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INVESTIGATION OF THE RELATIONSHIP BETWEEN IN CARE DIFFICULTIES AND COMPASSION FATIGUE OF PALLIATIVE CARE NURSES

PALYATIF BAKIM HEMŞIRELERININ YAŞADIĞI BAKIM ZORLUĞU VE MERHAMET YORGUNLUĞU ARASINDAKİ İLİŞKİNİN İNCELENMESİ

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ABSTRACT

Objective: It is to examine the relationship between in care difficulties and compassion fatigue of palliative care nurses

Method: This study is descriptive type, and it was conducted between 1-15 April 2021. The questionnaire scales were sent to the nurses online. 105 nurses who answered to the forms were included in the study. In collection of data were used the Personal Information Form, Palliative Care Difficulties Scale (PCDS), and Compassion Fatigue Short Scale (CF-SS).

Results: Average age of palliative care nurses 29.43±7.16, mean the working year was determined to be 2.88±2.46. It was determined that 80% of the nurses were women, 45.7% were married, and 74.3% were undergraduates. PCDS total score average 43.98±8.27; Communication sub-dimension 8.74 in multidisciplinary teams±2.27, patient and family communication sub-dimension 9.64±2.57, expert support sub-dimension 7.61±2.28, symptom reduction sub-dimension 9.47±2.73 and communication coordination sub-dimension 8.49±It was found to be 2.51. CF-SS total score average 65.34±21.68; secondary trauma sub-dimension 25.65±10.49 and occupational burnout sub-dimension 39.68±was found to be 13.48. It was found that as compassion fatigue and professional burnout levels of nurses increased, symptom management in palliative care was found to become more difficult ($p<0.05$).

Conclusion: It was found that the compassion fatigue and care difficulty of the palliative care nurses were moderate. It was found that as the nurse's professional burnout and compassion fatigue level increased, symptom management in palliative care became more difficult.

Keywords: Care Difficulty, Compassion Fatigue, Nursing, Palliative Care.

ÖZET

Amaç: Palyatif bakım hemşirelerinin yaşadığı bakım zorluğu ile merhamet yorgunluğu arasındaki ilişkiyi incelemektir.

Gereç ve Yöntem: Çalışma tanımlayıcı tiptedir ve 1-15 Nisan 2021 tarihleri arasında yürütüldü. Anket ve ölçekler hemşirelere online olarak gönderildi. Formları eksiksiz cevaplayan 105 hemşire araştırmaya alındı. Verilerin toplanmasında Kişisel Bilgi Formu, Palyatif Bakım Zorlukları Ölçeği (PCDS) ve Merhamet Yorgunluğu Kısa Ölçeği (MY-KÖ) kullanıldı.

Bulgular: Araştırmada palyatif bakım hemşirelerin yaş ortalamasının 29.43±7.16, ortalama çalışma yılının ise 2.88±2.46 olduğu belirlendi. Hemşirelerin %80'inin kadın, %45.7 'sinin evli, % 74.3 'ün lisan mezunu olduğu tespit edildi. PCDS toplam puan ortalaması 43.98±8.27; multidisipliner ekiplerde iletişim alt boyutu 8.74±2.27, hasta ve aile ile iletişim alt boyutu 9.64±2.57, uzman desteği alt boyutu 7.61±2.28, belirtilerin azaltılması alt boyutu 9.47±2.73 ve iletişim koordinasyonu alt boyutu 8.49±2.51 olarak saptandı. MY-KÖ toplam puan ortalaması 65.34±21.68; ikincil travma alt boyutu 25.65 ±10.49 ve mesleki tükenmişlik alt boyutu 39.68±13.48 olarak saptandı. MY-KÖ toplam ve "Mesleki Tükenmişlik" puan ortalaması arttıkça "Belirtilerin Azaltılması" puan ortalamasının da arttığı saptandı ($p<0.05$).

Sonuç: Palyatif bakım hemşirelerinin bakım zorluğu ve merhamet yorgunluğunun orta düzeyde olduğu belirlendi. Hemşirelerin merhamet yorgunluğu ve mesleki tükenmişlik düzeyi arttıkça palyatif bakımda semptom yönetiminin de zorlaştığı tespit edildi.

Anahtar Kelimeler: Bakım Zorluğu, Hemşirelik, Merhamet Yorgunluğu, Palyatif Bakım.

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INTRODUCTION

Palliative care is an application that raises the quality of life of the patient and family members, who encounter a serious life-threatening illness, by providing early detection and treatment of other physical, spiritual problems, and psychosocial, especially pain. Individuals with chronic diseases such as chronic respiratory diseases, cardiovascular diseases, cancer, and chronic kidney failure need palliative care (World Health Organization, 2018). Patients receiving palliative care experience many problems such as fatigue, pain, respiratory distress, weakness, mucositis, nausea, vomiting, loss of appetite, constipation, weight loss, depression, and anxiety during the disease process (Alves, Abril, & Neto, 2017). Nurses providing palliative care play a significant role in identifying patient needs and possible difficulties possible difficulties they may encounter in palliative care (Kudubes et al., 2019).

Palliative care nursing aims to increase patients' and their families' life quality during illness and death, and the family's quality of life after death. To succeed in this, nurses must have important roles such as treatment, education, care, coordination, and leadership. While performing these roles, the nurse should consider that patients' and their families' physical, psychosocial, and spiritual needs are different. Different emotional reactions and privacy of the patient and family should be respected. The nurse should help the patient establish positive and strong relationships with themselves, their environment, their family, and others as much as possible. The nurse should help the patient maintain hope, not let them lose their sense of control (Kennedy & Connolly, 2018). Even if nurses are knowledgeable and equipped about palliative care, giving care to these patients is a challenging and stressful situation for nurses. It is difficult for the nurse to empathize with the dying patients, the illness and its effects are severe, various communication problems due to the tense and stressful situation of the patient and the family, the resistance of the patients and their families to the treatment, the demands of the patients and their families are among the most stressful reasons. Although this situation negatively affects nursing care (Uzen Cura & Ates, 2020), it also causes healthcare workers who experience persistently high stress levels more vulnerable to compassion fatigue (Godsil, Kiss, Spedding, & Jay, 2013).

Compassion fatigue is explained as physical exhaustion and emotional, in which depersonalization is seen against patient problems, and a decrease in the capacity and interest in dealing with individuals who suffer (Mathieu, 2014). Compassion fatigue is expressed as the cost of nursing care as a natural consequence of the care relationship. Variables such as empathic anxiety, ability to empathize, empathetic behavior, exposure to the patient's trauma, compassion stress, disconnection from the patient, long-term care for the sick individual, sense of accomplishment, traumatic memories, and life interruption contribute to the development of compassion fatigue (Dikmen & Aydin, 2016). Compassion fatigue affects the quality of care given by the nurse in many ways. Nurses who experience compassion fatigue can be reluctant, nervous, and insensitive to patients during the patient care process. When the nurse experiences depersonalization, the probability of misinterpretation of the information given to the nurse increases significantly. There are often negative changes in the moral and professional values of the nurse with compassion fatigue (Sirin & Yurttas, 2015). Compassion fatigue, which develops with this depersonalization and changes, is shown as increased medical errors, decreased patient satisfaction, and important reasons for leaving the profession (Maiden et al., 2011; Romano et al., 2013). The likelihood of secondary traumatic stress increases in nurses who constantly listen to and try to relieve patients' experiences of pain and fear (Mathieu, 2014; Sacco & Copel, 2018; Wentzel & Brysiewicz, 2014). In a study by Godsil et al. (Godsil et al., 2013), it was reported that those with stress disorders such as compassion fatigue or secondary traumatic stress have dysfunction in the areas of the brain responsible for executive tasks and emotional regulation.

The aging world population has increased the need for compassionate care in parallel with the increase in the need for special quality care such as palliative care, along with the increase in fatal diseases such as cancer (Ugurlu & Aslan, 2017). Failure to address compassion fatigue in the early stages may permanently change the ability of healthcare professionals to provide compassionate care, resulting in the loss of the ability to provide compassionate care (Makic, 2015). When the literature was examined, no study was found that examined the relationship between care difficulty and compassion fatigue in palliative care nurses. For this reason, the study examined the relationship between the care difficulty experienced by palliative care nurses and compassion fatigue.

MATERIALS AND METHODS

Sample and Type of the research

This study is descriptive type, and it was conducted between 1-15 April 2021. With this online questionnaire, 126 palliative care nurses were reached. 17% of the patients refused to participate in the study. In this study, there were no participants who gave incomplete answers to the survey questions. 105 (83% participation) palliative care nurses who responded to the questionnaires were included in the study. Research inclusion criteria were working as a nurse in a palliative care clinic, agreeing to take part in the study and answering all the survey questions. Research exclusion criteria were not working as a nurse in a palliative care clinic, not agreeing to participate in the study, and answering the survey questions incompletely. Post-hoc power analysis of the study was calculated in the GPower 3.1 program. According to the results of this study, an effect size of 0.30 was obtained with 89% power and a 0.05 margin of error. It was determined that the data collected by the power analysis was sufficient (Capik, 2014).

Data Collection Tools

In the collection of data, the Personal Information Form, Palliative Care Difficulties Scale (PCDS), and Compassion Fatigue Short Scale (CF-SS) were used.

Introductory Information Form

This form includes questions about the age, marital status, education level, and working years in palliative care of the palliative care nurses, and the researchers prepared it.

Compassion Fatigue-Short Scale (CF-SS)

This scale was developed by Adams et al. to determine the compassion fatigue of individual (Adams, Boscarino, & Figley, 2006). It was conducted to Turkish validity and reliability by Dinç & Ekinci (2019). The 13-item scale has two sub-dimensions: occupational burnout and secondary trauma. It is a 10-point Likert-type scale. A score on the scale is between 13 and 130. Higher scores show a higher level of compassion fatigue (Adams et al., 2006). The total Cronbach's Alpha value of the scale was 87; 0.85 for the occupational burnout sub-dimension and 0.74 for the second trauma sub-dimension (Dinc & Ekinci, 2019). In this study, if the total Cronbach's Alpha value was 0.88; 0.82 for the occupational burnout sub-dimension and 0.84 for the second trauma sub-dimension.

Palliative Care Challenges Scale (PCDS)

This scale according to Nakazawa et al. to identify palliative care challenges (Nakazawa et al., 2010). It was conducted to Turkish validity and reliability by Kudubes et al. (2019). The scale has five sub-dimensions: communication with patients and families, communication in multidisciplinary teams, symptom reduction, expert support, and communication coordination. The scale was prepared according to the five-point Likert system. A score on the scale is between 15 and 75. Sub-dimension scores are between 3 and 15 (Kudubes et al., 2019). The total Cronbach's Alpha value was determined to be 0.81 by Kudubes et al. (2019). The total Cronbach's Alphaα value was found to be 0.82 in the study.

Collection of Data

"Snowball sampling method", a non-random sampling method, was used in the study. The forms were prepared with the GoogleDocs program. Nurses working in palliative care units in Turkey who were asked to fill in the forms online (e-mail, whatsapp, facebook, Instagram). They were also asked to share with the palliative care nurses around them.

Evaluation of Data

The analyses were performed with the Statistical Package for Social Sciences (SPSS) 22 program. Skewness and Kurtosis values were used to determine whether the data were normally distributed. The descriptive statics (Mean, standard deviation, numbers, percentages) were used in analysis. Pearson correlation analysis was used to examine the relationships between numerical variables since the data showed conformity to normal distribution. Cronbach Alpha reliability analysis was used to measure the internal consistency of the scales on our sample. In this study, the statistical significance level was accepted as $p<0.05$.

Ethical Approval of Research

Approval was obtained for the research from the Ethics Committee (2020/02 issue). In the research, it was explained the purpose of the study to the nurses and was obtained their consent as online. Declaration of Helsinki ethical standards were adhered to in the study. All participants volunteered for the study and personal identity information was kept confidential.

Limitation of the research

Limitations of the research is that the results can be applied only to the participants in the research and therefore cannot be generalized.

RESULTS

The average age of palliative care nurses was 29.43±7.16, and the average working year was found to be 2.88±2.46. The study determined that 80% of the nurses were women, 45.7% were married and 74.3% were undergraduates. 48.6% of the nurses reported that they were affected by the emotions of the patients around them in the hospital, 59% reported that they felt happy to be able to help the needy patient, and 72.4% reported that the suffering of the patient they care for affected them (Table 1).

Table 1. Distribution of Palliative Care Nurses by Descriptive Characteristics (n=105)

Variables	**n**	**%**
Gender		
Female	84	80
Male	21	20
Marital Status		
Married	48	45.7
Single	57	54.3
Level of Education		
High school	6	5.7
Associate degree	10	9.5
Bachelor's degree	78	74.3
Postgraduate	11	10.5
Are you affected by the emotions of the patients around you in the hospital?		
Yes	51	48.6
No	5	4.8
Sometimes	49	46.7
How does it make you feel that patients are "in need" of you?		
Happiness for I can help	62	59
Compassion	3	2.9
Anything	1	1
Sadness	39	37.1
Does the "pain" of the patient you care for affect you?		
Yes	76	72.4
Sometimes	29	27.6
	X̄±SD	
Mean age	29.43±7.16	
Working years	2.88±2.46	

X̄: Mean; SD: Standard Deviation.

The mean PCDS score for palliative care nurses was 43.98±8.27. When the mean score of the sub-dimensions of PCDS is examined; communication in multidisciplinary teams sub-dimension was found as 8.74±2.27, patient and family communication sub-dimension was found as 9.64±2.57, expert support sub-dimension was found as 7.61±2.28, symptom reduction sub-dimension was found as 9.47±2.73 and communication coordination sub-dimension was found as 8.49±2.51. CF-SS total score average was

found as 65.34±21.68; the secondary trauma sub-dimension was found as 25.65±10.49 and occupational burnout sub-dimension was found as 39.68±13.48 (Table 2).

Table 2. Mean Scores of Nurses' PCDS and CF-SS Sub-Dimensions (n=105)

	SCALES	Min.	Max.	X̄±SD
PCDS and its Sub-Dimensions	Communication in Multidisciplinary Teams Sub-Dimension	5	15	8.74±2.27
	Communication with Patient and Family Sub-Dimension	3	15	9.64±2.57
	Expert Support Sub-Dimension	3	14	7.61±2.28
	Reduction of Symptoms Sub-Dimension	3	15	9.47±2.73
	Communication Coordination Sub-Dimension	3	15	8.49±2.51
	PCDS Total	23	67	43.98±8.27
CF-SS and Sub-Dimen	Secondary Trauma Sub-Dimension	5	50	25.65 ± 10.43
	Occupational Burnout Sub-Dimension	11	77	39.68±13.48
	CF-SS Total	19	123	65.34±21.68
	SCALES	**Min.**	**Max.**	**X̄±SD**
PCDS and its Sub-Dimensions	Communication in Multidisciplinary Teams Sub-Dimension	5	15	8.74±2.27
	Communication with Patient and Family Sub-Dimension	3	15	9.64±2.57
	Expert Support Sub-Dimension	3	14	7.61±2.28
	Reduction of Symptoms Sub-Dimension	3	15	9.47±2.73
	Communication Coordination Sub-Dimension	3	15	8.49±2.51
	PCDS Total	23	67	43.98±8.27
CF-SS and Sub-Dimen	Secondary Trauma Sub-Dimension	5	50	25.65 ± 10.43
	Occupational Burnout Sub-Dimension	11	77	39.68±13.48
	CF-SS Total	19	123	65.34±21.68

CF-SS: Compassion Fatigue-Short Scale; PCDS: Palliative Care Challenges Scale; SD: Standard Deviation; X̄: Mean.

It was seen in table 3 that as the mean scores of total CF-SS increased, the reduction of symptoms from PCDS sub-dimensions also increased. In addition, it was found that as the mean scores of occupational burnout from CF-SS sub-dimensions increases the reduction of symptoms from PCDS sub-dimensions also increases ($p<0.05$).

Table 3. PCDS, CFSS and Sub-Dimensions Comparison

	r/p Test Values	Communication Sub-Dimension in Multidisciplinary Teams	Communication with Patient and Family Sub-Expert Support Sub-Dimension	Reduction of Symptoms Sub-Dimension	Communication Coordination Sub-Dimension	PCDS Total
Secondary Trauma Sub-Dimension	**r**	-0.081	0.149	-0.022	0.182	0.023	0.085
	p	0.412	0.130	0.826	0.063	0.819	0.388
Occupational Burnout	**r**	0.016	0.057	0.010	0.274	0.048	0.130
	p	0.867	0.561	0.921	**0.005***	0.627	0.186
CF-SS Total	**r**	-0.029	0.107	-0.004	0.258	0.041	0.122
	p	0.772	0.276	0.965	**0.008***	0.680	0.215

r: Pearson Correlation; *p<0.05; PCDS: Palliative Care Challenges Scale; CF-SS: Compassion Fatigue-Short Scale.

DISCUSSION

Despite being both professionally and personally rewarding, working in palliative care also brings problems such as compassion fatigue and care difficulty (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015) For this reason, the study was conducted to determine the relationship between the care difficulty experienced by palliative care nurses and compassion fatigue.

The care difficulty experienced by palliative care nurses was found to be moderate (Table 2). It has been reported in the studies that the palliative care difficulty perceived by the nurses is at a moderate level (Kudubes et al., 2019; Morita et al., 2013; Sato et al., 2014). The results found in the study were parallel with the literature. In addition, it has been reported in the literature that nurses who care for patients in need of palliative care experience hesitancy in providing care due to lack of knowledge and skills, lack of experience and self-confidence, and lack of adequate professional support, and in parallel, they often have difficulties in providing care (Hirooka et al., 2014). Accordingly, by providing training and expert support to palliative care nurses who provide end-of-life care to the patient and their families, it can be helped to reduce the perceived difficulty of care and thus to increase the quality of palliative care.

In the study, it was concluded that palliative care nurses had the most difficulty in communicating with the patient and their families, as well as in reducing the symptoms experienced by the patients (Table 2). Palliative care nurses have an important role in symptom management as they communicate more frequently and continuously with patients and their families compared to other healthcare personnel (Senderovich & Wignarajah, 2017). Nurses should treat patients and their families humanely, with dignity and respect, build trust through open communication, inform, provide symptom control, and provide psychological support in palliative care delivery (Ozcelik et al., 2014). In the qualitative study of Okcin et al., in which the professional life experiences of palliative nurses were examined, nurses stated that "in the communication process with patients, they sometimes have difficulties in maintaining appropriate communication and protecting their boundaries, and they turn empathy into sympathy" (Okcin, 2019). Moreover, while it is reported in the literature that nurses should communicate appropriately with patients and their families during the symptom management process (Alves et al., 2017), it was stated that symptom management became difficult as a result of this failure, and problems were experienced in the planning and evaluation of care (Murray, 2016; Ovayolu & Ovayolu, 2017; Senderovich & Wignarajah, 2017). It was found that the results of the present study were in parallel with results reported in the literature. Considering that palliative care nurses have a key role in the early diagnosis and relief of pain and symptoms of patients and their families, from the diagnosis of the disease to death, and in increasing the quality of life by providing psychosocial and spiritual support, nurses can help in communicating with the patient and their families during the care process, as well as in reducing the symptoms experienced by the patients. difficulties are considered inevitable.

In the study, it was found that the palliative care nurses' mean total compassion fatigue score mean the compassion fatigue was moderate (Table 2). Studies in the literature have also found evidence that nurses have moderate compassion fatigue (Khan, Khan, & Malik, 2015; Kim, 2013; Xie et al., 2021). In a systematic review, it was reported that palliative care nurses experience compassion fatigue because they routinely experience the suffering and death of the patient population they care for (Cross, 2019). The research results were found to be similar to the literature. It is an expected result that palliative care nurses experience compassion fatigue because they constantly empathize with patients and are with them in every trauma that patients experience. It was determined that palliative care nurses' the compassion fatigue subscale mean scores were high in the field of professional burnout (Table 2). It becomes inevitable for palliative care nurses to experience burnout as a result of being exposed to difficult situations in their daily practices and giving care to individuals with terminal illnesses (Gómez-Urquiza et al., 2020). In recent studies, it has been reported that nurses providing palliative care often experience burnout from psychological problems as well as physical disorders (Gómez-Urquiza et al., 2020; Okcin, 2019; Tertemiz & Tuyluoglu, 2019; Uzen Cura & Ates, 2020). The research results were found to be similar to the literature.

It was determined that more than half of the nurses in the research population were affected by the emotions of the patients around them in the hospital, they felt happy because they could help the needy patient, and were affected by the suffering of the patient they care for (Table 1). It has been reported in the literature that as a result of taking care of patients who have suffered trauma and

experienced devastating injuries, being in close relationships with patients and identifying with them, it is likely that compassion fatigue will increase and the quality of care will decrease (Flarity, Gentry, & Mesnikoff, 2013). From this point of view, although the care difficulty and compassion fatigue experienced by palliative nurses are at a moderate level, it is thought that these problems of nurses will increase in the long run if individual and institutional measures are not taken.

In the study, level of compassion fatigue and professional burnout were found to be increased, the difficulty experienced by nurses in reducing the symptoms experienced by patients also increased ($p<0.05$) (Table 3). The nurse should be able to cope with stress effectively and benefit from support resources while caring for a palliative care patient. As a result of these failures, it is inevitable that the nurses who are faced with the loss of the individuals they care for and who are in compassion fatigue will burnout after a while (Inci & Oz, 2012). As a result of compassion fatigue and burnout, the ability of nurses to make decisions and give care is impaired (Cocker & Joss, 2016; Sacco et al., 2015). Therefore, it is an expected result that compassion fatigue and burnout seen in palliative care nurses working in one of the long-term care settings negatively affect the symptom management of the patients.

CONCLUSION

In this study, palliative care nurses' care difficulty and compassion fatigue were found to be moderate. As compassion fatigue and professional burnout levels of nurses increased, symptom management in palliative care became more difficult. For this reason, it can be recommended to increase the awareness of difficulty in care and compassion fatigue in all units of health institutions, especially in palliative care services. This study is thought to contribute to the literature as it is the first and only study examining the relationship between carelessness and compassion fatigue. Managers' evaluation of care difficulties and compassion fatigue in nurses and taking precautions against them can help provide and improve quality patient care. In addition, considering that nurses who provide palliative care constantly put the needs of others before their own needs, it may be beneficial for nurses to provide self-care (healthy diet, exercise, hobby, etc.) to reduce the difficulty of care due to compassion fatigue. However, it may be recommended to increase research to deal with care difficulty and compassion fatigue in a more comprehensive way within the framework of a different and larger sample.

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Conflict of interest
There is no conflict of interest in the research.

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