Stamm (2010) operationalized BO as

negative feelings usually of gradual onset that can reflect the feeling that one's efforts make no difference, or they may be associated with a very high workload or a non-supportive work environment.

2. *CS* – Stamm (2010) defined CS as the pleasure one derives from being able to do one's work well. CS was also measured using Stamm's (2010) Professional Quality of Life (ProQOL) Scale (see Appendix D). Stamm (2010) operationalized CS as a positive or resilient outcome such as feeling positively about colleagues or one's ability to contribute to the work setting or the greater good of society.
3. *Intent to Stay* – Intent to stay has been described as a positive aspect that causes employees to be willing to remain in their current position and organization (Johari et al., 2012; Youcef, Ahmed, & Ahmed, 2016). Intent to stay was measured using Mayfield and Mayfield's (2007) Intentions to Stay Scale (see Appendix E).

ProQOL. The idea for the ProQOL was originated by Charles Figley in the late 1980s and further developed by his mentee and colleague, Barbara Hudnall Stamm, beginning in 1996 (2010). Through a positive joint agreement, between Figley and Stamm, the measure shifted entirely to Stamm in the late 1990s and was renamed the Professional Quality of Life Scale (Stamm, 2010). The author has granted permission for use (see Appendix F) as long as the author is credited, no changes are made to the scale, and the scale is not sold (Stamm, 2010). The ProQOL is the most commonly used measure of both positive and negative effects of working with people who have

experienced extremely stressful events (Stamm, 2010). There is good construct validity with more than 200 published papers and over 100,000 articles (Stamm, 2010). Cronbach's reliabilities range from alpha = 0.77 to alpha = 0.89 (Stamm, 2010).

Intentions to Stay Scale. The Intentions to Stay Scale was developed by Mayfield and Mayfield (2007) to study the effects of leader communication on worker's intent to stay (see Appendix E). The Intentions to Stay Scale is a seven-item, 5-point Likert scale used to elicit positive or negative reactions to the intent to stay (Mayfield & Mayfield, 2007). Three of the statements reflect positive intention. Four of the statements reflect negative intention. Cronbach's reliability for the negative responses is alpha = 0.77 and for the positive responses is alpha = 0.66. Although no validity data are provided (Mayfield & Mayfield, 2007), the authors stated the overall model has a goodness-of-fit index of 0.93 (Mayfield & Mayfield, 2007). I reached out to the original authors through electronic communication and was granted permission to use the scale (see Appendix G).

Naim and Lenka (2017) used the Intentions to Stay Scale to investigate the impact of mentoring on intent to stay for employees within the field of information technology. In the course of their research, Naim and Lenka (2017) found the Intentions to Stay Scale produced similar reliability to the original (alpha = 0.76). The Intentions to Stay Scale was an appropriate tool to collect data regarding the variable of intent to stay based on the questionnaire statements regarding the intention to stay, reflecting the opinion of the participant at the precise moment they participated in the survey. The Intentions to Stay

Scale measured participants' feelings about their employment (Mayfield & Mayfield, 2007; Naim & Lenka, 2017).

Data Analysis

I used Statistical Package for the Social Sciences (SPSS) v25 to analyze my data. SPSS is one of many statistical programs used by statisticians and researchers. The program allows manual entry, importing, and exporting of data. The program's feature to accept imported information helped minimize data entry errors (Wagner, 2017). Data screening and cleaning was simplified as the program locates missing data from participants if any survey questions or statements were not answered or addressed. Missing data could skew results.

The RQ was as follows: What is the relationship between CS and BO and intent to stay in nurse leaders?

For RQ, Pearson's R coefficient was used as it is extremely robust related to violations of assumptions (Norman, 2010) to show the relationship between CS, BO, and intent to stay. I used multiple linear regression, model fit, and descriptive statistics. Wald statistic, log-likelihood statistic, z-statistic and multiple correlation coefficient R were used in the logistic regression to evaluate predictions of outcomes based on the independent variables and the dependent variable.

Threats to Validity

External Threats

The major threat to external validity for the survey approach was sample characteristics (Edmonds & Kennedy, 2017). Potential external threats to researching the

relationship between CS and BO and intent to stay in nurse leaders came mainly from participant interaction in data collection and testing of data in the analysis. Primarily, participant interaction was anonymous through a self-directed online survey that took time to complete. Another potential threat was obtaining enough participant numbers for the needed sample size. Both potential threats were mitigated by ensuring the survey was made available for enough length of time for the chosen platform to circulate to participants, and making every effort to streamline the survey tool to minimize participant time needed to complete it (Edmonds & Kennedy, 2017). The external threat of testing the data was mitigated by using multiple regression as previously identified to test the research question and hypotheses.

Internal Threats

Internal threats were statistical regression and instrumentation. The target population might have self-reported with very high or very low scores. These extremes could influence data analysis (Edmonds & Kennedy, 2017). If extreme outliers had occurred, those data points would have been evaluated and removed from the dataset. Instrumentation may have been a threat due to the length of the instruments and construct validity. Every effort was made to minimize the time needed to complete the survey.

Construct and Statistical Validity

Construct validity. Construct validity is a form of threat that often occurs when definitions of variables or operational definitions are not in alignment with the theory or construct of the study (Edmonds & Kennedy, 2017). All efforts were made to mitigate malalignment. The definitions of the variables were carefully studied and defined.

Threats to construct may also exist in the choice of data collection tools in a quantitative study. Construct validity threat was minimized as the chosen instruments have been used in previous research. Although statistical validity information was not available for the Intentions to Stay Scale, the ProQOL is well established and validated.

Statistical validity. Threats to statistical validity occur when inferences are incorrectly or broadly made by statistical certainty about how variables relate to each other. Validity is impacted by low population size (*n* size), low statistical power of the tests used, and when test assumptions are compromised such as multicollinearity and homoscedasticity (Edmonds & Kennedy, 2017). The threat to statistical validity was real in that the sampling was conducted by convenience, and there was a possibility that the target size for the sample might not have been reached. The smaller the sample size, the smaller the statistical significance of the data. As such, incorrect generalizations could be made for the population. Care was taken to watch data collection for proper sample size but was accepted as a potential threat to the validity of the data.

Ethical Procedures

The ethical and safe treatment of research participants is a critical part of any research (Roush, 2015). Every effort was taken to minimize issues for the participants of my study. The target population for my study was educated professional nurses who were in leadership positions and were not considered a vulnerable population (Roush, 2015). Steps were taken to ensure participants were kept safe and protected. The entire survey took no longer than 10 minutes to complete.

Permissions. I obtained access to the members of the AONL through authorized application. AONL does not have an IRB. As such, researchers must apply for access to their membership, and include an executive summary of the research proposal, copies of the survey instrument(s), and evidence of Walden University IRB approval. My survey was posted into AONL's online platform following acceptance of the necessary documentation and approved application. The only other permission required to conduct my study was IRB approval from Walden University. Walden IRB approval (#02-13-20-0596016) and AONL approval were obtained prior to data collection.

Participants and informed consent. Recruitment of participants pose minor ethical concerns and were managed through study disclosure and informed consent via an online survey tool. With the use of Survey Monkey ®, there was a statement addressing participants' approval, and they were given the choice to agree or disagree to move forward with the survey. If participants agreed to move forward, by clicking "Agree," their agreement to participate was an indication that they gave consent for their information to be utilized and they were advanced to the study survey. Approval of informed consent was granted by the Walden University IRB (#02-13-20-0596016).

Summary

Chapter 3 describes the research plan and approach to sampling, data collection, and proposed data testing. The study was a descriptive, correlational quantitative design, which was conducted as an anonymous online survey. The study's purpose was to discover if there was a relationship between CS and BO and intent to stay in nurse leaders. The instruments that were selected were based on their use in similar studies and

the constructs they measured (CS, BO, and intent to stay). The instruments selected were the ProQOL and the Intentions to Stay Scale. Both instruments have been shown to be reliable and valid in other similar studies.

The target population was nurses serving in formal leadership roles for at least one year, along with other inclusionary and exclusionary criteria. The data collection and statistical testing were identified, as well as any threats to study validity.

I will discuss the results of my study in Chapter 4.

Chapter 4: Results

The purpose of this quantitative study was to determine if there was a relationship between CS and BO and intent to stay in nurse leaders. Stamm's (2009) theoretical model of CS and CF provided the theoretical foundation for conducting this descriptive, correlational study that addressed CS, BO, and intent to stay among nurse leaders. The research question and hypotheses were as follows:

RQ: What is the relationship between CS and BO and intent to stay in nurse leaders?

$H_0$1: There is no relationship between CS and BO and intent to stay in nurse leaders.

H_a1: There is a relationship between CS and BO and intent to stay in nurse leaders.

In this chapter, I explain how the data were collected, the time frame of collection, demographic information, population representation, how the data collection plan was followed, and the results of the data analyzed by the prescribed statistical tests. The results section answers the research question by addressing the hypotheses.

Data Collection

Time Frame

Data collection began with the opening and distribution of the survey on Monday, April 6, 2020, after Walden's IRB granted approval. Data collection completed with the close of the survey on Wednesday, July 1, 2020.

Response Rates

Response rates were low initially as the survey link and invitation to participate were only posted on the AONL electronic newsletter and platform, which were sent out twice weekly. AONL, in accordance with their research contract, kept my survey advertisement and link posted throughout the allotted 90-day timeframe. I closed the survey a few days early after survey response rates surpassed the G*Power estimate.

My goal was to obtain a minimum of 55 participants to meet the sample size as calculated by G*Power (see Faul et al., 2007), a flexible statistical power analysis program (power = 0.8, medium effect, two tailed, alpha = .05). Participants were sought out anonymously through AONL and offered the study survey link through SurveyMonkey. There was a potential participant pool of over 9,700 (AONE, n.d.), and I received 99 responses. Based on the estimated membership of AONL, the response rate was less than 1%. After reviewing all participant responses, all 99 participant responses were found to be complete and included in the data analysis.

Plan Discrepancies and Fidelity

The study plan was followed as planned in Chapter 3 with one exception. Participation lagged during the first month after launching the survey. As such, I communicated the lack of response to other AONL members living in North Carolina, which resulted in a substantially large number of participants (65%) from that state (see Table 1). There has been no report of adverse outcomes due to participation in this study.

Sample Characteristics

Sample participants were recruited (see Appendix B) from nurse leaders within the United States who were members of the AONL. The target population estimated by AONL was 9,700. I received 99 responses. Based on the estimated membership of AONL, the response rate was less than 1%. After reviewing all participant responses, all 99 participant responses were found to be complete and included in the data analysis. Study participants from 24 of the 50 states responded (see Table 1). The sample reflected the general representation of the nursing work force in gender as it closely mimicked recent estimations of male to female nurses in the United States with 8% male and 92% female (see Table 1). The mean age of study participants was 50.7 years (see Table 1). Number of years in the current position ranged from 6 weeks to 38 years. Sixteen participants reported to the chief executive officer (16.16%). Thirty-five participants reported to the CNO (35.35%). Five participants reported to the chief operating officer (5.05%). Three participants reported to the chief medical officer (3.03%). Forty-two participants reported to other leaders such as vice-president or director. Facility bed sizes ranged from 12 to 1,500, with a mean of 378. Time spent in direct patient care ranged from zero to 100%. The number of FTEs each participant was responsible for ranged from 1 to greater than 100. Most participants reported Master of Science in Nursing degrees (40.4%; $n = 40$) as their highest academic degree (see Table 1). Just over 8% of participants held Associate Degrees in Nursing (8.08%; $n = 8$), 15.15% ($n = 15$) held Bachelor of Science in Nursing degrees, 2.02% ($n = 2$) held Diplomas in Nursing, 16.16% ($n = 16$) held Doctor of Nursing Practice degrees, 5.05% ($n = 5$) held Doctor of

Philosophy degrees, and 13.13% (n = 13) listed other degrees such as Master of Business Administration degrees (see Table 1.) Number of years in nursing ranged from 1 to 50 with a mean of 24.04 years.

Representativeness

The target population was aimed at nursing leaders in the United States. This sample reflected the general representation of the nursing work force in gender as it closely mimicked recent estimations of male to female nurses in the United States. The study had 8% male and 92% female participants, mirroring the recently estimated percentages in the United States of 9% male and 91% female nurses (see Fastaff, 2016). In 2019, the American Association of Colleges of Nursing reported that there were more than 3.8 million RNs nationwide, with an estimated 10% (380,000) being nurse leaders. This sample size is only a fraction of the overall number of estimated nurse leaders. However, gender was in alignment with the larger target population, and 24 of the 50 states were represented in the sample (see Table 1). There was a disproportionate number of respondents from North Carolina (65%), most likely arising from conversations between myself and other members of AONL residing in North Carolina.

The remaining demographic results were mixed in comparison to the overall nursing demographic statistics for the United States as reported in the 2017 National Nursing Workforce Survey (see Smiley et al., 2018). Smiley et al. (2018) reported the average age of registered nurses was 51, which was comparable to the mean age of 50.7 years in the current participant pool (see Table 1). However, 40.4% of the current study participants held Master's degrees, 16.16% held Doctor of Nursing Practice degrees, and

5.05% held Doctor of Philosophy degrees (see Table 1) compared to 17.1% of RNs with Master's degrees, 1.1% of RNs with Doctor of Nursing Practice degrees, and 0.6% of RNs with Doctor of Philosophy degrees in the Smiley et al. (2018) study.

Results

Descriptive Statistics

Several demographic questions were asked to evaluate if the target population of this study was representative of the larger body of nurse leaders. Table 1 displays the demographic information reported by participants.

Table 1

Demographic Information of Participants (Categorical Variables)

	N	%
Gender		
Male	8	8%
Female	91	92%
Age range		
Youngest	29 years	
Oldest	71 years	
Mean	50.7 years	
Years in position		
Least	6 weeks	
Most	38 years	
Mean	6.43 years	
Supervisor		
CEO	16	16.16%
CNO	35	35.35%
COO	5	5.05%
CMO	3	3.03%
Other	42	42.42%
Bed Size		
Least	12	
Most	1500	
Mean	378	
Time in direct care		
None	38	38.78%
0-25%	40	40.82%
25-50%	6	6.12%
50-75%	9	9.18%
75-100%	5	5.10%
Highest degree		
ADN	8	8.08%
BSN	15	15.15%
Diploma	2	2.02%
MSN	40	40.40%
PhD	5	5.05%
DNP	16	16.16%
Other	13	13.13%
State Res		
AL	1	1%
CA	5	5%
HI	1	1%
IA	1	1%
ID	2	2%
IL	1	1%
IN	2	2%
MA	1	1%
MD	1	1%
MO	1	1%
NC	64	65%
NE	1	1%
NJ	3	3%
NM	1	1%
NY	1	1%
OH	2	2%
OK	1	1%
OR	1	1%
PA	1	1%
SC	1	1%
TN	3	3%
TX	2	2%
VA	1	1%
WV	1	1%

	N	*%*
# of FTEs		
0-25	39	39.39%
26-50	25	25.25%
51-75	4	4.04%
76-100	8	8.08%
>100	23	23.23%
Years in nursing		
Least	1 year	
Most	50 years	
Mean	24.04 years	

All statistical assumptions were reviewed to ensure quality and outcomes of the tests run. The assumptions for correlation were not violated for any test. For multiple linear regression, no assumptions were violated as all variables were evenly distributed using 5-point Likert scales. All scale items were reviewed to evaluate the need for reverse scoring. Five items in the BO subscale of the ProQOL required reverse scoring. No items in the CS subscale of the ProQOL required reverse scoring. Four items in the Intentions to Stay Scale required reverse scoring. Recoding for reverse scored items was in alignment with statistical data analysis norms. No other revisions or recoding was necessary to analyze the data.

I measured the statistical impact of the independent variables of CS and BO on the dependent variable of intent to stay. Data were collected using an internet-based survey. Each variable was operationalized using an associated scale. CS and BO were measured using the ProQOL (see Stamm, 2009). Intent to stay was measured using the Intentions to Stay Scale (see Mayfield & Mayfield, 2007). Table 2 displays the descriptive statistics for all three variables.

Table 2

Descriptive Statistics

	Mean	Std. Deviation	*N*
Intent	17.828	6.48867	99
Burnout	21.1919	5.28509	99
Compassion	42.4747	5.03730	99

Burnout. The independent variable of BO was operationalized using the ProQOL (Stamm, 2009). This scale is a 30-item Likert scale. The ProQOL has three subscales of 10 items each: CS, BO, and STS. Five items on the BO scale were reverse scored as directed by the author of the ProQOL (Stamm, 2010) prior to data analysis. In past uses, ProQOL's reliability scores ranged from 71% to 89%, and convergent and discriminant validity ranged from 14% to 23% (Stamm, 2010). The reliability score from my data was 74% which is consistent with previously reported reliability

Compassion satisfaction. The independent variable of CS was operationalized using the ProQOL (Stamm, 2009). This scale is a 30-item Likert scale. As previously noted, the ProQOL has three subscales of 10 items each: CS, BO, and STS. No items were reverse scored as directed by the author of the ProQOL (Stamm, 2010). ProQOL's reliability scores ranged from 71% to 89% in past uses, and convergent and discriminant validity ranged from 14% to 23% (Stamm, 2010). The reliability score from my data was 74% which is consistent with previously reported reliability.

Intent to stay. The dependent variable of Intent to Stay was operationalized using the Intentions to Stay Scale (Mayfield & Mayfield, 2007). The Intentions to Stay Scale is a 7-item Likert scale used to elicit positive or negative reactions to the intent to stay (Mayfield & Mayfield, 2007). Three of the statements reflect positive intention. Four of the statements reflect negative intention. The four items that reflect negative intention were reverse scored as directed by the authors prior to data analysis (Mayfield & Mayfield, 2007). Cronbach's reliability for the negative responses was alpha = 0.77 and for the positive responses was alpha = 0.66. Although no validity data were provided

(Mayfield & Mayfield, 2007), the authors stated the overall model has a goodness-of-fit index of 0.93 (Mayfield & Mayfield, 2007).

Statistical Analysis

A multiple linear regression was performed using IBM SPSS 25.0 on the following model:

- Dependent Variable: Intent to Stay
- Independent Variable: CS
- Independent Variable: BO

Table 3 displays the analysis of variance.

Table 3

Analysis of Variance

	Sum of squares	*df*	Mean square	*F*	Sig
Regression	646.452	2	323.226	8.918	.000
Residual	3479.629	96	36.246		
Total	4126.081	98			

Note. Dependent variable = intent to stay; predictors = (constant) CS and BO.

The data were fairly normally distributed. Figure 3 shows a histogram of the distribution of the data.

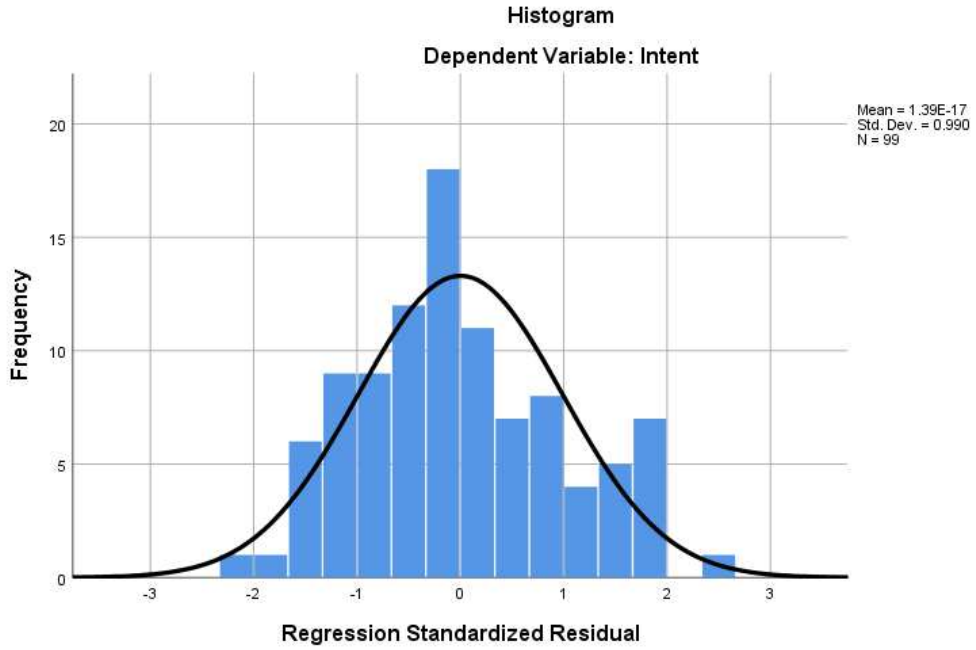

Figure 3. Histogram of the data.

There was a strong negative relationship between BO and CS scores (r=-0.74, p-value=0.00). The correlation can suggest multicollinearity between the independent variables which may have had an effect on the linear regression. The relationship with the dependent variable, intent to stay, was moderately negative for CS (r=-0.284, p-value=0.002) and moderately positive for BO (r=0.396, p-value=0.000) respectively. Table 4 displays the correlations.

Table 4

Correlations

Pearson	Intent	Burnout	Compassion
Intent	1.000	.396	-.284
Burnout	.396	1.000	-.745
Compassion	-.284	-.745	…… 1.000

Sig. (1-tailed)	Intent	Burnout	Compassion
Intent		.000	.002
Burnout	.000		.000
Compassion	.002	.000……	
N			
Intent	99	99	99
Burnout	99	99	99
Compassion	99	99	……99

The actual linear regression did not suggest multicollinearity. The VIF scale was normal (less than 10) amongst the variables in the model. Because the VIF was not greater than 10 for any of the variables, it was suggestive that the multicollinearity was not strong amongst the independent variables. Table 5 displays the VIF scale and collinearity statistics.

Table 5

VIF Scale and Collinearity Statistics

	Collinearity statistics VIF
(Constant)	
Burnout	2.245
Compassion	…… 2.245

a. Dependent Variable: Total stay

The Durbin-Watson was between 1.5 and 2.5 at a value of 1.777, and the R-Square value of 0.157 suggested 15.7% of the variability could be explained by the model.

In terms of the model itself, there was a statistical significance in BO (mean=0.506, std=0.172, p-value=0.004). One-unit increase in the BO score raised the intent to stay by 0.5 units. CS was not statistically significant (mean=0.029, std=0.181, p-value=0.871). Table 6 displays the model itself.

Table 6

Coefficients

	B	Std. Error	Beta	*t*	Sig.
(Constant)	5.844	10.704		.546	.586
Burnout	.506	.172	.413	2.937	.004
Compassion	.029	.181……	.023	.163	.871

The results of the regression for the dependent variable, intent to stay, indicated that BO explained 15.7% of the variance (R Square = 0.157). CS did not contribute to predict the outcome of intent to stay. Figure 4 shows the homoscedasticity of the predicted slope of BO to intent to stay.

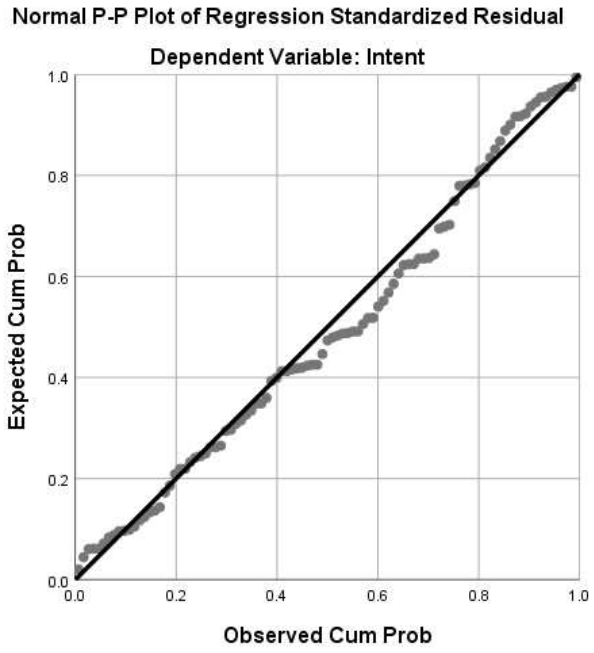

Figure 4. Homoscedasticity of intent to stay. This figure shows the predicted relationship of BO on intent to stay.

Research Question

What is the relationship between CS and BO and intent to stay in nurse leaders? The null hypothesis stated that there would be no relationship between CS and BO and intent to stay in nurse leaders. The alternate hypothesis stated that there would be a relationship between CS and BO and intent to stay in nurse leaders.

There was a strong negative relationship between the BO and CS scores (r=-0.74, p-value=0.00), which could suggest multicollinearity between the independent variables. The relationship with the dependent variable, intent to stay, was moderately negative for CS (r=-0.284, p-value=0.002) and moderately positive for BO (r=0.396, p-value=0.000) respectively. Therefore, the null hypothesis which suggested there would be no relationship between CS and BO and intent to stay in nurse leaders was rejected.

Correlation. In completing the analysis of the relationship between CS, BO, and intent to stay among nurse leaders, I conducted a general correlation on all three variables with intent to stay being the dependent variable. The results revealed a strong negative correlation between the BO and CS scores (r=-0.74, p-value=0.00). This correlation could suggest multicollinearity between the independent variables which may have had an effect on the linear regression. The relationship with the dependent variable, intent to stay, was moderately negative for CS (r=-0.284, p-value=0.002) and moderately positive for BO (r=0.396, p-value<0.001) respectively.

Regression. The actual linear regression did not suggest multicollinearity. The variance inflation factor (VIF) scale was normal (2.245) amongst the variables in the model, suggesting it was possible to assess accurately the contribution of predictors to the

model. The Durbin-Watson was between 1.5 and 2.5 at a value of 1.777, indicating a positive autocorrelation. In terms of the model itself, there was a statistical significance in BO (mean=0.506, std=0.172, p-value=0.004). As such, one-unit increase in the BO score raised the intent to stay by 0.5 units. The CS score was not statistically significant (p-value=0.871). The R-squared value, or coefficient of determination, was 0.157, suggesting 15.7% of the variability could be explained by the model.

Summary

In this chapter, the analysis of data related to the research question, "What is the relationship between CS and BO and intent to stay in nurse leaders?" was provided. The data showed that there was a significant relationship between the independent variable of BO and the dependent variable of intent to stay. As the BO score raised, the intent to stay increased. CS was not found to be significant to intent to stay but there was a strong negative correlation between BO and CS which could suggest multicollinearity between the independent variables. In Chapter 5, I will interpret the findings of this chapter, as well as compare it to the previous literature, research, and theoretical framework.

Chapter 5: Discussion, Conclusions, and Recommendations

Nurse leaders play an important role in organizational culture and the work environment. In the ever-changing healthcare environment, retention of caring, compassionate, experienced nurse leaders is highly valued (Boyle, 2015). Previous research focused primarily on assisting nurse leaders in the maintenance of a healthy workforce by evaluating CS and CF among direct care providers in various nursing specialties (Abendroth & Flannery, 2006; Adriaenssens et al., 2015; Cho & Jung, 2014; Meyer et al., 2015; Sacco et al., 2015) and understanding and predicting CS and CF within the ranks (Potter et al., 2013; Slatten et al., 2011; Zeidner & Hadar, 2014). Other researchers examined nurse leader retention and turnover and employee intent to stay (Johari et al., 2012; Jones et al., 2008). Further studies suggested expanded role responsibilities, increased job demands, and limited authority to make decisions could lead to disengagement, BO, and nurse leader turnover (Nelson, 2017, Wong & Spence Laschinger, 2015). The purpose of this quantitative, cross-sectional study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders. Correlation and multiple linear regression were used to evaluate whether a relationship did exist between the variables, and, if so, the extent to which those variables predicted the outcome of intent to stay.

Key findings of the data analysis revealed that BO had a significant impact on intent to stay while CS did not have a significant impact on intent to stay. As such, the null hypothesis was rejected. In the remainder of this chapter, I reflect upon the findings

of the data analysis, describe the limitations of this research, offer recommendations for future study, and discuss the implications for social change.

Interpretation of the Findings

The findings add to the current body of knowledge related to the roles CS and BO might play in turnover or intent to stay among nurse leaders. The purpose of my study was to determine if there was a relationship between CS and BO and intent to stay among nurse leaders. The findings revealed a strong negative correlation between CS and BO. CS did not have a significant impact on intent to stay while BO did have a significant impact on intent to stay. As the BO score increased, the intent to stay score increased as well (mean = 0.506, std = 0.172, *p*-value = 0.004). A one-unit increase in the BO score raised the intent to stay by 0.5 units. CS was tested using multiple regression with the dependent variable as intent to stay. CS was not statistically significant (mean = 0.029, std = 0.181, *p*-value = 0.871). The *R*-squared value, or coefficient of determination, was 0.157, suggesting 15.7% of the variability could be explained by the model.

Burnout

BO has been described as being associated with workplace stressors, lack of camaraderie and teamwork, staffing shortages, working long hours, intense workloads, conflicts with other nurses and healthcare providers, and time pressures (Boyle, 2015). In a recent systematic review of studies measuring BO in healthcare settings, more errors were significantly associated with health practitioner BO (Hall et al., 2016). My research supports Kelly and Adams's (2018) findings that BO may manifest differently in nurse leaders. While BO has historically had a negative effect on intent to stay among staff

nurses (Hall et al., 2016), my research revealed that BO had a significant positive effect on intent to stay among nurse leaders. However, this finding may be related to the current novel coronavirus (COVID-19) pandemic. Fernandez et al. (2020) found that nurses' sense of duty, dedication to patient care, personal sacrifice, and professional collegiality was heightened during a pandemic or epidemic. However, many studies on BO have addressed its causes and associated factors, prevalence rates, and prevention programs in individuals without discussing or analyzing the concept of BO as a societal aspect (Heinemann & Heinemann, 2017; Slatten et al., 2011; Thieman, 2018; Young et al., 2016).

Compassion Satisfaction

In a recent exploration of CS, BO, and CF in a large regional healthcare system in western North Carolina, CS was more predominant than BO in nurse leader participants (DePaola et al., 2018). CS was not found to be significant to intent to stay in my research; however, there was a strong negative correlation between BO and CS, which would suggest that as BO increases, CS decreases, and as CS increases, BO decreases. DePaola et al. (2018) conducted their study prior to the current worldwide COVID-19 pandemic. As previously noted, nurses' sense of duty, dedication to patient care, personal sacrifice, and professional collegiality is heightened during a pandemic or epidemic (Fernandez et al., 2020).

Findings related to the predictability of the variables on the intent to stay suggested CS alone was not enough to encourage nurse leaders to remain in their current positions while BO significantly affected the intent to stay in nurse leaders. A one-unit

increase in the BO score raised the intent to stay by 0.5 units (mean = 0.506, std = 0.172, *p*-value = 0.004). CS was not statistically significant (mean = 0.029, std = 0.181, *p*-value = 0.871). The statistical analysis revealed that BO explained 15.7% of the variance in intent to stay while CS did not contribute to predict the outcome of intent to stay.

Theoretical Findings

Stamm's (2009) theory of CS and CF was used to frame and test the research question related to the existence or absence of a relationship between CS, BO, and intent to stay among nurse leaders. Increasing importance has been placed on resiliency and transforming negative into positive outcomes and emotions (Stamm, 2010). Stamm (2010) posited that CS involves the positive aspects of helping others, and CF involves the negative aspects of helping others. CF is comprised of two elements: BO and STS (Stamm, 2009). BO is gradual in onset and associated with feelings of hopelessness and may manifest as difficulties in dealing with work or in doing one's job effectively (Stamm, 2009). STS is usually rapid in onset and associated with a specific event (Stamm, 2009). STS is associated with work related secondary exposure to extremely stressful or traumatic events (Stamm, 2009). I focused only on CS and BO as nurse leaders historically have not experienced STS in their leadership roles. Perhaps during the COVID-19 pandemic, this factor changed.

Stamm (2010) defined key environments within the theory of CS and CF as the work environment, the client or person helped environment, and the personal environment (Stamm, 2010). The work environment was defined as the actual work situation (Stamm, 2010). The client or person helped environment was defined as the

environment of the individual for whom one was providing care or assistance, including direct reports (Stamm, 2010). The personal environment was defined as that environment that individuals bring to the workplace (Stamm, 2010). The current COVID-19 pandemic has changed all three environments in healthcare and society in general (Gavin, Hayden, Adamis, & McNicholas, 2020). The results of this study support the theory of CS and CF (Stamm, 2009) and have the potential for social change, revealing a relationship between CS, BO, and intent to stay among nurse leaders. As CS increased, BO decreased, and as BO increased, CS decreased. However, only BO had a statistically significant effect on intent to stay. This finding may be an outlier and related to the current COVID-19 pandemic.

Limitations of the Study

Generalizability and Sample Size

Generalizability to overall nurse leaders was difficult to ascertain because there has been no research conducted regarding nurse leaders' intention to stay related to CS and BO found in current literature and minimal demographic information from which to make comparisons. The generalizability of the results is limited to the nurse leaders in this study. My sample size was 99, which surpassed my power analysis calculations. Despite having adequate numbers for the sample size and although demographics collected from the target population revealed a wide spread of nurse leaders throughout the United States, covering 24 of 50 states, a disproportionate amount (65%) were from North Carolina. As such, future studies should attempt to have a more diverse, evenly

distributed sample to afford a larger representation of nurse leaders. In addition, the presence of a worldwide pandemic may have impacted the strength of the data analysis.

Study Design

Instrumentation. Instrumentation was identified as a possible limitation due to the length of the tools used for the survey questionnaire. The overall length of the final questionnaire was 47 items (10 demographic items and 37 survey items). The average time that it took the participants was 6 minutes. No participants were excluded due to incomplete survey responses.

Correlational design. A correlational study method and design were identified as potential limitations in that correlation does not offer explanation or causality. While the correlational design was ideal for answering questions about the existence of relationships between study variables, it did not offer answers to why questions or provide an in depth understanding of cause and effect. This was a limitation as data analysis generated questions regarding why one variable had more of an impact on intent to stay than another.

Recommendations

The findings suggest that more research needs to be conducted regarding nurse leaders' intent to stay and to seek a better understanding of how CS and BO affect individual nurse leaders, both before and after the pandemic subsides. In previous research, CS was more predominant than BO in nurse leader participants (DePaola et al., 2018). However, intent to stay was not evaluated.

The findings of this study suggest that there is more to intent to stay for nurse leaders beyond CS and BO. Perhaps a mixed method study combining the survey tool used in this study with qualitative, open-ended questions would be more effective.

Implications

The potential positive social change implications of my research stem from the examination of CS and BO and intent to stay in the nurse leader population, which may positively influence team members, strengthen the organization, and contribute to retention of nurses and nurse leaders (see Thacker et al., 2016). Although the healthcare industry continues to investigate ways to retain direct care staff, the nurse leader population has been overlooked. CS and BO and intent to stay must be studied in the nurse leader population as nurse leaders are key to the success of the organization and retention of direct care staff. My findings can pave the way to a better understanding of CS and BO and intent to stay among nurse leaders, thereby improving the retention potential of these essential individuals.

Conclusion

This study was an investigation into the existence or nonexistence of a relationship between CS, BO, and the intent to stay among nurse leaders. Despite the limiting factors of the length of the survey tool, the presence of a worldwide pandemic, and a disproportionately large number of respondents from one state, this study revealed significant data reflecting a strong negative relationship between CS and BO, indicating as CS increased, BO decreased and as BO increased, CS decreased. The statistical analysis revealed that BO explained 15.7% of the variance in intent to stay while CS did not contribute to predict the outcome of intent to stay. The findings of this study have significant implications for the future of nursing and nursing leadership. Further research is needed to ascertain if these findings can be reproduced once the pandemic has been eradicated.

References

Abendroth, M., & Flannery, J. (2006). Predicting the risk of compassion fatigue: A study of hospice nurses. *Journal of Hospice & Palliative Nursing, 8*(6), 346-356. Retrieved from journals.lww.com/jhpn/pages/default.aspx

Adriaenssens, J., De Bucht, V., & Maes, S. (2015). Determinants and prevalence of burnout in emergency nurses: A systematic review of 25 years of research. *International Journal of Nursing Studies, 52*(2015), 649-661. doi:10.1016/j.ijnurstu.2014.11.004

American Association of Colleges of Nursing. (2019, April 1). Nursing fact sheet. Retrieved from http://www.aacnnursing.org/News-Information/Fact-Sheets

American Organization of Nurse Executives. (n.d.). AONE membership. Retrieved from http://www.aone.org/membership/overview.shtml

Bernard, N. (2019). Resilience and professional joy: A toolkit for nurse leaders. *Nurse Leader, 17*(1), 43-48. doi:10.1016/j.mnl.2018.09.007

Boyle, D. A. (2015). Compassion fatigue: The cost of caring. *Nursing 2015, 45*(7), 48-51. doi:10.1097/01.NURSE.0000461857.48809.a1

Burkeholder, G. J., Cox, K. A., & Crawford, L. M. (2016). *The scholar-practitioner's guide to research design*. Baltimore, MD: Laureate Publishing.

Cho., H. J. Jung, M. S. (2014). Effect of empathy, resilience, self-care on compassion fatigue in oncology nurses. *Journal of Korean Academy of Nursing Administration, 20*(4), 373-382. doi:10.11111/jkana.2014.20.4.373

Cox, K. A. (2016). Survey research. In G. J. Burkholder, K. A. Cox, & L. M. Crawford (Eds.), *The scholar-practitioner's guide to research design* (pp. 215-226). Baltimore, MD: Laureate Publishing.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Curtis, E. A., Comiskey, C., & Dempsey, O. (2016). Correlational research: Importance and use in nursing and health research. *Nurse Researcher, 23*(6), 20-25. doi:10.7748/nr.2016.e1382

Davern, M. (2013). Nonresponse rates are a problematic indicator of nonresponse bias in survey research. *Health Services Research, 48*(3), 905-912. doi:10.1111/1475-6773.12070

DePaola, M., Guyette, K. C., & Hooper, V. (2018, November). *An exploration of compassion satisfaction, burnout and compassion fatigue in a large regional healthcare system.* Paper presented at the meeting of the American Academy of Nursing, Washington, D.C.

Dyess, S. M., Prestia, A. S., & Smith, M. C. (2015). Support for caring and resiliency among successful nurse leaders. *Nursing Administration Quarterly, 39*(2), 104-116. doi:10.1097/NAQ.0000000000000101

Edmonds, W. A., & Kennedy, T. D. (2017). *An applied guide to research designs: Quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Fahey, D. M., & Glasofer, A. (2016). An inverse relationship: Compassion satisfaction,

compassion fatigue, and critical care nurses. *Nursing 2016 Critical Care, 11*(5), 30-35. doi:10.1097/01.CCN.0000490957.22107.50

Fastaff. (2016, February 9). Male nursing statistics. Retrieved from http://www.fastaff.com/blog/male-nursing-statistics.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 38, 175-191. doi:103758/BF03193146

Fernandez, R., Lord, H., Halcomb, E., Moxham, L., Middleton, R., Alananzeh, I., & Ellwood, L. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. *International Journal of Nursing Studies* (8 May 2020), 1-14. doi:10.1016/j.ijnurstu.2020.103637

Frankfort-Nachmias, C., & Leon-Guerrero, A. (2015*). Social statistics for a diverse society* (7th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Friedlander, J. (2017, September). Keep it real: The secrets of being authentic (and why it's important). *Success*, 51-54.

Gavin, B., Hayden, J., Adamis, D., & McNicholas, F. (2020). Caring for the psychological well-being of healthcare professionals in the Covid-19 pandemic crisis. *Irish Medical Journal, 113*(4), 51-53. Retrieved from imj,ie

Griner, T. E., Shirk, M., Brown, G., & Hain, P. (2017). Cumulative stress debriefings: Support for clinicians and nurse leaders. *Nurse Leader, 15*(1), 53-55. doi:10.1016/j.mnl.2016.09.009

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff well-being, burnout, and patient safety: A systematic review. *PLoS ONE, 11*(7), e0159015. doi:10.1371/journal.pone.0159015

Heinemann, L. V., & Heinemann, T. (2017). Burnout research: Emergency and scientific investigation of a contested diagnosis. *SAGE Open, January-March* (2017),1-12. doi:10.1177/2158244017697154

Hewko, S. J., Brown, P., Fraser, K. D., Wong, C. A., & Cummings, G. G. (2015). Factors influencing nurse managers' intent to stay or leave: A quantitative analysis. *Journal of Nursing Management, 23*, 1058-1066. doi:10.1111jonm.12252

Hunsaker, S., Chen, H. C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship, 47*(2), 186-194. doi:10.1111/jnu.12122

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing, 60*(1), 1-9. doi:10.1111/j.1365-2648.2007.04412.x

Johari, J., Yean, T. F., Adnan, Z., Yahya, K. K., & Ahmad, M. N. (2012). Promoting employee intention to stay: Do human resource management practices matter? *International Journal of Economics and Management, 6*(2), 396-416. Retrieved from https://www.researchgate.net/publication/281190297

Jones, C. B., Havens, D. S., & Thompson, P. A. (2008). Chief nursing officer retention and turnover: A crisis brewing? Results of a national survey. *Journal of*

Healthcare Management, 53(2), 89-105. Retrieved from journals.lww/jhmonline

Kelly, L. A., & Adams, J. M. (2018). Nurse leader burnout: How to find your joy. *Nurse Leader, 16*(1), 24-28. doi:10.1016/j.mnl.2017.10.006

Ledesma, J. (2014). Conceptual frameworks and research models on resilience in leadership. *SAGE Open*, *4*(3), 1-8. doi:10.1177/2158244014545464

Ledoux, K. (2015). Understanding compassion fatigue: Understanding compassion. *Journal of Advanced Nursing, 71*(9), 2041-2050. doi:10.1111/jan.12686

Maslach, C., & Leiter, M. P. (2008). Early predictors of job burnout and engagement. Journal of Applied Psychology, 93(3), 498-512. doi:10.1037/0021-9010.93.3.498

Mayfield, J., & Mayfield, M. (2007). The effects of leader communication on a worker's intent to stay: An investigation using structural equation modeling. *Human Performance, 20*(2), 85-102. doi:10.1080/08959280701332018

McCusker, K., & Gunaydin, S. (2015). Research using qualitative, quantitative or mixed methods and choice based on the research. *Perfusion, 30*(7), 537-542. doi:10.1177/0267659114559116

Mendes, A. (2014). Recognising and combating compassion fatigue in nursing. *British Journal of Nursing, 23*(21), 1146. doi:10.12968/bjon.2014.23.21.1146

Meyer, R. M. L., Li, A., Klaristenfeld, J., & Gold, J. I. (2015). Pediatric novice nurses: Examining compassion fatigue as a mediator between stress exposure and compassion satisfaction, burnout, and job satisfaction. *Journal of Pediatric Nursing, 30*(1), 174-183. doi:10.1016/j.pedn.2013.12.008

Mooney, C., Fetter, K., Gross, B. W., Rinehart, C., Lynch, C., & Rogers, F. B. (2017). A

preliminary analysis of compassion satisfaction and compassion fatigue with considerations for nursing unit specialization and demographic factors. *Journal of Trauma Nursing, 24*(3), 158-163. doi:10.1097/JTN.0000000000000284

Naim, M. F., & Lenka, U. (2017). Mentoring, social media, and Gen Y employees' intention to stay: Towards a conceptual model. *International Journal of Business and Systems Research, 11*(1-2). doi:10.1504/IJBSR.2017.080832

Nelson, K. E. (2017). Nurse manager perceptions of work overload and strategies to address it. *Nurse Leader, 15*(6), 406-408. doi:10.1016/j.mnl.2017.09.009

Norman, G. (2010). Likert scales, levels of measurement and the "laws" of statistics. *Advances in Health Sciences Educations, 15*(5), 623-632. doi:10.1007/s10459-010-9222-y

Pipe, T., FitzPatrick, K., Doucette, J. N., Cotton, A., & Arnow, D. (2016). The mindful nurse leader. *Nursing Management, 47*(9), 44-48. doi:10.1097/01.NUMA.0000491135.836013e

Potter, P., Deshields, T., & Rodriguez, S. (2013). Developing a systemic program for compassion fatigue. *Nursing Administration Quarterly, 37*(4), 326-332. doi:10.1097/NAQ.0b013e3182a2f9dd

Press Ganey. (2017). *2017 Press Ganey nursing special report: The influence of nurse manager leadership on patient and nurse outcomes and the mediating effects of the nurse work environment.* South Bend, IN: Press Ganey.

Richards, K. (2014). The power of self-care to transform culture, improve retention, and boost resilience. *Nurse Leader, 12*(1), 57-59. doi:10.1016/j.mnl.2013.11.003

Roberts, P., & Strauss, K. (2015). The power of the positive. *American Nurse Today,10*(7)13-14. Retrieved from myamericannurse.com

Roush, K. (2015). *A nurse's step-by-step guide to writing your dissertation or capstone*. Indianapolis, IN: Sigma Theta Tau International.

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse, 35*(4), 32-44. doi:10.4037/ccn2015392

Salloum, A., Kondrat, D. C., Johnco., C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children & Youth Services Review, 49*(Feb), 54-61. doi:10.1016/j.childyouth.2014.12.023

Sheppard, K. (2015). Compassion fatigue among registered nurses: Connecting theory and research. *Applied Nursing Research, 28*(2015), 57-59. doi:10.1016/j.apnr.2014.10.007

Slatten, L. A., Carson, K. D., & Carson, P. P. (2011). Compassion fatigue and burnout: What managers should know. *The Health Care Manager, 30*(4), 325-333. doi:10.1097/HCM.0b013e31823511f7

Smiley, R. A., Lauer, P., Bienemy, C., Berg, J. G., Shireman, E., Reneau, K. A., & Alexander, M. (2018). The 2017 national nursing workforce survey. *Journal of Nursing Regulation, 9*(3) supplement, S1-S88. doi:10.1016/S2155-8256(18)30131-5

Stamm, B. H. (2009). *Professional quality of life: Compassion satisfaction and fatigue*

version 5 (ProQOL). Retrieved from ProQOL.org

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Pocatello, ID: ProQOL.org

Steege, L. M., Pinekenstein, B. J., Knudsen, E. A., & Rainbow, J. G. (2017). Exploring nurse leader fatigue: A mixed methods study. *Journal of Nursing Management*, *25*, 276-286. doi:10.1111/jonm.12464

Thacker, K., Haas Stavarski, D., Brancato, V., Flay, C., & Greenawald, D. (2016). An investigation into the health-promoting lifestyle practices of RNs. The American Journal of Nursing, 116(4), 24-30. doi:10.1097/01.NAJ.0000482141.42919.b7

Thew, J. (2019, April 11). AONE changes its name to better reflect nurse leadership. *Health Leaders Magazine, 22*(2), Supplemental Index.

Thieman, L. (2018). Selfcare for healthcare: The best way to care for patients is to care for ourselves. *Nurse Leader, 16*(6), 393-397. doi:10.1016/j.mnl.2018.07.014

Turner, S. B. (2014). The resilient nurse: An emerging concept. *Nurse Leader, 12*(6), 71-73, 90. doi:10.1016/j.mnl.2014.03.013

Wagner, W. E. (2017). *Using IBM SPSS statistics for research methods and social science statistics* (6th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Warshawsky, N. E., & Havens, D. S. (2014). Nurse manager job satisfaction and intent to leave. Nursing Economics, 32(1), 32-39. PMID:24689156

Wei, H., Sewell, K. A., Woody, G., & Rose, M. A. (2018). The state of the science of nurse work environments in the United States: A systematic review. International *Journal of Nursing Sciences, 5*(2018), 287-300. doi:10.1016/j.ijnss.2018.04.010

Williamson, E. (2017, May 23). Nurse manager versus nurse leader: What's the

difference? *Nurse.com* [blog post] Retrieved from https://www.nurse.com/blog/2017/05/23/nurse-manager-vs-nurseleader-what's-the-difference/

Winwood, P. C., Winefield, A. H., Dawson, D., & Lushington, K. (2005). Development and validation of a scale to measure work-related fatigue and recovery: The occupational fatigue exhaustion/recovery scale (OFER). *Journal of Occupational and Environmental Medicine, 47*(6), 594-606. doi:10.1097/01.jom.0000161740.71049.c4

Wong, C. A., & Spence Laschinger, H. K. (2015). The influence of frontline manager job strain on burnout, commitment and turnover intention: A cross-sectional study. *International Journal of Nursing Studies, 52*(2015), 1824-1833. doi:10.1016/j.ijnurstu.2015.09.006

Worth, T. (2017, December 26). The importance of nurse managers. *ANA Nurse Career Brief*. Retrieved from http://www.renalandneurologynews.com/the-importance-of-nurse-managers/printarticle/720228/

Youcef, S., Ahmed, S. S., & Ahmed, B. (2016). The impact of job satisfaction on turnover intention by the existence of organization commitment, and intent to stay as intermediates variables using approach PLS in sample worker department of transport saida. *Management, 6*(6), 198-202. doi:10.5923/j.mm.20160606.03

Young, S., Duff, S., & Stanney, K. (2016). How nurse leaders can reduce burnout: Focus on mental energy. *Nurse Leader, 14*(2), 139-141. doi:10.1016/j.mnl.2015.07.011

Zeidner, M., & Hadar, D. (2014). Some individual difference predictors of professional

well-being and satisfaction of health professionals. *Personality and Individual Differences, 65*(2014), 91-95. doi:10.1016/j.paid.2014.01.032

Appendix A: AONL Research Agreement

Placement: Placement of requests for research participation will appear in a designated section of AONL eNews and AWFY; "RESEARCH PARTICIPATION OPPORTUNITIES". The design and formatting of the research language is the responsibility of the researcher and must meet the parameters of AONL's electronic newsletter platform.

Indemnification: It is understood that the Researcher is acting as an independent contractor and assumes the entire responsibility for performance under this agreement. AONL, its employees and agents are harmless against all liabilities, claims, causes of action, losses and damages to persons and property, including expenses and attorneys' fees, arising out of or caused by the researcher's performance, excluding any such liability caused by the sole negligence of AONL, its employees and agents.

Duration: This Agreement will begin on the first publication of the research request and conclude on the last published date. This Agreement may be cancelled by either party in writing within 14 days.

Miscellaneous: 1. This Agreement supersedes all prior agreements, oral or written, and constitutes the entire understanding among both parties. 2. This Agreement shall be governed by the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have executed this AGREEMENT by and between the American Organization for Nursing Leadership (AONL), a subsidiary of the American Hospital Association (AHA), an Illinois not-for-profit corporation with principal offices at 155 North Wacker, Chicago, IL 60606.

Appendix B: Recruitment Flyer

If you are a nurse leader working in the US who has been in at least one formal nursing leadership position (either currently or in the last 3 years) for at least one year, reported to a senior administrative officer, supervised at least one department with no smaller than 15 FTEs, have a minimum of a Bachelor of Science in Nursing, or equivalent time (diploma) with RN licensure, have been employed in a formal nursing leadership position in a facility with a bed size of no less than twenty beds, and spent less than 50% of the position in direct patient care, I invite you to participate in my study about CS, BO, and intent to stay among nurse leaders. You will be directly contributing to new nursing knowledge and making a difference in our profession. This study is being conducted by a researcher named Lisa Surby, who is a doctoral student at Walden University.

Appendix C: Demographic Information Questions

1. How long have you been in your current formal leadership position?
2. What is your age in years?
3. What is your gender?
4. To Whom do you directly report?
5. What is the bed size of the facility in which you serve in your current formal leadership position?
6. What percentage of time do you spend in direct patient care?
7. What is your highest professional degree?
8. In which state do you work?
9. How many FTEs are you responsible for?
10. How many years have you worked in the nursing profession?

Appendix D: Compassion Satisfaction and Compassion Fatigue (PROQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative. as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days.*

1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Very Often

1. I am happy. BO (reverse score)
2. I am preoccupied with more than one person I help. STS
3. I get satisfaction from being able to help people. CS
4. I feel connected to others. BO (reverse score)
5. I jump or am startled by unexpected sounds. STS
6. I feel invigorated after working with those I help. CS
7. I find it difficult to separate my personal life from my life as a helper. STS
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help. BO
9. I think that I might have been affected by the traumatic stress of those I help. STS
10. I feel trapped by my job as a helper. BO
11. Because of my helping, I have felt “on edge” about various things. STS
12. I like my work as a helper. CS

13. I feel depressed because of the traumatic experiences of the people I help. STS
14. I feel as though I am experiencing the trauma of someone I have helped. STS
15. I have beliefs that sustain me. BO (reverse score)
16. I am pleased with how I am able to keep up with helping techniques and protocols. CS
17. I am the person I always wanted to be. BO (reverse score)
18. My work makes me feel satisfied. CS
19. I feel worn out because of my work as a helper. BO
20. I have happy thoughts and feelings about those I help and how I can help them. CS
21. I feel overwhelmed because my case (work) load seems endless. BO
22. I believe I can make a difference through my work. CS
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help. STS
24. I am proud of what I can do to help. CS
25. As a result of my helping, I have intrusive, frightening thoughts. STS
26. I feel “bogged down” by the system. BO
27. I have thoughts that I am a “success” as a helper. CS
28. I can’t recall important parts of my work with trauma victims. STS
29. I am a very caring person. BO (reverse score)
30. I am happy that I chose to do this work. CS

Appendix E: Intentions to Stay Scale

This instrument consists of seven items, each rated for agreement on a five-point scale with the following response options: Strongly Disagree, Disagree, Neutral, Agree, and Strongly Agree. Consider each of the following questions about you and your current work situation. Select the number that best describes your feelings about your current work situation.

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

1. I expect to be working for my current employer one year from now.
2. I would change jobs if I could find another position that pays as well as my current one. (reverse scored, #32 on Survey Monkey)
3. I am actively looking for another job. (reverse scored, #33 on Survey Monkey)
4. I would like to work for my current employer until I retire.
5. I would prefer to be working at another organization. (reverse scored, #35 on Survey Monkey)
6. I can't see myself working for any other organization.
7. I would feel very happy about working for another employer (reverse scored, #37 on Survey Monkey)

Appendix F: Permission to Use PROQOL

Stamm, B.H. (2010). The Concise ProQOL Manual, 2nd Ed. Pocatello, ID

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Appendix G: Permission to Use Intentions to Stay Scale

Mayfield, Jacqueline R <XXX@tamiu.edu>
Thu 10/17/2019 3:17 PM
To:

- Lisa Surby;
- Mayfield, Milton R <XXX@tamiu.edu>

Cc:Leslie C. Hussey <XXX@mail.waldenu.edu>

Hi Lisa,

You are welcome to use the scale. We have released it under a Creative Commons license. Please let us know if you have any further questions.

Your dissertation sounds very interesting. Best wishes for a successful and fulfilling journey!

Kind regards,
Jackie and Milton

Professors of Management, A. R. Sanchez Jr. School of Business
Co-Editors, International Journal of Business Communication

Jacqueline R Mayfield
Professor
Division of International Business & Technology Studies