Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2022

Critical Care Nurses' Experiences of Compassion Satisfaction During a Pandemic

Michael W. Bailey
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

 Part of the Nursing Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Michael Bailey

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Carolyn Sipes, Committee Chairperson, Nursing Faculty
Dr. Janice Long, Committee Member, Nursing Faculty
Dr. Deborah Lewis, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

Critical Care Nurses' Experiences of Compassion Satisfaction During a Pandemic

by

Michael Bailey

MS, Walden University, 2018

BS, University of South Florida, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

August 2022

Abstract

Nursing shortages caused by burnout (BO) and compassion fatigue (CF) are a concern for nursing leaders in the United States. Researchers have discussed the mediating effect compassion satisfaction (CS) has on BO and CF in current studies; however, no qualitative studies have analyzed the experiences of nurses with CS. A combination of the compassion fatigue resilience model and Roy's adaptation model were used to guide this study that examined critical care nurses' lived experiences with CS during the COVID-19 pandemic. Convenience sampling was used to recruit the critical care nurses who participated in semistructured interviews. Data saturation was met after five interviews. The resulting data were analyzed using interpretive profiles and manual coding to generate categories and themes. The emergent themes were recognition, helping, and support, indicating that the positive feelings of receiving recognition, providing care, and receiving support from colleagues promoted CS. Recommendations for future research include a mixed methods study that examines quantitative levels of CS prior to semistructured interviews that could be conducted to confirm and expand upon the findings of this study. The potential for positive social change from this study lies in the ability to both maintain and increase the CS of nurses within critical care. Increasing CS may act to mitigate the effects of CF, resulting in less critical care nurse BO and turnover.

Critical Care Nurses' Experiences of Compassion Satisfaction During a Pandemic

by

Michael Bailey

MS, Walden University, 2018

BS, University of South Florida, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

August 2022

Dedication

I dedicate this study to my wife, Samantha “Sam,” who stood by me every step of the way. She has been my cheerleader when the workload seemed too difficult and my taskmaster when I needed to be directed back to my goals. To my father-in-law, Mike, who believed in me until his last day and reminded me that good things come out of the hard work we do. I also dedicate this study to my son, Aidan-Michael, who reminded me constantly that I could do whatever I tried to do as long as I was willing to put in the work.

Acknowledgments

I would like to take an opportunity to thank everyone who helped me in this journey. Thank you to the nurses who volunteered their time and shared their experiences with me. A very special thanks to my dissertation chair, Dr. Carolyn Sipes, who kept me on task and provided endless support through both her own personal struggles and mine. She was always available to speak to or assist professionally. Thank you also goes to Dr. Janice Long and Dr. Leslie Hussey for the support I have received from them throughout my masters and doctoral journey. I am forever grateful to everyone else I did not mention but who contributed in some fashion to the successful completion of this dissertation.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

The numbers of bedside nurses needed today is more than the numbers of those that are available (Gennaro, 2020). The demand for nurses skilled in critical care delivery is particularly high in view of the COVID-19 pandemic that increased patient admissions to excessive levels in critical care hospital units; yet, little is known about the experiences nurses in critical care settings had during the pandemic. Several factors have been studied in the past to demonstrate the impact of compassion fatigue (CF), burnout (BO), secondary traumatic stress (STS), and compassion satisfaction (CS) on nurses caring for critically ill patients; however, no researchers have qualitatively studied the lived experiences of nurses during the COVID-19 pandemic. CF and BO can lead to nurses leaving the profession, while in contrast, CS acts to mitigate the effects of CF and BO by causing an increased sense of satisfaction in one's work (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). The current study was important to conduct now because identifying factors or situations that maintain or increase CS can help health care leaders alleviate the effects of BO.

In this chapter, I present the background of the study and the problem statement related to the existing gap in literature. The purpose, research question, theoretical framework, and nature of the study are also provided. Additionally, I define related terms as well as discuss the assumptions, scope, limitations, and the significance of the study.

Background of the Study

The field of nursing is experiencing a shortage of available bedside nurses (Gennaro, 2020). The COVID-19 pandemic has increased this shortage due to the increased stressors placed on nurses (Credland, 2021). Conditions that lead to nurses leaving the bedside nursing role are important to address to reduce a further increase in the shortage. Nursing schools provide opportunities for people to become nurses, but preventing them from leaving the bedside prematurely remains a focus for current researchers (Gennaro, 2020).

Nurses, as caregivers, may experience STS through their daily work with patients (Figley, 1995), and STS can lead to nurses leaving their positions as bedside caregivers due to BO and CF (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Ruiz-Fernández, Ramos-Pichardo, et al., 2020; Sarosi et al., 2021). Figley (1995) and Stamm (2021) discussed the concepts of CS and CF where having higher levels of CS is the preferred state for caregivers. Increasing nurses' CS has also been discussed as a mitigating factor to prevent BO in nurses caused by CF (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). CF and CS are on opposite ends of the Professional Quality of Life (PROQOL) scale but are not directly related (Stamm, 2010). For example, having a high CS score does not correlate to having a low CF score (Stamm, 2010). The positive effect of CS is that it can limit the effects of CF and reduce the chances of the nurses experiencing BO and leaving the field of nursing.

In this study, I addressed the gap in knowledge of the experiences of critical care nurses during a pandemic with a focus on experiences with CS. Previous researchers have provided CS scores in their research into CF, but the concept of CS has not been researched thoroughly. The current body of research is focused on CF rather than CS. The findings of this study may provide the information needed for health care leaders to initiate programs and processes to increase nurses' CS. With a better understanding of what the nurses' experiences are with CS, health care leaders may be able to modify the environment to increase staff CS, which could lead to positive social change through the increased job satisfaction of and increased quality of care by nurses as well as reduced nurse turnover.

Problem Statement

The research problem addressed in this study was the lack of understanding of the experiences of critical care nursing staff that contribute to nurses feeling CS in their work. I identified the lack of research into CS as a meaningful gap in the current body of research. One of the studies I reviewed found that CS scores for nurses increased during the peak of the pandemic in Spain but failed to identify the cause for the increase (Ruiz-Fernández, Ramos-Pichardo, et al. 2020). The nursing field today is experiencing a lack of nurses working in hospitals (Gennaro, 2020). This nursing shortage is accentuated by the added stress caused by increased census and patient acuity during the COVID-19 pandemic (Credland, 2021) One factor that can add to this nursing shortage is the attrition of existing nurses prior to retirement age (Sacco, 2017). CF and BO have both been shown to be a causative factor in nurses' early retirement (Boamah & Laschinger, 2015).

In my work as a pediatric trauma nurse, I experienced CF and BO when caring for pediatric trauma patients, resulting in me leaving the field of pediatric nursing. CF can be described as the negative feeling or emotions a caregiver experiences when caring for those who are suffering (Ruiz-Fernández, Pérez-García, et al., 2020). BO and STS have been identified as component parts of CF, and BO was identified as a determining factor in nurses leaving the profession (Ruiz-Fernández, Pérez-García, et al., 2020; Stamm, 2010).

CS, which is the positive feelings one derives from work, was identified as having a negative correlation to CF (Babaei & Haratian, 2020; Okoli et al., 2019). Researchers have reported average mean scores for CS amongst nurses in the studied populations, based on the ratings set forth in the PROQOL tool, but have failed to determine what accounts for the score (Babaei & Haratian, 2020; Balinbin et al., 2020; Okoli et al., 2019; Ruiz-Fernández, Pérez-García, et al., 2020; Ruiz-Fernández, Ramos-Pichardo, et al., 2020). Authors noted that the mitigating effect CS has on CF suggests that increasing CS will reduce the effects of CF (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). Ruiz-Fernández, Ramos-Pichardo, et al. (2020) reported one incidence in which CS scores for nurses increased while scores for physicians decreased. The social support movement was identified as a likely cause for the increased CS. Identifying and sharing the experiences of critical care nurses related to CS may help determine ways to increase CS for other nurses and address the gap in research literature.

Purpose of the Study

The purpose of this qualitative, interpretive, phenomenological study was to explore the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. Ruiz-Fernández, Ramos-Pichardo, et al. (2020) found that nurses experienced higher levels of CS during the peak of the epidemic in Spain and posited that the increased CS may have been a result of the recognition the nurses received from the general public. I conducted semistructured interviews with open-ended questions to gather the critical care nurses' experiences related to CS during the COVID-19 pandemic.

Research Question

What are critical care nurses' lived experiences with CS during the COVID-19 pandemic?

Theoretical Foundation

The models that grounded this study were Figley's compassion fatigue resilience model (CFRM) and Roy's adaptation model (RAM; see Figley & Figley, 2017; McEwen & Wills, 2019). The logical connections between the framework presented and the nature of the current study include Figley's (1995) work on CF as a foundation to the current research on CF and CS. Figley's research with the use of the CFRM relates to my research problem and purpose because it describes and defines resilience within the care provider that acts to mitigate the effects of the stressful working environment by preventing increased CF. According to Figley and Figley (2017), one way to increase resilience is to increase CS that mitigates CF.

The CFRM includes a description of the effects of the satisfaction a care provider receives from their work (Figley & Figley, 2017). This sense of satisfaction can be quantified as CS using the PROQOL scale, which uses Likert-style questions to generate scores for CS and CF (Stamm, 2010). The PROQOL, a validated tool, further divides CF into BO and STS and is accepted as the standard for measuring CS, BO, and STS (Babaei & Haratian, 2020; Balinbin et al., 2020; Hunt et al., 2019; Okoli et al., 2019; Ruiz-Fernández, Pérez-García, et al., 2020; Ruiz-Fernández, Ramos-Pichardo, et al., 2020; Yu et al., 2021). I did not use the PROQOL scale in this research study, but it may be useful to employ in follow-up studies. The CFRM also addresses the need to monitor the environment of workers as a first step to lowering compassion stress and preventing CF (Figley & Figley, 2017). The response to the environment discussed in the CFRM supports the use of RAM.

RAM is representative of a grand nursing theory in which the conceptual framework is focused on the interconnected, holistic individual and their interaction with the environment (McEwen & Wills, 2019). RAM provides a framework for identifying phenomena that influence individuals' responses to stressful situations as described in the stimuli created by the work environment. The key concept of RAM is the effect of the environment. In RAM, the person interacts with their environment and is seen as an adaptive system (McEwen & Wills, 2019). Figley and Figley (2017) discussed how the environment can affect CF in their work with the CFRM.

The individual's adaptation to the environment was a focus of this study. I created semistructured interview questions to explore this adaptation according to RAM and

discussed the environment in which the critical care nurses work and how it affects their CS. I evaluated which component(s) in the environment added to the CS of each nurse in this study.

Nature of the Study

To address the research question in this qualitative study, I employed an interpretive phenomenological approach using open-ended, semistructured interview questions to explore critical care nurses' experiences with CS (see Reiners, 2012). I used the interpretive phenomenological approach to understand CS as it is perceived by the nurses experiencing it (see Cypress, 2018; Lopez & Willis, 2004). The interviews were facilitated by me, but participants were encouraged to describe their own experiences and perceptions without interruption.

Prior to beginning interviews, I provided participants with a basic description of the study, including the potential for social change. Participants were also provided with an electronic consent form for them to complete prior to the interviews beginning. I gave each study participant a number for identification rather than using their names to maintain confidentiality and mask the participants' identities. All transcripts and recordings were identified by number rather than participants' names.

I audio recorded the interviews and kept a researcher journal to aid in the analysis of transcribed data. Interviews continued until data saturation was achieved (see Guest et al., 2020). Transcriptions of interviews were coded to derive thematic codes and patterns using the constant comparison of information entered into a code book to allow for the identification of recurrent themes. I carried out thematic analysis and coding on all the

interview transcripts to determine the underlying themes and concepts as well as determine when data saturation was met. In addition to coding and thematic analysis, the transcribed portions of the interview responses were placed into a word cloud generator to determine if there were similarities between participants' answers. I was unable to find research showing if word clouds assist in interpretation but thought the unbiased nature of a computer program may prove beneficial. Digital recordings and transcripts were stored on an encrypted thumb drive and will be kept in a locked, secure location for 5 years. Paper versions of transcripts were shredded and destroyed once the information was stored digitally.

Definitions

The following key terms are used frequently throughout the study and are defined to provide clarity and understanding:

BO: A negative secondary outcome of CF that, if too high, can lead to an individual leaving their occupation (Stamm, 2010)

CF: The negative feeling or emotions a caregiver experiences when caring for those whom are suffering (Ruiz-Fernández, Pérez-García, et al., 2020)

CS: The pleasure, satisfaction, or sense of well-being an individual derives from the work they do (Stamm, 2010)

STS: The emotional distress or duress a caregiver experiences when witnessing others experiencing stress (Figley, 1995)

Assumptions

Theofanidis (2018) noted that assumptions are inherent in all research, defining them as ideas, views, or conditions the researcher accepts to be true. The primary assumption I made in this study was that there would be enough participants willing to take part in the study. Nurses practicing in critical care areas are busy due to the increased patient load caused by the current COVID-19 pandemic. Because their personal time is important to them, nurses may not have been willing to take the time to share their experiences with me in their off time. A further assumption was that the participants would be both able and willing to share their experiences regarding CS while working in critical care. There existed a possibility that the nurses were not experiencing CS in their daily positions. The absence of CS is something that I was aware of as being a potential concern. In an attempt to increase their willingness to participate, participants were ensured that their identities would be kept confidential. One final assumption was that the nurses would have examples of experiences with CS to share. CS is not a topic that has been discussed frequently in nursing. The study participants may have had experiences that fall into the concept of CS but may not have realized that they met the definition and goals of this research study.

Scope and Delimitations

Delimitations are limitations set by researchers and include things such as the boundaries and scope of a study (Theofanidis, 2018). The scope of this study included full-time RNs working in intensive care units whose primary role is bedside nursing. Nurses whose primary roles are supervisory in nature were excluded. I chose intensive

care nursing because of the increased likelihood of the nurses' exposure to patients' traumatic events related to illnesses. In my experience, critical care areas are infrequently pushed beyond standard staffing ratios. The increased stress caused by staffing ratios and other external factors for general floor nursing are may to interfere with the goals of this study. Repeating this study in different nursing settings is a potential plan for future research. The goal for the current study was to recruit between five and 30 nurses to take part in the study with the hope that this will lead to saturation (see Guest et al., 2020). Saturation may be reached once interviews fail to reveal little or no new information (Guest et al., 2020).

Boundaries within a research plan are also seen as delimitations (Theofanidis, 2018). I established boundaries for the pool of potential participants. The participants, as discussed above, were limited to those nurses working in intensive care units. Although there are multiple critical care units, I set my boundary and excluded those not working in trauma care units. The population of trauma nurses is a further specialization that can be studied in the future.

I considered Watson's theory of caring as an early option for a foundational theory but ruled it out due to its position as a grand theory that focused so closely on the nurse-patient relationship. CS is a product of both the caregiver relationship with the patient and the environment (Figley & Figley, 2017). I also included RAM in the conceptual framework to add a focus on the effect of the environment. Watson's theory, while potentially useful to explain the relationship between the patient and the caregiver, cannot be easily used to address the interactions with the environment.

Limitations

Theofanidis (2018) noted that limitations are outside of the control of the researcher but can affect a study's results. One limitation in this study has a potential to affect transferability. This study only included the experiences of intensive care nurses, which may not be appropriate or representative outside of the critical care areas. The day-to-day experiences and stressors of floor nursing may not be the same as critical care nursing. The critical nature of the intensive care unit dictates smaller staff ratios that are not seen on general medical units. My hope is that the critical care nurses' experiences gathered in this study were general enough to not only be applicable to nurses in all areas but to all those providing care as a profession.

The second limitation of this study was the introduction of personal bias. I have experienced both CF and CS in my current and former roles. There is a potential that my own preconceived ideas of what increases CS cause bias to be introduced in this study. Creswell (2018) stated that researchers should list their potential biases in their studies. To reduce the chances that bias would affect this study, I recorded and transcribed all interviews and used participants' wording when possible. Interview questions were open ended without the use of leading questions.

The presence of the COVID-19 pandemic was another limitation of the study. The current state of nursing has been affected by the pandemic, and this research study addressed the effects of CS during the current pandemic. The limitation lies in the idea that the effects of the pandemic are expected to subside as the COVID-19 pandemic

comes under control. The experiences that increased CS during the pandemic may not be the same after the pandemic has passed.

Significance of the Study

This study is significant in that it helps to identify the lived experiences of critical care nurses in relation to CS. CS is a mitigating factor to both CF and BO (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). Identifying these experiences could lead to a positive social change by allowing the development of a model and the creation of environments that lead to increased CS in other nursing populations. Higher CS scores should mitigate BO, increase staff satisfaction, and decrease turnover.

Significance to Practice

This study is significant in that it helps identify the lived experiences of critical care nurses in relation to CS. Current literature has focused on investigations into CF and the negative aspects STS. While these researchers have investigated what aspects of nursing care create negative feelings, research into CS focuses on how to create and encourage the positive feelings a person receives through caring for the same patients. Since current research into CS is limited, the topic was an important one to study. Identifying experiences related to CS could lead to the development of a model that helps to increase CS in critical care and other nursing populations. CS is a mitigating factor to CF and BO (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). Higher CS scores should mitigate BO, increase staff satisfaction, and decrease turnover.

Significance to Theory

The current research regarding CS and CF is primarily discussed in relation to Stamm's (2010) PROQOL scale, which was built upon the work of Figley. Researchers have studied CF and different ways to reduce it in recent studies (i.e., Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). This study, with its focus on CS, adds another dimension to the discussion surrounding the use of the PROQOL scale in the field of nursing. If experiences are identified that add to caregivers' CS in nursing, it may lead other researchers to study similar effects in other caregiving professions.

Significance to Social Change

Increasing CS in nurses is the positive social change that may result from this study. Identifying what helps nurses feel a greater sense of satisfaction from their jobs will both help them personally and professionally (Sacco, 2017). Increased levels of CS may also lead to greater personal satisfaction, lower turnover, and increased quality of care (Sacco, 2017).

Summary and Transition

In this chapter, I presented the background of the study and the problem statement related to the existing gap in literature. I also provided the purpose, research question, theoretical framework, and nature of the study. Important terminology was described, along with the assumptions, scope and delimitations, limitations, and the significance of the study. In Chapter 2, I will present a literature review as well as the strategies I used to identify relevant key research articles.

Chapter 2: Literature Review

The social problem addressed in this study was understanding the CS experiences of critical care nursing staff during the COVID-19 pandemic. The purpose of this qualitative, interpretive, phenomenological study was to explore the lived experiences of critical care nurses working during the COVID-19 pandemic related to CS. In this literature review, I focus on the concept of the lived experiences of nurses working in health care in relation to CS, including the current literature on both CS and CF because they are interrelated through the PROQOL. The literature review also contains a discussion of the gap in research and how my chosen methodology addressed it.

Literature Search Strategy

I conducted a comprehensive search of existing literature and continued to review new publications throughout the research process. To begin, I used a general search tool that accesses multiple databases concurrently. The databases searched included CINAHL, Medline, PsycInfo, ScienceDirect, ProQuest, and PubMed. I also conducted a separate search using the Embase database to access articles from around the world. The search was limited to peer-reviewed articles published from 2016 to 2021. The keyword search terms used were *compassion satisfaction, qualitative, nurse, nursing, critical care, intensive care,* and *ICU.* I searched these same terms in all databases, resulting in 120 potential articles. The abstracts for each of the articles were reviewed for content to determine if they should be included in this study. Articles that did not meet the needs of this study were discarded. I also set up an email alert to look for new articles related to

the above search terms and scheduled for Fridays. New articles were reviewed as they were located until this study was completed.

Little is known about the experiences nurses in critical care settings had during the COVID-19 pandemic. Several factors have been studied in the past to demonstrate the impact of CF, BO, STS, and CS on nurses caring for critically ill patients; however, no previous researchers have qualitatively studied the lived experiences of nurses during the COVID-19 pandemic. This study's aim was to address these gaps in the research literature.

Theoretical Foundation

CFRM

The CFRM was developed to predict which caregivers would be more likely to be vulnerable to the stress of caring for suffering clients (Ludick & Figley, 2017). An important component of the CFRM is self-care, which is described as practices and activities aimed at increasing the overall well-being of an individual (Figley & Figley, 2017). Self-care is an approach that limits the negative effects of CF (Ludick & Figley, 2017). This was useful to this study because one of the strategies the CFRM discusses is the sense of satisfaction of care providers. Stamm (2010) defined this sense of satisfaction as CS.

The CFRM contains three strategies to reduce the effect of STS on caregivers (Figley & Figley, 2017). One of the components of the model is a sense of satisfaction (Ludick & Figley, 2017). The sense of satisfaction detailed in the CFRM is also referred to as CS, which Stamm (2010) defined as the positive feelings a person derives from

caring for suffering persons. Wang et al. (2020) described the sense of satisfaction derived from trauma work as a way to reduce the effects of CF in caregivers working with trauma patients. Other researchers have identified negative relationships between CS and CF, such as Babaei and Haratian (2020) and Okoli et al. (2019) who found a significant inverse correlation between CS and CF.

The satisfaction component of the CFRM pertained directly to this study. The goal of this study was to explore the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. Ludick and Figley (2017) provided a framework to explain the empathetic ability of caregivers that could lead to CF resilience. One of the components that was discussed but has not been studied to a great extent is the satisfaction of caregivers that Stamm (2010) described as CS. Exploring the concept of CS provides the opportunity to promote social change through increasing staff satisfaction and reducing the effects of CF. In this manner, this study has the potential to decrease BO in critical care nurses and increasing the quality of care they provide to patients. Nursing BO can lead to nurses leaving the profession, which increases the existing staff shortage (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Ruiz-Fernández, Ramos-Pichardo, et al., 2020; Sarosi et al., 2021). The presence of CS is important, but identifying the factors that lead to it was the focus of this study. I identified RAM as a complementary model that helped identify environmental factors affecting CS.

RAM

RAM was another core theoretical foundation for this study. RAM is based on the assumption that a nurse's interactions with the environment affects their ability to adapt to situations (McEwen & Wills, 2019). The key concept of RAM is the effect of the environment on nurses. It is necessary for nurses to adapt in order to be able to respond positively to their patients' health or level of illness (Roy & Andrews, 2008). RAM is relevant to this study because of its focus on the nurses' interactions with environmental factors and how they influence the nurse as a holistic individual (see McEwen & Wills, 2019).

Previous researchers have begun to tease out the relationship between RAM and CF. Browning Callis (2020) applied RAM in conjunction with an existing nursing program to assist nurses in developing self-care programs to help reduce the effects of CF. However, the concept of CS and how increasing it can help reduce the effects of CF was not addressed in the study. In the current study, I used the environmental effect concept of RAM as a basis for exploring the lived experiences of critical care nurses in relation to CS. Identifying environmental factors that increase CS presents the opportunity for positive social change by increasing nurse satisfaction and reducing the effects of CF.

Literature Review

PROQOL

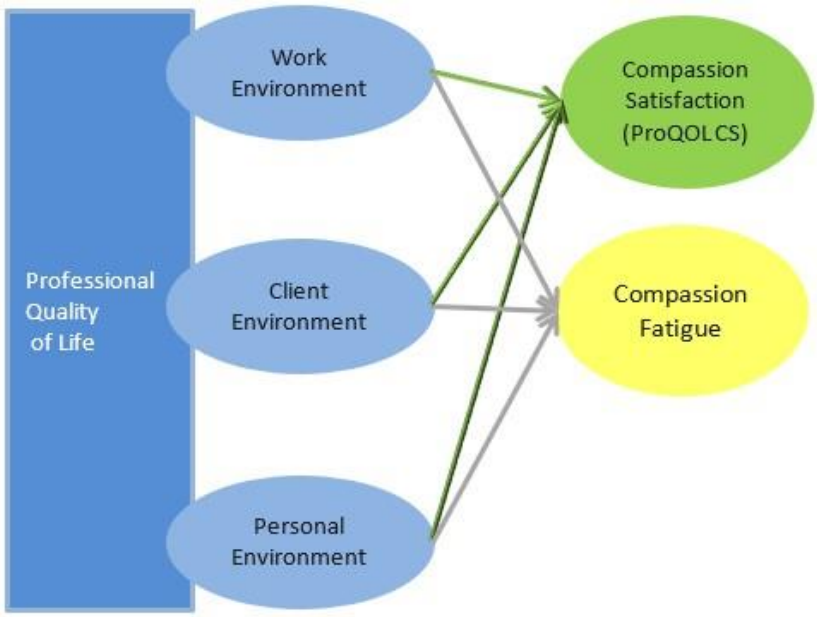
PROQOL is a description of how a care provider feels in relation to their work helping others (Stamm, 2010). The quality is affected by both positive and negative work

environments and interactions. Nurses and many other health care professionals fall under the category of workers described in the PROQOL. The PROQOL is divided into two categories: CS and CF (Stamm, 2010). CS is described as the positive feelings one obtains from caring for others. CF, which is further divided into BO and STS, is the negative emotions or feelings caregivers experience as a result of caring for others. Organizational prevention programs are believed to increase caregiver CS while reducing the risk of CF and BO (Stamm, 2010).

Organizations that implement programs to increase CS are more likely to have both increased job satisfaction and employee well-being (Sacco et al., 2015). The complexity in the PROQOL lies in the concept that both CS and CF are affected by the work, client, and personal environment. Figure 1 shows a portion of Stamm's PROQOL with the interactions between environments and CS. The environments that interact with the nurse affect both the CF and CS portions of the PROQOL. The review of extant research provided information about CF and CS, but CS has not been a focus of previous research. CS levels of nurses and other caregivers are provided in current research regarding CF and the PROQOL, but they are not extensively addressed.

Figure 1

Professional Quality of Life



Adapted from "The Concise ProQOL manual," by B. H. Stamm, 2010, p. 11 (https://proqol.org/proqol-manual)

Predictors of CS

Nurses working with patients that are suffering are at risk for internalizing their patient's suffering (Figley, 1995; Okoli et al., 2019). CS can be achieved from relieving the suffering of patients and be an inspiration to continue working with them (Yu et al., 2016). Unfortunately, in the current health care environment, there is no test or indicator that reveals if a nurse is likely to have higher levels of CS. However, Yu et al. (2016) found there to be predictors that helped to show which nurses would have higher levels of CS. Yu et al. performed a cross-sectional survey of 669 oncology nurses in the hospitals of Shanghai, China, using a demographic questionnaire; the Chinese version of the

PROQOL; and four other tools designed to measure empathy, coping style, social support, and the Chinese Big Five Personality Inventory to collect data. The researchers identified that empathy, social support, and active coping styles were positively correlated to CS with statistical significance. Four of the personality traits measured (i.e., openness, extraversion, agreeableness, and conscientiousness) had a significant positive relationship, with only neuroticism having a negative relationship with CS. Notably, one dimension of empathy stood out as accounting for 23% of the variance related to CS. Perspective taking was identified as the strongest predictor of CS in the group studied (Yu et al., 2016). Indeed, Figley (1995) had previously identified empathy as a risk factor for CF in nurses. In further studies, Figley (2002) stated that levels of empathy could predict levels of CF. Nursing holds empathy as a core value and a pillar of nursing care (Kelly, 2019). This conflict points to the idea that empathy is a predictor of both CS and CF, leading to the need for further research into the subscales of empathy. If consistent predictors for CS in nurses can be identified, it could lead to the development of screening tools for staff in areas with higher risks of CF.

While the current study focuses on critical care nurses, Yu et al. (2016) highlighted the population of oncology nurses within the Chinese health system. Other scholars have identified oncology nurses as being at high risk for developing CF (Okoli et al., 2019; Sacco et al., 2015; Wang et al., 2020). However, critical care nurses are similar in their risk to developing CF as oncology nurses (Okoli et al., 2019; Sacco et al., 2015; Wang et al., 2020; Yu et al., 2021). Critical care nurses are not only exposed to patients suffering from oncologic diseases but also many other traumatizing diagnoses. Inherent

personal predictors are components of the personal environment discussed in the PROQOL.

Work environments can affect both CS and CF levels of critical care nurses (Figley, 1995; Stamm, 2010). Negative aspects of the work environment can cause staff to feel the effects of BO and CF (Figley, 1995, 2002). Ruiz-Fernández, Pérez-García, et al. (2020) conducted a study of 1,521 nurses working in the Andalusian Public Health System of Spain that was designed to investigate relationships between socio-demographic and work environments and nurses' quality of life, as measured by the PROQOL (as an approved Spanish translation offered by the PROQOL office). Extensive socio-demographic and work-related data were collected for each participant prior to providing them with the PROQOL questionnaire. Participants worked in a combination of primary care and hospital settings across rural, urban, and semiurban settings in Spain. One component lacking in the study was the number of staff working in critical care settings. Age, marital status, and shift worked were determined to have a significant correlation to CS. Age was negatively correlated to CS. Divorced participants had a higher level of CS when compared to married participants. Morning shift and 12-hour shift nurses had significantly higher mean scores than morning/evening or morning/evening/night shift nurses. After initial differences were identified, the researchers developed models to attempt to predict CS and CF. Linear regression was performed to assess the predictive capacity of each of the models created. In regards to CS, Model 5 had the greatest predictive capacity. The variables identified to decrease CS were urban area, primary care, morning/evening/night shift, and age. Of these findings,

the data surrounding age conflicts with the findings of other studies performed on the topic. Previous studies have identified either no correlation or a positive correlation between age and CS (Sacco et al., 2015; Yu et al., 2016).

The study conducted by Ruiz-Fernández, Pérez-García, et al. (2020) is another example of a quantitative study designed to explore CF, BO, and CS in nurses. Their study reinforces the idea that there are existing variables within the environment of nurses that help to affect or predict the nurses' quality of life. CS is the component of the quality of life that was of the most interest in the current study. Ruiz-Fernández, Pérez-García, et al.'s published demographics do not identify the ratios of the different levels of care but remain valuable in that the data shows that the social and work environment does affect CS.

Chen et al. (2018) reported the results of a quantitative, cross-sectional, descriptive study of 173 female nurses working in pediatric areas of a Taiwanese children's hospital. The purpose of their study was to describe personality traits and their association with CS and CF and to identify determinants of CS and CF based on socio-demographic variables and personality traits. They used the Chinese versions of Figley's Compassion Satisfaction and Fatigue Test and the revised NEO-Personality Inventory. The three-part study began with the collection of socio-demographic information followed by the Compassion Satisfaction and Fatigue Test and the revised NEO-Personality Inventory. G-power calculations estimated the necessary sample size to be 139, but the researchers were able to recruit 173 suitable participants. The majority of the

nurses surveyed (60.7%) worked in critical care areas. The data used were collected in 2014, which was well before the COVID-19 pandemic.

In their study, Chen et al. (2018) identified that all five of the personality traits measured (i.e., openness, conscientiousness, extraversion, agreeableness, and emotional stability) were positively associated with CS. CF was negatively associated with conscientiousness, agreeableness, and emotional stability. While CS and CF were not shown to be associated with each other, the three common traits identified could be used to develop a strategy to increase CS and decrease CF.

In an attempt to assess determinants of personality traits and socio-demographic factors on CS and CF, Chen et al. (2018) performed multiple linear regressions using the socio-demographic variables and personality traits. Four determinants were identified as accounting for 43.6% of the variance for CS. The determinants, in order of magnitude, were agreeableness (22.3%), extraversion (12.2%), conscientiousness (7.1%), and engaging in outdoor activities (2%). Only two factors were identified as predictors of CF, accounting for 26.1% of the variance. The identified factors were emotional stability (23.1%) and being single (3%). Both factors were seen to have negative relationships with CF in that being more emotionally stable and having a marital partner related to lower CF.

The reported CS of the study participants were higher and CF levels were lower than in other studies Chen et al. (2018) discussed. The hospital used for their study had programs in place and a workplace culture designed to be supportive. Bonuses, programs supporting group social activities, and debriefing programs may have had an effect on the

overall CS and CF scores. A comparative study with another hospital without these programs could be beneficial in identifying programs that help increase CS and decrease CF. Because their study population comprised only female nurses from only one hospital and only from the pediatrics unit, their results are difficult to compare to other hospitals and specialties, but the identified relationships can be used as a background for other studies.

CS Quantitative Studies in Critical Care

Critical care nursing offers challenges of its own. Sacco et al. (2015) stated the stress of caring for patients in a critical care setting are often increased due to the increased ability to spend time with each patient. In a two-part study conducted by Jakimowicz et al. the researchers focused on critical care nursing and its relationship to CS and CF. The study began with a cross-sectional survey of critical care nurses working in two Australian intensive care units, Jakimowicz et al. (2018) sought to identify factors that contribute to and would predict CS and CF (2018). The PROQOL survey tool was provided for nurses at both sites with a secure survey submission collection container (Jakimowicz et al., 2018a). Demographics were analyzed and reported for both survey sites. Demographic and occupational characteristics were analyzed by site and between sites to determine the presence of factors that could be linked to difference in CS, CF, STS, and BO scores. Findings common to both sites revealed a significant negative relationship between CS and BO (Jakimowicz et al., 2018a). The positive feelings and personal satisfaction felt decreased the chance of burnout in study participants. Education level, years of practice, tenure, and place of work were identified as having significant

influence on CS and CF. Years of experience and tenure were positively related to CS. Postgraduate education was linked to higher CS but was not found to be independently predictive. Nurses at in one unit had significantly higher CS scores and lower STS scores. Researchers reported this difference as likely being related to the unit being a more specialized unit.

Nevertheless, the study was observational by design, limiting the ability to determine causal relationships. The presence of differences points to the need for further research designed to assess causality and of factors related to CS differences. The limited sample size of the Jakimowicz (2018a) study, in whole and at each site, reduces its generalizability to other populations outside of the two hospitals studied. Authors identified the need for further qualitative studies to explore CS in critical care nurses.

CS Qualitative Study

In a follow up to the original study, Jakimowicz et al. (2018b) explored the relationships between patient-centered nursing, CS, and CF. Researchers used in-depth interviews with 21 of the critical care nurses from the Australian intensive care units surveyed in their 2016 study (Jakimowicz et al., 2018b). Researchers used Charmaz's grounded theory constructivist methodology in the interview and research process. The qualitative portion of the study included 21 of the original 117 critical care nurses. Participants recounted both positive and negative events in their work which were analyzed using NVIVO 11 software and coded by the primary researcher. All researchers agreed to the coding as emerging themes were identified.

Jakimowicz et al. (2018b) identified a core category of expectation as a balance between CS and CF. When the nurses felt they were meeting their expectations they would have more moments of CS. When the nurses identified they were not meeting their expectations they would have more moments of CF. The core category of expectations was subdivided into the nurses' perceived expectations of self, regulatory bodies, work (management team and culture), and colleagues. Nurses were identified as moving along a continuum between meeting and not meeting expectations correlating to moving from more CS to more CF and back depending on the moment. Findings from the Jakimowicz follow up study support the idea that work and personal environments have an effect on CS and CF levels. Work environments can be compared to the expectations of regulatory bodies, place of work, and colleagues. In my study, the expectations of self and colleagues will be discussed as personal environments.

The follow up Jakimowicz study focused on 21 Australian nurses working in two hospitals. This limited study location and population may limit the ability to generalize the results to the larger population of critical care nurses. The qualitative nature of the study points to the idea that more qualitative research may be beneficial to the greater body of nursing. The limited number of qualitative studies can be interpreted as a gap in research that needs to be filled.

Mediating Factors of CS

Lee et al. (2021) performed a quantitative, cross-sectional study of female RNs from Korean hospitals to evaluate the mediating effects of STS and CS on BO and professional quality of life. Researchers used the Korean version of the Nurses' Health

Study, which began in the United States in 1976. The Korean study was based on the original study protocols. PROQOL Version 5 was used to measure STS, BO and CS for study participants. The final study population consisted of 10,305 female nurses working in different Korean hospitals. Within the population, the largest percentage of nurses worked in inpatient units (40.0%). Critical care nurses ranked third in percentage, making up 15.8% of the population.

The results of the study showed that both STS and CS had mediating effects on BO in relation to stress (Lee et al., 2021). STS had a positive relationship BO caused by stress and CS had a negative relationship. The magnitude of the effect of CS on BO was significantly greater than the relationship of STS. Identifying processes, programs, or policies that increase CS will have the effect of reducing BO (Lee et al., 2021). Reducing BO will reduce the likelihood that nurses will leave the profession.

The limitations of this study primarily exist within the study population. The participants were only female. While there is a large percentage of females in the nursing profession, the field of nursing does contain other gender identities. Within the Korean health system 4.8% of the nurses identify as male (Lee et al., 2021). The study was secondary in nature, reducing the ability to identify causality in the results. The study did not provide the ability to determine what factors led to CS levels in the nurses. While CS scores were measured, the quantitative design did not allow for a discussion of what environmental factors predicted CS levels.

In a cross-sectional survey of five secondary hospitals in Manila, Philippines, Balinbin et al. (2020) sought to determine CS and CF levels of nurses working on

medical-surgical units while trying to identify the occupational determinants that affected them. The sample consisted of 121 nurses from secondary and tertiary hospitals. Subjects were provided with the PROQOL, McCloskey-Mueller Satisfaction Survey, Eden Warmth Survey-Employee Questionnaire, and a demographic profile sheet. The McCloskey-Mueller Satisfaction Survey was chosen as a measure of job satisfaction while the Eden Warmth Survey measures nurse-colleague relationships.

The study results reported by Balinbin et al. (2020) revealed nurses as having moderate levels of CS, BO, and STS with above midpoint scores for job satisfaction and nurse colleague relationships. Of the occupational determinants measured (monthly income, duration of work hours, job satisfaction, and nurse colleague relationships) only job satisfaction and nurse colleague relationships had an influence on CS. The influence of nurse colleague relationships (adjusted $\beta = .28$, $p = .004$) was slightly stronger than job satisfaction (adjusted $\beta = .27$, $p = .006$). Higher monthly income has a significant positive influence on both BO and STS levels (subscales of CF). Nurse colleague relationships had a negative influence on both BO and STS levels. A larger percentage of nurses (90.09%) were shown to have moderate to high CS levels than those with moderate to high levels of BO and STS (74.38% and 83.47%, respectively).

Important findings of this study show that both nurse-colleague relationships and job satisfaction positively influenced CS while negatively influencing the subscales of CF. Identifying factors that promote colleague relationships could help facilities to positively influence CS in their staff. Nurse salary was shown as having positive influence on BO and STS. The reasons behind this finding were not measured, but

researchers theorized that the increased responsibilities often seen with increased pay played a role in this finding.

The scope of the survey being limited to medical-surgical areas prevents directly generalizing the results to nurses working in critical care areas. The cross-sectional design of the study does not allow the researcher to determine the effects of a nurse having a negative work interaction on the day of the study, negatively affecting survey results. The sample size could help to reduce this possible influence, but not entirely. The focus on secondary and tertiary hospitals further limits the generalizability of the findings to primary care hospitals.

CS During COVID-19

In a 2020 study performed by Ruiz-Fernández, Ramos-Pichardo, et al. CS, CF, BO, and perceived stress were measured in healthcare professionals working in Spain during the first peak of COVID-19. One key finding of the study showed that nurses' CS was increasing despite the added stresses of the COVID-19 pandemic (Ruiz-Fernández, Ramos-Pichardo, et al., 2020). The study design used was a cross-sectional descriptive quantitative study utilizing online surveys to maintain social distancing. Data collection was completed during March and April 2020. From the 587 professionals that responded 506 surveys were considered eligible. Study participants included both nurses and physicians working in hospitals performing patient care.

CS, in this study, was inversely related to CF, BO and perceived stress. This relationship is consistent with the finding of other studies (Babaei & Haratian, 2020; Figley, 1995; Gribben et al., 2019; Lee et al., 2021; Okoli et al., 2019; Ruiz-Fernández,

Pérez-García, et al., 2020; Sacco et al., 2015; Yu et al., 2016). CF and BO levels of professionals were higher during the COVID-19 pandemic when compared to pre-pandemic levels (Ruiz-Fernández Ramos-Pichardo, et al., 2020). CF and BO scores in both nurses and physicians increased during the pandemic. One key finding was that the CS scores of nurses were significantly higher than CS scores for physicians. The nurses' CS scores during the pandemic were also higher than CS scores measured in the same setting just prior to the pandemic.

The measured increase in CS scores was hypothesized to be a result of nurses feeling supported by local social movements of support. The ability of nurses to see direct results of their hard work was also identified as a potential reason for the increase in CS levels. The increase in CS levels is an important finding to follow up, but the conditions or factors that cause the increase were not identified. The design of the study allowed for measurement of scores but not for identification of causative factors. The data reported in the study did not differentiate whether the staff identified as working in critical care were nurses or physicians. This lack of differentiation prevents determining the changes in CS scores for each of the groups of nurses in the study.

Chosen Methodology

I wanted my study to fill the existing gap in literature which is the lack of studies that explore the lived experiences of critical care nurses working during the COVID-19 pandemic related to CS. As presented above, there are numerous studies published that have measured CS, BO, and STS in nurses working in different areas of the hospitals. None of the studies identified addresses nurses working in critical care using qualitative

methodologies. Because the COVID-19 pandemic is new, there is little research into its effects on CS and CF. To address this gap in literature, I performed a qualitative interpretive phenomenological study utilizing semi-structured interviews to focus on the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic.

Cypress (2018) described phenomenology as an approach that seeks to explore and understand the daily experiences of people. Interpretive phenomenology seeks to understand the significance of the experiences of people as they are reported by those experiencing them without removing the researchers own knowledge (Fuster Guillen, 2019; Lewis & Willis, 2004). Qualitative studies utilizing a phenomenological approach focus on identifying common themes within lived experiences among a specific group of people with the goal of describing the phenomenon being studied (Creswell, 2018). The findings of interpretive phenomenology are a combination of the understandings of the participants and the researcher (Lewis & Willis, 2004).

What Needs to be Studied

The gap in current literature is the absence of studies addressing CS in nurses before or during a global health pandemic. The current body of has been focused primarily on CF, while only reporting incidental findings related to CS. Only one studied identified included a qualitative approach focused on CS. This single study does not fill the void that exists in the understanding of CS in nurses or other healthcare providers.

Summary and Conclusions

The above literature review included an examination of current literature related to CS. One study included nurses' perceptions of factors related to CS, but no study addressed the lived experiences of critical care nurses related to CS. There are numerous studies that have been done on CF fatigue that also report CS levels, but none of the studies were directly focused on CS. BO in nurses has been directly linked to nurse attrition. CS has been shown to be a limiting factor to BO and CF. Identifying factors or conditions that lead to increased CS or help maintain current CS levels could help reduce staff loss due to BO.

Chapter 3 will include a description of the qualitative interpretive phenomenological approach that will be used to explore the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. It will include a discussion of the chosen research design, my role as the researcher, qualitative methodology. The chapter will also include a description of the study design and how the issues of trustworthiness will be addressed.

Chapter 3: Research Method

The purpose of this qualitative, interpretive, phenomenological study was to explore the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. In this chapter, I describe the research design and methods. The rationale; my role as researcher; the participant selection process; the instrumentation; the procedures for recruitment, participation, and data collection; the data analysis plan; issues of trustworthiness; and ethical procedures are also presented.

Research Design and Rationale

The research question at the center of this study was: What are critical care nurses' lived experiences with CS during the COVID-19 pandemic? The research design used for this study was a qualitative, interpretive, phenomenological approach based on Heidegger's approach to phenomenology. Interpretive phenomenology involves the use of an interpretive approach rather than the descriptive approach of Husserl (Reiners, 2012). Heidegger's approach to phenomenology assumes the researcher's knowledge and background are both present and important in interpretive phenomenology (Lopez & Willis, 2004). The phenomenon being studied was the lived experiences of CS in hospital critical care nurses during the COVID-19 pandemic. I chose an interpretive phenomenological design using semistructured interviews to allow the nurses to share their experiences in their own words and from their own views. Ravitch and Carl (2016) described semistructured interviews as a way for researchers to use a theoretical model to form the basic questions while allowing for follow-up questions to expand and clarify topics with participants.

I chose a phenomenological design because it allowed me to describe the lived experiences of the nurse participants experiencing the phenomenon of CS without having to remove my own knowledge of the phenomenon (see Gray et al., 2017; Lopez & Willis, 2004). Interpretive phenomenology is used to explore participants' lived experiences by listening to their day-to-day experiences in the context of their daily workplace and social interactions (Lopez & Willis, 2004). Having an increased understanding of the nurse participants' experiences was necessary to determine the factors that are affecting their CS. Identifying these factors allow for the possibility of positive social change by providing health care leaders with information to use to develop plans to increase nurse CS.

I considered other qualitative designs but opted against using them because they did not meet the needs of this study. Ethnographic qualitative research provides a framework for studying a culture or specific group of people with similar characteristics (Gray et al., 2017). The participant observation methods utilized in ethnographic research would not have allowed me to explore the breadth of lived experiences that were needed for this study. Case studies were immediately removed from consideration due to the need to hear the nurses' descriptions of their personal experiences. Open discussions with participants allow the researcher to observe the nonverbal reactions of the participant that may not be present in a written case study. Narrative researchers examine how stories are told and how participants make sense of their experiences (Gray et al., 2017). The lived experiences were discussed in the interviews, but I focused on the common themes shared between each of the participants rather than one participant's experiences. The

richness brought forth by including the individual experiences of multiple participants was the focus of this study.

Role of the Researcher

I functioned in the role of primary researcher, data collector, and data analyzer in this study. I recruited participants from the critical care areas of the hospital system where I work. The critical care areas were a focus due to the professional relationship I have with the nurses in the emergency departments of the same hospitals. Although I do not have a direct role in the professional lives of potential participants, I may have been the instructor for some classes they had attended. I am employed at the corporate level rather than at the local hospital level. This separation provided for a relationship with the nurses that is not supervisory in nature, only supportive in the classroom setting. I have experienced both CF and CS in my role as a pediatric critical care nurse, leading to my personal interest in this phenomenon.

I addressed confidentiality by de-identifying all study participant data. Participant records are identified by number only. Participants were informed of this practice and ensured that their names would not be recorded in any study-related documentation. The study location was adjacent to my own work environment. Because of this, I gave the participants the opportunity to leave the study at any time and have their information removed from the study. There was no expected conflict related to my role as instructor due to the voluntary aspect of all classes that I teach. The only mandatory class that I teach is orientation, but new employees were not included in this study. Prior to

beginning this study, I sought and received approval from the Walden University Institutional Review Board (IRB) as well as the IRBs of the hospital study sites.

Methodology

I used a qualitative phenomenological approach in this study of the lived experiences of CS in critical care nurses during the COVID-19 pandemic. Data were collected through a semistructured interview process. The interviews began with demographic data collection (see Appendix B), then I asked participants a series of semistructured, open-ended questions from the interview guide developed for this study (see Appendix A). The participants were asked to describe their experiences with CS in their role as critical care nurses because they have unique perceptions of their roles. Interviews were conducted via Zoom meetings and audio recorded without the use of video. Recordings were transcribed and analyzed through a manual coding and constant comparison process to discern themes and patterns using previously identified interview themes. Once interviews failed to provide new information, I determined data saturation had been met. All data underwent analysis and was prepared for presentation in Chapters 4 and 5.

Participant Selection Logic

I chose the participants for this study using convenience sampling, which allowed me to recruit enough nurses from the chosen population to meet the needs of the study. Demographic data were collected but were not required prior to selecting participants (see Gray et al., 2017). Using a convenience sample of willing participants provided results more efficiently than having to analyze the sample demographics and determining

how to obtain a sample with maximum variation. It is possible that some amount of snowball sampling happened, but participants were not asked to recruit new participants. However, participants were asked to let fellow staff members know how the interview process went.

Inclusion criteria for the study population were full- or part-time RNs working in intensive care units whose primary role was bedside nursing. There was no minimum education requirement for study participants. At the beginning of the study, there were no LPNs working in the critical care areas of the study site. During the study, LPNs did start working in critical care areas, but there were no LPNs that met the criteria to be included in the study. Nurses with more than 6 months of experience were encouraged to participate in the study. Because the orientation period for new nurses at the study site was 6 months, this allowed the nurses in the sample to be working on their own. Experiences of the nurses during their orientation period were not excluded from this study because gathering the participants' personal lived experiences was the goal of this study.

Exclusion criteria for study participants included supervisors and trauma nurses. Nurses whose primary roles were supervisory were excluded from this study. This decision was made to allow for the focus to be on practicing bedside nurses' experiences rather than those of leaders. Trauma critical care nurses were also excluded from the study due to their focus being solely with the trauma population. Only one of the study site facilities had a trauma designation. Trauma critical care nurses experience a different patient population as well as different stressors, so collecting the lived experiences of

trauma critical care nurses may be a good topic for follow-up studies to determine if there are differences between the critical care areas.

I recruited nurses by discussing the study with the executive leadership teams of each hospital. After obtaining permission to study nurses in each hospital, I scheduled meetings with the directors of selected critical care units in each of the four area hospitals to obtain permission for a participant recruitment poster to be placed in breakrooms. I presented a brief description of the study at team huddles and staff meetings. An email introducing the study's purpose was sent to the nurses working in the critical care units using a prebuilt, dynamic email list. Posters and emails included a description of the inclusion and exclusion criteria for prospective participants. Willing participants were provided with my contact information to allow for the scheduling of interview sessions.

My goal was to recruit enough nurses to take part in the study to reach data saturation (see Guest et al., 2020). The original goal was to recruit five nurses for the study; however, I knew that more nurses would have to be recruited if data saturation was not met. Saturation was met after five interviews because no new information was being found (Guest et al., 2020). Interview transcripts underwent coding and thematic analysis after each interview to help determine when the study reached saturation. I used constant comparative analysis to compare data collected between interviews to assess for similarities and differences. When the transcripts began to have redundant themes and answers, all data were reviewed to determine if data saturation had been achieved.

Instrumentation

I collected data during the interview sessions by using a digital audio recorder. If the interview occurred on the phone, the conversation would have been recorded by using speaker phone. All participants were informed of the use of a recording device prior to beginning the interview. I also utilized a journal for keeping specific notes during the interview. Each recording was transferred to a secure, encrypted thumb drive and kept securely in a locked, fireproof safe. I am the only person with access to the safe. Transcripts were created using the Dictate tool in Microsoft Word 365. Using the constant-comparative method, I compared transcripts to the audio recordings to ensure their accuracy.

A review of current literature did not result in the identification of an existing data collection tool that directly matched the goals of this study. Therefore, I created an interview guide for use in the semistructured interviews (see Appendix A). Ravitch and Carl (2016) stated that the purpose of an interview guide in a semistructured interview is to guide the interviewer but that it can include specific and follow-up questions. The interview guide listed questions that were asked of all participants but allowed me the flexibility to ask follow-up questions when necessary.

I developed the interview guide based on a review of current literature. Jakimowicz (2018b) and the PROQOL manual questions were adapted to meet the needs of this study. Constant comparative analysis ensured that the interview guide was revised based on the results of each interview. If new information was obtained in an interview

that could be revealed with a new question in future interviews, I added the question to the interview guide.

Other than recording and transcribing tools, there were no other data collection instruments used. All data collected in this study were obtained during real-time interviews. Data from outside sources, such as data repositories, were not utilized in this study.

Procedures for Recruitment, Participation, and Data Collection

To recruit participants, I created a flyer describing the study and my goal to use it for partial completion of my doctorate program. Flyers also included my contact information for the participants and a description of the potential interview process. I stated the expected length of in-depth interviews for interested participants to be approximately 1 hour. The flyer was posted in the critical care areas of four local hospitals after obtaining the permission of the units' leadership team. I also created an electronic version of the flyer that was sent out via email to the nurses working in the same critical care areas. When potential participants contacted me, I ensured they met inclusion criteria and arranged an interview date, time, and location with them. If the original four hospitals had not provided enough study participants to reach data saturation, there were three other groups of four hospitals in which I could have expanded the participant recruiting process once permission was received from their leadership. Participants were provided with the appropriate Walden University IRB consent form to be completed prior to their interviews. The Walden IRB approval code is 02-28-22-0686227.

I was the sole researcher and interviewer for this study. I utilized a digital audio recorder and paper journal during each interview. The semistructured interview guide was followed in each interview (see Appendix A). Each participant was provided with a participant number to maintain participant confidentiality. I conducted face-to-face interviews via the Zoom meeting platform when the participants were willing to meet with me. Upon completion of the interview, participants were thanked for their participation and given my contact information. I also reminded them that their information would be kept confidential. I offered them the chance to receive a final copy of the published study and asked how they would like to receive it.

I addressed confidentiality by de-identifying all study participant information. Participant records were identified by number only. Participants were informed of this practice and ensured that their names would not be recorded in any study-related documentation. The study location was adjacent to my own work environment. Because of this, participants were given the opportunity to leave the study at any time and have their information removed from the study. There was no expected conflict related to my role as instructor due to the voluntary aspect of all classes that I teach. The only mandatory class that I teach is orientation, but new employees were not included in this study. Prior to beginning this study, I obtained approval from the Walden University IRB as well as the IRBs of the hospital study sites.

Data Analysis Plan

I collected data during the interview sessions by using a digital audio recorder. All participants were informed of the use of a recording device prior to beginning the

interview. I also utilized a journal for keeping specific notes during the interviews. Each recording was transferred to a secure, encrypted thumb drive and kept securely in a locked, fireproof safe. I am the only person with access to the safe. Transcripts were created using the Dictate tool in Microsoft Word 365. Using the constant-comparative method, transcripts were compared to audio recordings to ensure accuracy.

I analyzed and coded data manually, without the use of available software and stored it on a secure, encrypted drive. Using a manual coding process allowed me to have a better sense of the themes and subthemes as well as to interpret and code the data in a personal rather than clinical way. The decision to avoid existing software removed the need to learn how to use the software and allowed me to focus on the study itself.

Once interviews were transcribed, I compared them to the audio recordings. If edits were needed, they were done prior to printing new transcripts. Transcripts were then read fully before I made any types of notations. Following the recommendations of Cypress (2018), I read the transcripts several times to fully understand the entire interview and describe the connection of data to the research question. Notes in a different colored ink were made in the margins of both the transcript and my field journal. After this process was completed, I created interpretive profiles for each interview.

Interpretive profiles allow the researcher to analyze each interview and compare it across interviews (Oerther, 2020). Oerther (2020)describes a three-step process for creating interpretive profiles. The first step involves defining the case. In my study each case was an individual person. The second step provides a background of the participant.

In this stage, the researcher defines the participants' demographics, describes their work area, and conveys their general demeanor. The background stage also includes the field notes taken during the interview. This section allows the researcher to create a broad sketch of the participant enabling them to be recalled by the researcher when reviewing this section. The third step is focused on the aims of the study and involves the collection of coded excerpts from the interview. Coded excerpts were listed under the major codes.

The coding process was a repetitive cycle using descriptive codes in the first cycle. Saldana (2015) described the coding process from initial descriptive codes to identifying themes and concepts. First pass coding used descriptive codes to represent different statements made by the participants. These first codes were identified after reading the transcripts of each interview multiple times. After this first cycle, I looked for patterns within the identified codes. Each identified pattern or group of similar codes was further collected into a category. The categories identified were reviewed for completeness and inclusion of all initial codes. If some initial codes were not represented in a category I would have needed to determine if they were data outliers or if they could stand alone as distinct codes (see Saldana, 2015). There were no outliers or discrepant cases identified.

The final goal of the coding process is to identify common themes or concepts (Saldana, 2015). The identified categories and themes were further grouped together into any identified themes or concepts. The themes identified in each interview transcript were then compared to those of the other transcripts using the constant-comparative

method. In this stage, I looked for themes that were common between each of the participants.

The profiles from each interview were constantly compared to the profiles of previous interviews to determine when data saturation was met (Ravitch & Carl, 2016). Once interviews failed to provide new information, interviews were determined to be complete. At that point, the combined information from all interviews was analyzed for themes and data was be compiled for presentation.

Issues of Trustworthiness

Credibility

Credibility in research is met when the research findings are consistent with reality (Stahl & King, 2020). Credibility was maintained through saturation. Interviews continued until there was very little or no new information being obtained from participants (Ravitch & Carl, 2016). Interview were conducted with several participants rather than relying on only a few participants. Continuing interviews until little new information was obtained adds to the credibility of this study by reducing the chance of outliers affecting the data.

Transferability

Transferability in qualitative research is the ability to generalize of transfer the findings of a study to another setting (Stahl & King, 2020). Transferability of research was achieved through a thorough description of the study and the factors affecting it. A full description of the demographics of participants and study locations was maintained allowing for a thick description of the study.

Dependability

For qualitative research to be dependable it would need to produce the same results if conducted or analyzed by another researcher (Creswell & Creswell, 2018). Dependability in this research was maintained by a modified peer review process. I presented the findings of my research to my dissertation chair to ensure that the information I collected and my interpretations were reflective of the research conducted. Triangulation is evident in my use of reflective journaling throughout the research process.

Confirmability

When qualitative research is as close to objective as possible, it is deemed to be confirmable (Creswell & Creswell, 2018). I met the requirements of confirmability by utilizing a reflective journal. I also read the raw data multiple times prior to coding and reread after coding was completed to ensure the results remained consistent. Data were also be submitted to my dissertation chair to check for accuracy.

Ethical Procedures

My research plan and goals were submitted, using the proper forms, to Walden's IRB for review and authorization prior to performing any research or recruitment. The IRB for the local hospital system was also involved prior to beginning the research process. I have completed the doctoral student research training through the Citi Program (certificate number 40122039). All participants completed an informed consent prior to becoming a participant. Participants were informed of their right to stop the interview process at any time as well as having their information removed. Strict confidentiality of

participants and their information has been maintained. Data will be kept on a secure encrypted thumb drive which will be locked securely in a safe until it is destroyed in accordance with the time line set by the Walden University IRB.

Summary

In this chapter, I detailed the methodology of my research including the research design and rationale; my role as researcher; the participant selection process; the instrumentation; the procedures for recruitment, participation, and data collection; the data analysis plan; issues of trustworthiness; and ethical procedures. Chapter 4 will provide the details regarding the research setting, participant demographics, data collection and data analysis. It will also describe and provide evidence of trustworthiness.

Chapter 4: Results

In this interpretive phenomenological study, I explored the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. I conducted individual, semistructured interviews with the five participants recruited from the critical care units of three local hospitals. This study was conducted to identify common factors that critical care nurses used to develop, maintain, or increase their CS while working with critically ill patients. I researched CS to understand what improves nurses' CS levels. The information obtained from this study can be used by health care leaders to improve and maintain CS levels of nurses. By maintaining CS levels, leadership may be able to reduce BO and staff turnover. In this chapter, I present the results of the study as well as discuss the research setting, data collection methods, identification of themes, and evidence of trustworthiness.

Research Setting

I conducted individual interviews for this study using the Zoom conferencing platform. Participants were encouraged to pick a location that offered both comfort and privacy for each interview. I conducted interviews from my own private office. Participants had been selected and screened using the inclusion and exclusion criteria detailed in previous chapters. To recruit participants, flyers were posted in the breakrooms of the three facilities that I selected for this study and invitation letters were sent via email to all critical care nurses in the three hospitals. Prospective participants emailed me to express their interest. All participants reported seeing the flyers in their

break areas and locker rooms. Staffing challenges existed during recruitment, which likely extended the time required to identify enough nurses to reach data saturation.

Demographics

I conducted interviews with five nurses before reaching data saturation. All communication with participants took place via email prior to the interviews. Each candidate provided an electronic consent via email prior to scheduling an interview time. All candidates were working full-time in mixed critical care areas and identified as female. Table 1 provides the participant demographic data.

Table 1

Participant Demographics

Demographic Information	No. of participants
Worked in critical care < 5 years	3
Worked in critical care 5–15 years	2
Associate's degree	1
Bachelor's degree	4

Data Collection

I started data collection in March 2022 and ended in June 2022. I conducted individual interviews during this time with participants as they were able to. Interviews times and dates were selected by participants to increase their ability to dedicate the time needed as well as provide for their comfort. Interviews were conducted using Zoom Meetings and recorded with a digital audio recorder. I followed the data collection plan described in Chapter 3 without the need for exceptions. Participants all used video during the meetings, which resulted in rich data collection. I journaled using pen and paper

during each of the interviews. Journaling was used to annotate participants' demeanor and body language, but it did not provide added information for the study.

Interview durations ranged from 12 to 25 minutes in length. Each interview began with a predetermined script to provide the participant with standard information and allow them to become comfortable before being asked questions (see Appendix A). By following this practice, I allowed participants to be at the same starting point as each other as well as understand the process for the study and the interview. Once participants were comfortable and ready, I began recording and asked the open-ended questions listed on the semistructured interview guide. I allowed and encouraged participants to share as much information as they felt was necessary. Participants shared their experiences without interruption. I asked clarifying questions as needed during the interviews without redirecting the conversation. Some of the participants misunderstood the difference between compassion and CS causing me to clarify the goal of detailing CS rather than nurse compassion. All interviews proceeded without natural or electronic interruption.

Data Analysis

I immediately collected the data in each interview and transcribed them for initial coding. I compared initial coding to previous interview codes to check for data saturation. The codes derived from each interview matched previous interviews from the second interview. I found that data saturation could have been identified after the second interview but chose to continue for a total of five interviews before deciding data saturation was met.

I transcribed the interviews by processing the digital recording with Microsoft 365 Word transcription. I read and compared transcriptions to the audio recording three times before considering them accurate and correct. Each transcript was then added to a Microsoft Excel spreadsheet for passage highlighting. The spreadsheet was divided between questions and answers as well as by participant. I highlighted participants' statements to identify the responses that inspired each code. I identified the combined codes of all participants on the spreadsheet and used them to determine the overarching themes identified by the research. The themes identified were (a) recognition, (b) helping, and (c) support.

Evidence of Trustworthiness

Credibility

Credibility in research is met when the research findings are consistent with reality (Stahl & King, 2020). I conducted interviews with five participants to ensure data saturation was met. The codes derived from each interview were matching after the second interview, but I chose to continue interviewing a total of five participants to meet the intent of credibility in research.

Transferability

Transferability in qualitative research is the ability to generalize or transfer the findings of a study to another setting (Stahl & King, 2020). I provided the relevant demographic data and work location information to allow others to understand the backgrounds and work settings of the study participants. Other researchers and readers

can transfer the findings of this study based the results provided without the need to replicate the study in their own setting.

Dependability

For qualitative research to be dependable, it would need to produce the same results if conducted or analyzed by another researcher (Creswell & Creswell, 2018). Dependability was met by ensuring the transcripts of the recordings were accurate and complete. I compared my journal notes created during each interview to the transcripts to ensure the transcripts were accurate, complete, and matched the message being provided by each participant. I conducted interviews at times and locations chosen by participants to meet their needs. This process was used to ensure that the environment and time of interview did not affect the quality of data obtained during each interview.

Confirmability

When qualitative research is as close to objective as possible, it is deemed to be confirmable (Creswell & Creswell, 2018). To address confirmability, I provided transcripts and data to my chair for guidance during the research process. Transcripts were put through an intense, repetitive review process to ensure data accuracy. Codes were chosen based on participants' own words rather than my own.

Study Results

I used the following research question to explore the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic: What are critical care nurses' lived experiences with CS during the COVID-19

pandemic? The themes identified are detailed and presented in the following subsections and tables.

Theme 1: Recognition

Participants detailed the positive feelings generated from the recognition they received. Recognition of their work and importance was identified from patients and their families as well as from leadership and the public (see Table 2).

Table 2

Response: Recognition

Theme	Description	Participant	Responses
Recognition	The recognition received about the work they were doing and care they were providing	P1	Some patients are very grateful, and some families are very grateful
		P2	Having support and recognition from my peers
		P3	They (leadership) understand what we really needed
		P4	The way I was treated by the patient recognition from them
			Leadership being cognizant of how hard we work
			Managers and supervisors recognize you
		P5	When patients are appreciative as well, you know or their family
			If somebody says thank you

Theme 2: Helping

Participants described the positive feeling they received through their own acts of caring. Identifying their own part in the process of their patients getting through and better from their illnesses provided for positive feelings that helped CS (see Table 3).

Table 3

Response: Helping

Theme	Description	Participant	Responses
Helping	Participants seeing their patients through their course of treatment	P1	One person who I saw survived COVID
		P2	Being able to tell amazing stories when we saved someone
		P3	Patients that made it out of ICU and it was a great, great feeling
		P4	I still enjoyed, especially when we had good outcomes
		P5	That one person you do help out of 1,000 really does make a huge impact and you take that little piece of the one positive thing

Note. ICU = intensive care unit.

Theme 3: Support

Participants explained that support received from colleagues, leaders, and the public went towards developing positive feelings and a sense of purpose in their work. The positive feelings described helped both maintain and increase their individual CS (see Table 4).

Table 4

Response: Support

Theme	Description	Participant	Responses
Support	Help received to allow them to care for their patients	P1	Studies and new medications that were coming gave you like an extra push to keep going
		P2	Support from my peers and being able to talk about our feelings, frustrations, and anxiety helped us feel better
		P3	Leadership were more involved and did work a shift on the floor
		P4	When families are cognizant of how hard we work Staffing ratios
		P5	When good strong leaders support you as a nurse

Summary

In this study, I explored the experiences of critical care nurses related to CS while working in a critical care setting during the COVID-19 pandemic. All participants were recruited through the use of flyers and emails. Once their interest was identified, I emailed participants to detail the consent process. After consent was obtained, I conducted individual semistructured interviews depending on each participant's schedule and availability. The audio recordings of the interviews were transcribed and coded for theme identification.

Each participant shared their experiences and feelings in relation to CS in critical care. Three themes emerged describing participants' experiences with CS in critical care: (a) recognition, (b) helping, and (c) support. In Chapter 5, I will discuss the themes

identified, make recommendations, and present final conclusions based on the findings of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

In this interpretive phenomenological study, I explored the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. The following research question guided this study: What are critical care nurses' lived experiences with CS during the COVID-19 pandemic? The theoretical foundation for this study was a combination of Figley's CFRM and RAM. I designed the research question and interview questions to align with both the CFRM and RAM. The five participants interviewed in this study all worked in critical care during the COVID-19 pandemic. Their inherent experiences with CS were discussed during the semistructured interviews. The results of this study provide the foundation of an understanding of the experiences of critical care nurses with CS. Three common themes emerged related to maintaining and increasing CS: recognition, helping, and support. In this chapter, I provide the themes identified and limitations of the study, make recommendations for further research, and discuss the potential for social change.

Interpretation of Findings

CS has been identified as being a mitigating factor to the effects of CF (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). CF and BO have both been shown to be causative factors in nurses' early retirement (Boamah & Laschinger, 2015). Ruiz-Fernandez, Pérez-García, et al. (2020) found the desire to quit the nursing profession and not want to go to work were direct consequences of CF. Boamah and Laschinger (2015) showed that BO has a direct effect on staff turnover intentions. The existing research, detailed in Chapter 2, on CF and

CS focuses primarily on CF. Ruiz-Fernández, Ramos-Pichardo, et al. (2020) reported an increase in nurses' CS levels from a mean score of 39.7 to 39.9 during the COVID-19 pandemic in relation to nurses being able to connect with their own motivation for caregiving, seeing the results of their work, and the social support movement recognizing the efforts of health care professionals. During the same period, physician CS scores decreased from 38.2 to 37.1 (Ruiz-Fernandez, Pérez-García, et al., 2020, Ruiz-Fernandez, Ramos-Pichardo, et al., 2020). The themes identified in this study reinforce the findings of Ruiz-Fernandez, Ramos-Pichardo, et al. (2020).

Recognition

The five participants shared their experiences with recognition of their work. At its basic level, recognition is acknowledging how the nurses' efforts affected the experiences of the patients and their families. All participants described the sense of satisfaction and fulfillment they felt as a result of recognition they received. The recognition received came from patients, families, coworkers, and leadership teams.

Table 5

Recognition Sources

Source	Responses
Patients and families	Some patients are very grateful Some families are very grateful The way I was treated by the patient recognition from them When patients are appreciative If somebody says thank you
Coworkers	Having support and recognition from my peers
Leadership	They (leadership) understand what we really needed Leadership being cognizant of how hard we work Managers and supervisors recognize you

The CFRM provides a description of the satisfaction care providers receive from their work (Figley & Figley, 2017). Each of the participants described how the thankfulness of families and recognition of management helped foster a sense of satisfaction and provided the motivation to continue in their work. P1 and P5 both stated that receiving recognition and thanks from patients and families helped add to the satisfaction they received from caring for patients. P2 stated that the recognition she received from her coworkers increased the satisfaction she received from her work. P4 and P5 both stated the management team's recognition of their hard work added to their own CS. The health care environment described in RAM provides for an understanding of how recognition from family members and leadership is the stimulus that provides for the increased levels of CS (see McEwen & Wills, 2019). The increase in CS that the study participants described confirms the idea that care provider satisfaction can be

obtained through recognition and promoting an environment that allows for nurses to be recognized for their work.

Helping

The theme of helping is a combination of the personal sense of accomplishment derived from caring for others and the sense of success felt when a patient's situation improves as a result of the care received from the health care team. Each nurse on the team has their own personal motivation for choosing the nursing profession. Each participant stated that seeing patients survive and get better allowed them to feel satisfaction and encouraged them to keep doing their job (see Table 3). It is possible that the unique circumstances of the COVID-19 pandemic provided the opportunity for nurses to reconnect with their own motivation. Each of the participants described how seeing the results of their work provided the motivation to continue in their career and how it increased their own CS.

According to McEwen and Wills (2019), RAM describes the holistic nature of the environment and how its interactions effect the individuals within it. The nurses' responses to seeing their patients' situations improve reaffirms the interconnected nature of the care environment and the nurses' responses. It is important for nurses to see the fruits of their labor (i.e., see the results of their caring). It is beneficial for nurses to see that their efforts can lead to success for their patients.

Support

Support was the final identified theme. Support was what each nurse received that allowed them to continue their caring efforts. Organizational and leadership support can

lead to increased CS and employee well-being (Sacco et al., 2015; Stamm, 2010). All the participants recounted receiving some type of support that either allowed them to or helped them continue their daily work. Each participant's example of support differed while still exhibiting an underlying commonality.

Support for P1, who stated "studies and new medications that were coming gave you like an extra push to keep going," was derived from the larger community and scientists. P2, P3, P4, and P5 described the support received from coworkers and leadership in the form of listening or encouragement that their work was helping patients. Support from leadership was also described when leaders and managers took time to work on the floors with their staff, whether providing direct patient care or performing supportive tasks. P4 also reported the support she received from families when they were cognizant of how hard the staff were working helped to increase her satisfaction.

The supportive work environment described by participants confirms the concepts described in RAM. Nurses' interactions with environmental factors and how they influence the nurse as a holistic individual are described in RAM (Roy & Andrews, 2008). The positive interactions between the environment and the participants of this study added to their CS.

Limitations of the Study

One of the potential limitations for this study was the recruitment of participants from hospitals in close proximity to each other that were within the same hospital corporation. The leadership culture within similar hospitals may have effects on the work environment that are dissimilar to other hospitals. Transferability to nurses working for

hospitals outside of the company and area may be affected. This was not specifically accounted for in the design of the study but may be a factor for other researchers wishing to repeat the study. Information regarding hospitals and the themes derived were not identified as being specific to a particular leadership philosophy.

The recruitment of individuals during the COVID-19 pandemic acted as another limitation. Recruitment took much longer than I originally expected due to the staffing situations created by the pandemic. Existing nursing shortages were exacerbated during the research period, causing nurses to avoid the perceived extra work of participating in a research study. This was partially mediated by asking each participant to let their coworkers know about the study and the interview process as a part of snowball sampling.

The final limitation experienced was the lack of understanding of the concept of CS. Early participants thought the study was involving the compassion of nurses rather than the concept of CS. To limit the effect of this, I developed the recruitment flyer to include a definition of CS and reviewed this definition with the participants prior to each of the interviews. The potential for personal bias relating to my own experiences and preconceptions with CS were limited by sharing all interview transcripts with my chair and using the exact words of participants throughout the coding process.

Recommendations

CS has been identified as a mitigating factor to CF and BO (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). The existing body of research focuses on CF and its effects rather

than the concept of CS. Further research is needed to identify ways leadership can foster and improve CS in nurses. Nursing, however, is not the only caring profession in need of increasing CS (Figley, 1995). Figley (1995) listed other caring professions, such as psychology, social work, and teaching, that would benefit from increasing CS.

Follow-up qualitative studies in other nursing areas, such as emergency medicine, pediatrics, and general medicine, could lead to a better understanding of CF's effect and CS as a mitigating factor. Conducting similar research studies in other caring professions, such as social work and psychology, may also prove beneficial to increasing the overall knowledge of CS in caring professions. Repeating this study in other hospitals' critical care areas could help confirm the findings of this study.

This interpretive phenomenological study was the first qualitative study identified that addressed CS. The existing body of research used quantitative methods to explore CF while also providing CS scores. Stamm's PROQOL scale has been used extensively in quantitative research to measure CS and CF. A mixed methods study using the PROQOL scale to divide participants between levels of CS prior to conducting semistructured interviews with them could confirm and expand upon the findings of the current study.

Implications

This study's potential for positive social change lies in the ability to both maintain and increase the CS of nurses within the affected population. Increasing CS may act to mitigate the effects of CF, resulting in less nursing BO (Babaei & Haratian, 2020; Balinbin et al., 2020; Jarrad & Hammad, 2020; Okoli et al., 2019; Sarosi et al., 2021; Yu et al., 2021). According to Ruiz-Fernandez, Pérez-García, et al. (2020) and Stamm

(2020), BO results in nurses leaving the profession, so increasing CS will decrease nursing turnover in an environment where nursing shortages already exist. Nursing is a top caring profession, but it is important to care for those that are doing the caring.

Creating an environment that both helps maintain and increase CS in care providers may help with both staffing concerns and the quality of patient care. Developing new programs and expanding existing recognition programs will add to the overall sense of recognition and satisfaction for each nurse. Recognition programs, such as the Daisy program, recognize exemplary care providers, but these programs do not exist in every hospital. Organizations that implement programs to increase CS are more likely to have employees with both increased job satisfaction and well-being (Sacco et al., 2015). Organizational prevention programs are believed to increase caregiver CS while reducing the risk of CF and BO (Stamm, 2010).

Supportive leadership should be encouraged and developed rather than promoting high performing staff. The existing practice of recruiting and supporting leaders should include training programs that reinforce the need to be both supportive to clinical staff and present at the bedside rather than solely performing administrative duties, such as participating in meetings. One change in practice may be to only allow directors to attend meetings and have managers remain available to work with staff and patients.

The theme of helping can be supported by creating programs that allow patients' progress to be followed by their initial care providers. Critical care nurses experience the sense of satisfaction by seeing their patients transfer out of critical care, but they do not see the final steps of their patients' progress. Staffing could also be arranged to allow care

providers to have the same patients for as many days as possible. This continuity of care has been a philosophy of some areas but can be interrupted when staffing necessitates nurses floating to other areas. It can also be affected by the need to train new care providers.

Conclusions

In this interpretive phenomenological study, I explored the lived experiences of nurses related to CS while working in a critical care setting during the COVID-19 pandemic. Data were collected through semistructured interviews and analyzed with a thematic approach. All participants provided their own experiences in response to interview questions, resulting in three common emergent themes: recognition, helping patients, and support. Each of the participants detailed how their experiences increased their levels of CS. Because CS acts to reduce the effects of CF, the themes identified in this first-of-its-kind study have the ability to affect the nursing field overall. The positive social change of increasing CS and decreasing turnover will benefit all nurses and have the potential to help members of other caring professions as well.

References

Babaei, S., & Haratian, M. (2020). Compassion satisfaction and fatigue in cardiovascular nurses: A cross-sectional descriptive study. *Iranian Journal of Nursing and Midwifery Research*, *25*(3), 212–216. https://doi.org/10.4103/ijnmr.ijnmr_112_19

Balinbin, C. V., Balatbat, K. R., Balayan, A. B., Balcueva, M. C., Balicat, M. B., Balidoy, T. S., Macindo, J. B., & Torres, G. S. (2020). Occupational determinants of compassion satisfaction and compassion fatigue among Filipino registered nurses. *Journal of Clinical Nursing*, *29*(5-6), 955–963. https://doi.org/10.1111/jocn.15163

Boamah, S. A., & Laschinger, H. (2015). The influence of areas of worklife fit and work-life interference on burnout and turnover intentions among new graduate nurses. *Journal of Nursing Management*, *24*(2), E164–E174. https://doi.org/10.1111/jonm.12318

(Browning) Callis, A. M. (2020). Application of the Roy adaptation theory to a care program for nurses. *Applied Nursing Research*, *56*, 151340. https://doi.org/10.1016/j.apnr.2020.151340

Chen, Y.-P., Tsai, J.-M., Lu, M.-H., Lin, L.-M., Lu, C.-H., & Wang, K.-W. K. (2018). The influence of personality traits and socio-demographic characteristics on paediatric nurses' compassion satisfaction and fatigue. *Journal of Advanced Nursing*, *74*(5), 1180–1188. https://doi.org/10.1111/jan.13516

Credland, N. (2021). ICU nursing shortage can no longer be ignored. *Emergency Nurse*, *29*(1), 14–14. https://doi.org/10.7748/en.29.1.14.s12

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications, Inc.

Cypress, B. (2018). Qualitative research methods: A phenomenological focus. *Dimensions of Critical Care Nursing*, *37*(6), 302–309. https://doi.org/10.1097/DCC.0000000000000322

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Taylor & Francis.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, *58*(11), 1433–1441. https://doi.org/10.1002/jclp.10090

Figley, C. R., & Figley, K. (2017). Compassion fatigue resilience. In E. M. Seppälä, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. Cameron, & J. R. Doty (Eds.), *The Oxford handbook of compassion science* (pp. 387–398). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190464684.013.28

Fuster Guillen, D. (2019). Qualitative research: Hermeneutical phenomenological method. *Propósitos y Representaciones*, *7*(1), 201–229. https://doi.org/10.20511/pyr2019.v7n1.267

Gennaro, S. (2020). 2020: The year of the nurse as seen through a coronavirus lens. *Journal of Nursing Scholarship*, *52*(3), 231–232. https://doi.org/10.1111/jnu.12556

Gray, J. R., Grove, S. K., & Sutherland, S. (2017). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (8th ed.). Elsevier.

Gribben, J. L., MacLean, S. A., Pour, T., Waldman, E. D., & Weintraub, A. S. (2019). A cross-sectional analysis of compassion fatigue, burnout, and compassion satisfaction in pediatric emergency medicine physicians in the United States. *Academic Emergency Medicine*, *26*(7), 732–743. https://doi.org/10.1111/acem.13670

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE*, *15*(5), e0232076. https://doi.org/10.1371/journal.pone.0232076

Jakimowicz, S., Perry, L., & Lewis, J. (2018a). Compassion satisfaction and fatigue: A cross-sectional survey of Australian intensive care nurses. *Australian Critical Care*, *31*(6), 396–405. https://doi.org/10.1016/j.aucc.2017.10.003

Jakimowicz, S., Perry, L., & Lewis, J. (2018b). Insights on compassion and patient-centred nursing in intensive care: A constructivist grounded theory. *Journal of Clinical Nursing*, *27*(7-8), 1599–1611. https://doi.org/10.1111/jocn.14231

Jarrad, R., & Hammad, S. (2020). Oncology nurses' compassion fatigue, burn out and compassion satisfaction. *Annals of General Psychiatry*, *19*(1). https://doi.org/10.1186/s12991-020-00272-9

Kelly, S. (2019). The hidden curriculum: Undergraduate nursing students' perspectives of socialization and professionalism. *Nursing Ethics*, *27*(5), 1250–1260. https://doi.org/10.1177/0969733019881714

Lee, H., Baek, W., Lim, A., Lee, D., Pang, Y., & Kim, O. (2021). Secondary traumatic stress and compassion satisfaction mediate the association between stress and

burnout among Korean hospital nurses: A cross-sectional study. *BMC Nursing*, *20*(1). https://doi.org/10.1186/s12912-021-00636-w

Lopez, K.A., & Willis, D. G. (2004, May). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qual Health Res.*, *14*(5), 726-735. https://doi.org/10.1177/1049732304263638

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology*, *23*(1), 112–123. https://doi.org/10.1037/trm0000096

McEwen, M., & Wills, E. M. (2019). *Theoretical basis for nursing* (5th ed.). Wolters Kluwer Health.

Oerther, S. (2020). Analysis methods in hermeneutic phenomenological research: Interpretive profiles. *Frontiers of Nursing*, *7*(4), 293–298. https://doi.org/10.2478/fon-2020-0038

Okoli, C. C., Seng, S., Otachi, J. K., Higgins, J. T., Lawrence, J., Lykins, A., & Bryant, E. (2019). A cross-sectional examination of factors associated with compassion satisfaction and compassion fatigue across healthcare workers in an academic medical centre. *International Journal of Mental Health Nursing*, *29*(3), 476–487. https://doi.org/10.1111/inm.12682

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage Publications.

Reiners, G. M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing &*

Care, *01*(05). https://doi.org/10.4172/2167-1168.1000119

Roy, S. C., & Andrews, H. (2008). *The Roy adaptation model* (3rd ed.). Pearson.

Ruiz-Fernández, M., Pérez-García, E., & Ortega-Galán, Á. (2020). Quality of life in nursing professionals: Burnout, fatigue, and compassion satisfaction. *International Journal of Environmental Research and Public Health*, *17*(4), 1253. https://doi.org/10.3390/ijerph17041253

Ruiz-Fernández, M., Ramos-Pichardo, J., Ibáñez-Masero, O., Cabrera-Troya, J., Carmona-Rega, M., & Ortega-Galán, Á. (2020). Compassion fatigue, burnout, compassion satisfaction and perceived stress in healthcare professionals during the COVID-19 health crisis in Spain. *Journal of Clinical Nursing*, *29*(21-22), 4321–4330. https://doi.org/10.1111/jocn.15469

Sacco, T. (2017). Compassion satisfaction: A concept analysis in nursing. *Nursing Research*, *66*(2), E119. https://doi.org/10.1111/nuf.12213

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), 32–42. https://doi.org/10.4037/ccn2015392

Saldana, J. (2015). *The coding manual for qualitative researchers* (3rd ed.). SAGE Publications Ltd.

Sarosi, A., Coakley, B. A., Berman, L., Mueller, C. M., Rialon, K. L., Brandt, M. L., Heiss, K., & Weintraub, A. S. (2021). A cross-sectional analysis of compassion fatigue, burnout, and compassion satisfaction in pediatric surgeons in the U.S. *Journal of Pediatric Surgery*. https://doi.org/10.1016/j.jpedsurg.2021.01.046

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, *44*(1), 26–28. http://www.ncde.appstate.edu/

Stamm, B. H. (2010). *The concise PROQOL manual*. Professional Quality of Life. https://PROQOL.org/uploads/PROQOLManual.pdf

Theofanidis, D. (2018). Limitations and delimitations in the research process. *Perioperative Nursing*, *7*(3), 155–163. https://doi.org/10.5281/zenodo.2552022

Wang, J., Okoli, C. T., He, H., Feng, F., Li, J., Zhuang, L., & Lin, M. (2020). Factors associated with compassion satisfaction, burnout, and secondary traumatic stress among Chinese nurses in tertiary hospitals: A cross-sectional study. *International Journal of Nursing Studies*, *102*, 1–8. https://doi.org/10.1016/j.ijnurstu.2019.103472

Yu, H., Jiang, A., & Shen, J. (2016). Prevalence and predictors of compassion fatigue, burnout and compassion satisfaction among oncology nurses: A cross-sectional survey. *International Journal of Nursing Studies*, *57*, 28–38. https://doi.org/10.1016/j.ijnurstu.2016.01.012

Yu, H., Qiao, A., & Gui, L. (2021). Predictors of compassion fatigue, burnout, and compassion satisfaction among emergency nurses: A cross-sectional survey. *International Emergency Nursing*, *55*, 100961. https://doi.org/10.1016/j.ienj.2020.100961

Appendix A: Interview Questions and Introduction

Introduction

Thank you for taking the time to meet with me today and agreeing to participate in this interview. I understand your time is important and I appreciate your willingness to contribute your experiences. The purpose of this interview is for me to gather data on the study I am performing in my doctoral program at Walden about the lived experiences of nurses related to compassion satisfaction while working in a critical care setting during the COVID-19 pandemic.

You have already completed your informed consent. I would like you permission to audio record our interview. The purpose of the recording and transcription of the interview is to allow me to look at the information you have provided me and analyze the experiences of you and other critical care nurses. I will synthesize all of the information gained and present my research findings in my final study. Do I have your permission to record our interview? Thank you.

I would like to remind you that your participation is voluntary. If, at any time, you decide to withdraw from the study, you can do so. There is no benefit or risk related to participating in this study. The recordings will be kept on this secure digital recorder until they can be transferred to a secure encrypted flash drive. Both devices require a password known only to me. Interview transcripts will be kept on the same secure flash drive, which will be locked in a safe when I am not using it. Each participant will be identified by a participant number known only to the participant. Transcripts without identifiers will

be shared with my university faculty upon their request. After my final study is complete, recordings and transcripts will be securely stored for 5 years, prior to destruction.

I will be asking you a series of questions and listening for your answers. The majority of my time will be spent listening to your experiences, without interruption. I may, however, need to ask some clarifying or follow up questions. I will also be taking notes for reference at a later time. Please speak slowly and clearly to maximize recording quality.

As a thank you for agreeing to participate in this study, I will give you a $20 Dunkin Donuts gift card. Do you have any questions before we start?

Interview Questions

1. What are your perceptions or understandings about compassion satisfaction?
2. Can you tell me about your experiences with compassion satisfaction while working in the ICU?
3. Can you tell me about your experiences with compassion satisfaction while working during the COVID 19 pandemic?
4. Is there anything that you feel helped create compassion satisfaction?
5. Is there anything that you feel helped create compassion satisfaction?

Closing Interview Script

That is great. Thank you. Before we stop, is there anything else you would like to say or add that you feel is important to this study?

Thank you. I appreciate your time and willingness to provide me with your experiences. This information is important to our profession and future nurses. Your answers will be kept confidential and will be part of a larger pool of data, and used to identify common themes. Once the study is final, you are welcome to your own copy. If you would like a copy, I will need your mailing address or a means of getting it to you. Again, I would like to say thank you.

Appendix B: Demographics Survey

What type of critical care unit do you work in?

- Mixed critical care
- Neuro critical care
- Cardiac critical care

If you worked as a nurse in an area before critical care, what type of area was it?

_____

How long have you worked in critical care?

- <5 years
- 5-15 years
- >15 years

What is your education level?

- Associates degree
- Bachelor's degree
- Master's degree
- Doctoral degree

What is your primary role?

- Bedside patient care
- Charge nurse / CNC
- Manager / director

Do you work full time, part time, or prn?

- Full time
- Part time
- PRN