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"Professional Quality of Life and Resilience Among Nurses in a Maternal and Child Hospital in Metro Manila, Philippines"

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The thesis attached hereto, entitled **"Professional Quality of Life and Resilience Among Nurses in a Maternal and Child Hospital in Metro Manila, Philippines"** prepared and submitted by **MS. MARY GRACE L. RIVERA,** in partial fulfillment of the requirements for the degree Master of Arts in Nursing with specialization in **Maternal and Child Nursing** is accepted.

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Accepted as partial fulfillment of the requirements for the degree of

MASTER OF ARTS IN NURSING

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APPROVAL SHEET

We, the members of the oral examination panel for **MS. MARY GRACE L. RIVERA** unanimously approved the thesis entitled **"Professional Quality of Life and Resilience Among Nurses in a Maternal and Child Hospital in Metro Manila, Philippines"**. The thesis attached hereto which was defended on February 18, 2020 at UPOU Learning Center in Manila for the degree of **Master of Arts in Nursing** is hereby accepted.

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We therefore recommend that **MS. MARY GRACE L. RIVERA** be awarded the degree of **Master of Arts in Nursing** from the **Faculty of Management and Development Studies**.

Very truly yours,

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ABSTRACT

International and local studies had shown prevalence of Compassion Fatigue (Burnout and Secondary Traumatic Stress), and Compassion satisfaction (Described as Professional Quality of Life) in different health care setting. These are considered positive and negative effects of caring which can be experienced by nurses in their workplaces. However, there are limited data on the status of Professional Quality of life of Maternal and Child nurses in the Philippines, and the role of resilience in this population which is globally known for this attribute. This study explored the level and correlation of Professional Quality of Life and resilience of Filipino nurses assigned in maternal and child locale, which is considered as one of the busiest subspecialties. A correlation research design was chosen and two hundred fifteen (215) registered nurses were sampled using a demographic questionnaire, Resilience scale questionnaire developed by Wagnild and Young (2010) and Professional Quality of Life (ProQOL version 5) developed by Stamm (2010). Results showed that despite high resilience, and high compassion satisfaction, there is high prevalence of burnout and moderate STS in this population suggesting that these positive and negative effects of caring can co-exist. High resilience and high compassion satisfaction do not diminished Burnout but may have correlation with the level of STS. Therefore, hospitals should not only focus on building resilience alone to combat Compassion Fatigue, but also to identify the root cause of Burn-out and address accordingly.

CHAPTER I

THE RESEARCH PROBLEM

Background of the Study

"The expectation that one can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" -- Naomi Rachel Remen.

In 1992, Joinson described a phenomenon among her fellow nurses who appeared to have "lost their ability to nurture" in the course of caring for their patients (Joinson, 1992). Twenty years later, it still continues to exist among nursing practitioners as it seems to affect the wellbeing of nurses holistically (Coetzee, Klopper as cited in Pehlivan 2017) which may manifest in the quality of their work in providing holistic aspect of care i.e., meeting the client needs holistically. According to Adams et al., this usually happens with health care professionals working in a clinical setting due to their consistent exposure to patient's suffering (2008).With this risk commonly imposed to healthcare workers, this becomes more interesting for Nurses in the Philippines as they face a numbers of challenges in their health care work setting such as understaffing, extra long working hours, high patient-nurse ratio and etcetera, further aggravated by the type of patients they cater to. This becomes more challenging in a Maternity hospital; due to fast turnover and notably large number of patients they accommodate on a daily basis which eventually doubles or triples depending on the number of neonates they will deliver. It seems a worthwhile study of interest to investigate the level of resilience (especially for Filipinos known for this character) and the status of the Professional Quality of life among the nurses rendering direct patient care in maternity hospital catering to as much as average of 90 deliveries

per day. According to Todaro-Franceschi, nurses' professional quality of life affects the quality of care rendered to patients, and how they are being cared for, bears influence on "their quality of living and dying" (Todaro-Franceschi 2013, as cited in Folse 2015). Constantly witnessing the suffering of other people may take its' toll to the care provider as they gradually lose the capacity to show empathy and compassion (Sabo 2011), Nonetheless, nurses are still expected to provide compassionate care amongst their patients since 'both empathy and compassion are indispensable qualities for positive healing environments and essential elements of holistic care and nurse role satisfaction' (Murphy, 2014). While Compassion fatigue (CF), represents the negative effects of caring or 'cost of caring for others in emotional and physical pain' (Figley, 1982), some individuals may or may not experience the phenomenon. There are professionals who, despite their exposure, still find their jobs rewarding and fulfilling, amidst all chaos. They find delight and satisfaction in being able to help or be of aid among their patients. This refers to the positive aspects of caring, while CF refers to the negative aspect of the latter encompassing Secondary traumatic stress and Burnout (Stamm, 2016). In studies exploring the reason why nurses remain in their work despite experiencing Compassion Fatigue, it was attributed to the positive feeling they obtained from helping others, known as Compassion Satisfaction (CS) (Stamm, 2016; Dunn, 2014). The balance between CF and CS is otherwise known in the Literature as Professional Quality of Life.

Nursing is acknowledged as one of the most stressful human service professions (Adriaenssens, De Gucht, & Maes, 2015). Most would agree that it entails a calling in order to persevere in this particular vocation as it implies constant exposure to highly demanding environment and discipline. Though some may be greatly affected, some bounce back from adversity and thrive despite the difficulty of the

situation. In a study done by Edwards in investigating the role of resilience among professionals, he identified resilient individuals as people who do “Not succumbed to the pressure of the workplace but rather, have continued to remain enthusiastic, empathic and skilled in their clinical approach to care, while others became burnt-out. These clinicians appeared to have an ability to move beyond the stressors of the moment time and time again. According to literature, resilient people are more empowered to face problems and likely more capable to have a sound judgment during tough situations (Kotze as cited in Sull et. Al., 2015).

Compassion fatigue and resilience had been studied among nurses in palliative care in Poland (Ogińska-Bulik, 2018) which obtained a negative correlation between resilience and secondary traumatic stress, one of the components of compassion fatigue. However, a study in Taiwan among nurses caring for Mass Burn (Tseng, 2018) demonstrated that resilience helps to ease the deterioration effect of secondary traumatic stress. A study in China among hospital nurses from 11 institution demonstrated low resilience, which is acknowledged as an important factor that aids maintaining their wellbeing and helps them to remain in the position (Yaxin & Ying, 2018). In a study in the Philippines regarding the work environment variable affecting Filipino nurses, their study reported high job satisfaction and nurses’ intention to stay in their work despite having lowest Physiologic and Safety needs (Dones, 2016). In a study among Filipino nurse educators, they have demonstrated that they remained resilient and positive despite experiencing occupational stress (Lumanlan, 2013). In one of studies in a tertiary hospital in the Philippines, majority of Filipino nurses were exceptionally fulfilled in providing quality patient care to their patients (Cashevelly as cited in R. Tamayo 2015) and they are proficient in using efficient personal techniques; hence ineffective coping is not a general concern amongst this group (Tamayo, 2015)

which is uniquely different from the common research findings. This might be attributed to resilience, one of the good traits Filipinos are known for which was observed during typhoons (Gulf news, 2012), disasters, (Fowler 2017), and even during war in Libya (Cobus, 2015) which according to President Duterte can be attributed to their strong faith in God (Manila Bulletin, 2019). Majority of the literature regarding nurse resilience describes high-intensity areas, such as the Emergency Department, oncology, and critical care environments (Kester, 2018) but Maternity units in hospital settings were not identified despite having a consistent high patient acuity leading to some of the hospital in UK to turndown mothers in labor (Donnelly, 2017) and in the Philippines, there are tandem beds shared by four mothers with their babies in a birthing hospital which has an average of 60 deliveries per day (Ward, 2018). Acknowledging the importance of these variables in patient care and safety, these facts led the researcher to study the Professional Quality of Life and Resilience among Filipino Nurses in a maternity hospital, which is a high-intensity area which has not been fully represented in the literature.

Statement of the Problem

This study determined the relationship between Professional Quality of Life and Resilience among Filipino nurses in a maternal and child hospital. Specifically, it sought to answer the following questions:

1. What is the profile of the nurses in terms of:

    1.1. Sex

    1.2. Age

    1.3. Nursing position

    1.4. Area of assignment

1.5. Length of service

2. What is the level of Professional Quality of Life among nurses in a maternal and child hospital in terms of?

2.1Compassion Fatigue

2.2 Burn-out

2.3 Secondary Traumatic stress

2.4 Compassion Satisfaction

3. What is the level of resilience among nurses in a maternal and child hospital?

4. Is there a significant relationship between Professional Quality of Life and resilience among nurses in a maternal and child hospital?

5. Is there a significant relationship between demographic profile and Professional Quality of Life among nurses in a maternal and child hospital?

6. Is there a significant relationship between demographic profile and resilience among nurses in a maternal and child hospital?

Significance of the study

According to Hooper et al., (2010) Nurses who experience Compassion Fatigue are at risk for making mistakes, demonstrate changes in job performance and experience health problems and are more likely to leave the profession. With the risks that would likely affect both the patients and the nurses, it seems a worthwhile topic to discuss. This study will benefit not only the patients, but the nurses and the organization they work at. Assessment findings of this study will enlighten nurses, on the prevalence and correlation of Resilience, Compassion Fatigue, and Compassion Satisfaction. Awareness of these variables may help them acknowledge their risk and empower them to use personal strategies they can adapt to mitigate the effects of

Compassion Fatigue and enhance their resilience and Compassion satisfaction status. The baseline data may also inspire further studies regarding possible interventions that can promote the holistic wellbeing of nurses which can become an instrument towards a better patient care and positive patient experience.

The organization cognizance of this occupational hazard may become helpful in coming up with preventive and interventional strategies as part of risk-management policy of the institution that can be reflected in their programs, policies, procedures, staff development, and periodic assessment of the working environment and its manpower holistic conditions. Data can be utilized by the organization to raise awareness and institute/recommend interventions that may halt development of the latter and promote psychosocial wellbeing of the nurses by acknowledging its reality amongst them and acting on it, at the organizational level. It is vital that the management, particularly the nurse leaders also assess and ensure that their staff are in their optimum condition to be of service to the patients similar to medical equipment undergoing regular preventive maintenance and calibration to ensure safety, the manpower should also be checked periodically.

Nurses' cognizance and institutional awareness of the possible correlation of professional quality of life and resilience of the nurses within the organization will help pave the way towards prevention and intervention. This will help recognize resilience, Compassion satisfaction and Compassion fatigue amongst nurses which can possibly affect patient care since development of compassion fatigue among caregivers may become a risk for termination of caregiving relationship, abuse or neglect (Petra B. et.al., 2016), that can possibly produce devastating outcomes. Awareness of these factors may lead to positive changes that can impact the wellbeing of our nurses which can be translated into better patient care.

Scope and Limitations of the Study

This study was conducted to investigate the relationship between Professional Quality of Life, Resilience and demographic variables of nurses in maternal and child hospital. The respondents included nurses rendering direct patient care only, hence findings are only limited to bedside nurses working in a maternal and child hospital setting. Nurses with administrative work, supervisory, managerial are excluded in the population of interest. Since this a cross sectional study, the participant may have answered based on their emotional well being at the time of data collection which can pose a bias, as response may just a be a representative of a bad day at work.

CHAPTER II

THEORETICAL BACKGROUND

Review of Related Literature and Studies

Compassion Fatigue

The term “compassion fatigue” was initially presented in the studies related to burn out. In 1992, Carla Joinson has used the term Compassion Fatigue to describe a behavior she noticed among the nurses in the Emergency room, who seemed to have lost their “ability to nurture” (Joinson, 1992). She described it as a form of Burn-out distinct among helping professions. These are people who work by being of service directly to their patients/clients i.e., to doctors, nurses, social workers, mental healthcare workers, etcetera on a regular basis. These populations are particularly at risk in developing such phenomenon due to prolonged and intense contact with patients. (Smart et al., 2014). In Joinson article “Coping with Compassion fatigue’” she recognizes four reasons for acknowledging compassion fatigue; it is emotionally devastating; caregiver’s personalities lead them toward it; the outside sources that causes are unavoidable; and compassion fatigue is impossible to recognize without a heightened awareness of it (Joinson, 1992). She has also identified three central issues in this phenomenon. First, she stated that the essential product they (counsellors) deliver is themselves which holds true in human service profession since they are the primary entity dispensing care. Second, human need is infinite and lastly, caregivrs fill multiple roles that can be psychologically conflicting (Joinson, 1992).

It is also used to refer to secondary traumatic stress obtained from being indirectly exposed to trauma and has been studied considerably in the field of Traumatology (Figley, 1995). According to Stamm, STS, is a natural, predictable,

treatable and preventable unwanted consequence of working with suffering people (Stamm, 1995/1999, 2002; Sabo, 2011), this phenomenon negatively affects those in helping or care giving profession thus being referred to as negative aspect of caring. In his article entitled “Psychosocial Adjustment Among Vietnam War Veterans,” Dr. Charles Figley, one of renowned authors of this field, has mentioned that family friends and professionals are susceptible to developing traumatic stress symptoms from being empathically engaged with victims of traumatic events (Cornielle & Meyers, 1999).

According to the definition, compassion fatigue is a progressive and cumulative result of prolonged, continuous, and intense contact with patients, the use of self and exposure to stress (Coetzee, Klopper as cited in Pehlivan 2017). It is also known as Secondary Traumatic Stress (STS), a condition characterized by gradual decline of Compassion over time common with individuals working directly with trauma victims or anyone who helps others out particularly family members, relatives and other informal caregivers taking care of patients with chronic illness (Joinson, 1992). While, the word “trauma” is used as a generally accepted term to refer to patients who experienced organ and tissue damage caused by blunt or penetrating injury’ (Emergency Nurses Association 2013), the American Psychiatric Association denotes traumatic stressors as “any incident (or incidents) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend.” Trauma also pertains to major disturbance, life-threatening events or unexpected calamity that create substantial harm and despair (Valent, 2012a, 2012b). Hence patients’ illnesses may qualify as traumatic experience to this group of individuals. By other definition, compassion fatigue is characterized by profound physical and emotional exhaustion and a marked change in helper’s ability to feel empathy for their patients, their loved-ones, and co-workers. It is ‘markedly increased

cynicism at work, loss of enjoyment of our career and eventually can lead to depression, secondary traumatic stress, and stress related illnesses' (Françoise, 2007). Unrecognized CF can considerably decrease productivity at work and may cause relative increase in absenteeism and staff turnover (Shephard, 2015). Nurses who left the profession early relate their resignation as only resort to leave unsubstantial condition (Pélissier, 2018). According to Patricia Potter, nurses who suffer from Compassion fatigue do not form a therapeutic relationship thus impair the ability of the health care provider and of the facility, to render high quality care (Potter et.al., 2013)

In 1995, Figley had defined it as "helpers stress" but has preferred using the term compassion fatigue instead, as the more" Friendly term" (Stamm, 1995/1999). By 1998, he redefined compassion fatigue as "a state of exhaustion and dysfunction – biologically, psychologically, and socially – because of prolonged exposure to compassion stress and all that it evokes. It is a form of burnout. Although unlike burnout which happens slowly, STSD can emerge without warning and exhibits sense of helplessness, confusion, and isolation (Figley, 1998). It is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1999). He emphasized that highly empathic people who responds compassionately with patient's suffering makes them more vulnerable in experiencing compassion fatigue (Figley, 2002). Boscarino et al (2006), identified compassion fatigue as reduced capacity or interest in being emphatic or bearing the suffering of clients. Compassion fatigue, encompasses two parts, the first part explores symptoms associated with burn out i.e., exhaustion, frustration and depression which may appear slowly and reflect a sense of helplessness or assessment of ineffectiveness in ones' work" (Stamm 2010a, P. 12). Maslach, Jackson and, Leiter (1996) identified depersonalization, reduced

personal accomplishment and emotional exhaustion as characteristics of typical of Burnout Syndrome with the latter recognized as the key element of Burnout where the helpers “feel they no longer able to give of themselves at a Psychological level” (Maslach et al., 1996, p. 192). Depersonalization can be observed when the professional tends to become emotionally detached from their patients, fostering negative emotion and attitudes towards their patients (Maslach et al., 1996). Reduced personal accomplishment on the other hand, refers to the worker’s negative view of ones’ work, decreasing confidence in their competence at work and increasing dissatisfaction with their accomplishments (Maslach et al., 1996).

The second part is Secondary traumatic stress (STS) a “Work- related secondary exposure to people who have experienced extremely or traumatically stressful event which may include sleep difficulties, intrusive images, or avoiding reminder of the persons’ traumatic experiences (Stamm 2010a. P. 13). Secondary traumatic stress (STS) may have more immediate onset. Jointly these two are being attributed towards development of Compassion Fatigue and measured by Professional Quality of Life (ProQOL V). Patricia Potter et. al (2013) suggested that “Definitions of burnout more often have environmental stressors, whereas definition of Compassion fatigue address the relational nature of the condition” (P. E56). In as much as the two terms seem almost related, they were convinced that these were still too different construct (Potter et al., 2013). Notwithstanding the skepticism, The ProQOL V remains to be the most used instruments in assessing Compassion Fatigue across countries since 1995. It has been translated to twenty-five different languages i.e., Arabic, Greek, French, Chinese etc.

Since it has been used by Joinson in 1992, compassion fatigue had been studied in different human profession such as Nurses, Physician, Social Workers,

Psychotherapist, Mental health workers and in other informal caregivers as well and different definitions were generated by these various professions. Amongst psychotherapist, they adapted the definition of compassion fatigue as a state of tension and anxiety that occurs from re-experiencing traumatic events with the patient, sense of helplessness and confusion, isolation from support that persist with constant emotionally challenging experiences with their clients (Figley, 2002). In one study among physicians aiming to illuminate the term in respect to the medical education program, they referred to compassion fatigue as an abrupt reaction with symptoms not even related to the real cause. They emphasized that being empathic put somebody at risk of experiencing the phenomenon (Huggard, 2003 as cited in Larsson EW et.al 2013).

In one of study amongst nurses, they came up with the definition in light of the scriptures as the emotional, social and spiritual exhaustion that causes a decline in the desire, ability and energy to feel and care for others, lost ability to experience satisfaction in professional and personal life (Mcholm, 2006). Among studies with social workers, they defined it as caregiver's inability or disinterest in being emphatic or sharing the suffering of clients. (Adams et., al 2006). In one studies across physician, nurses, mental health and allied health practitioners aiming to examine the effect of providing care has on health care workers and trauma workers, they had defined compassion fatigue as the symptoms and emotional response that occur from caring for traumatized persons (Robins et al., 2008). A study among nurse-daughters caring for elderly parents, they defined compassion fatigue as a distinct form of burnout, affecting physical, emotional, social health and wellbeing, where expectation surpass the resources (Griffin et al., 2011). Amongst nurses, compassion fatigue affects 16 to 39 percent of registered nurses regardless of their practice setting, though

they have identified nurses assigned at emergency (Hooper, 2010), oncology (ÜstünBet, 2018), hospice (Abendroth & Flannery, 2006), pediatric settings are at a higher risk of experiencing it (Potter et al., 2013).

One of the consistent definition of compassion fatigue was the formal caregivers reduced capacity or interest in being empathic or bearing the suffering of clients and is the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person (Figley, 1995; Figley 2002a, 2002b). Professionals affected by compassion fatigue experiences exhaustion, anger and irritability, negative coping behaviors including alcohol and drug abuse, reduced ability to feel sympathy and empathy, and diminished sense of enjoyment of satisfaction with work, increased absenteeism and an impaired ability to make decision and care for patients and/or clients (Matthieu, 2007). Nurses who experience compassion fatigue commonly despises going to work, may have low self-esteem, trouble concentrating and may feel anxious and pessimistic (Vrooemendurining, 2016). They may also detach with their patients and show lack of concern and pessimistic attitude which may otherwise cause patients not to receive the best care they can possibly be provided with which may also compromise their safety (Smart et al., 2014). Compassion fatigue can affect the quality of care and work health care providers give for their patient and their organization (Kashani et al., 2010). If CF is not acknowledged, it can also lead to several stress related chronic diseases (Figley CR, 2002).

Compassion Satisfaction

While they refer to compassion fatigue as the negative consequence of helping, compassion satisfaction refers to the positive outcome of being able to help**.** Despite

of being exposed to similar stressful situations there are helpers who find satisfaction of seeing their patients get well. Compassion satisfaction reduces the effects of Compassion fatigue and burnout (Najjar et al., 2009). This gives them a sense of fulfilment as a caregiver. Compassion satisfaction takes place when empathy takes precedence and leads to selfless behavior of the helper resulting to alleviation of pain and suffering of the patients mutually benefiting them by empowering them to cope with the negative effects of caring. This helps them continue their journey and their caregiving role (Radney & Figley, 2007). Stamm suggested compassion satisfaction as a factor which builds resiliency of the human spirit in preventing compassion fatigue. Compassion satisfaction serves a protective mechanism against development of compassion fatigue and burnout (Conrad & Kellar-Guenther, 2006). Nurses who experiences more compassion satisfaction express more job satisfaction (Saco, 2017). Being able to help at the weakest moment of the patients, can yield a sense of accomplishment amongst nurses which encourages a positive effect on the quality of care being rendered. (Slatten et al., 2011; Dunn, 2014). Seeing the patient suffer less because of ones' effort can motivate the caregiver to give more of themselves and share with the suffering of the patient. Experiencing compassion fatigue may also serve as motivation for human service professionals to mitigate its detrimental effects by finding sense of purpose and satisfaction in their work (Figley 1995, 2002a, 2002b; Potter et al., 2013). Stamm, elaborated that compassion fatigue can co-exists with compassion satisfaction and high levels of it can still be experienced despite experiencing compassion fatigue as these are not mutually exclusive constructs. (Stamm, 2010). Compassion satisfaction experienced by a nurse becomes advantageous for the patients as it not only increases retention at their work, it

positively influences the quality of care being rendered (Sekol & Kim, 2014), ensuing increase patient satisfaction and constructive outcomes (Dunn, 2014).

In one meta-analysis of 11 studies with 4,054 respondents of determinants of satisfaction, compassion fatigue and burnout in nursing, there was a strong positive correlation between compassion fatigue and burnout, whereas compassion satisfaction had weak negative correlation with compassion fatigue but moderate with burnout identified (Zhang et.al., 2018). Positive affect also had a moderately positive relationship with compassion satisfaction which is helpful in achieving the latter. (Zhang et.al., 2018). In a meta-synthesis of compassion fatigue amongst nurses from 1992 to 2016, work stress was identified as one of the identified triggering factors in compassion fatigue (Nolte et.al., 2017). Four themes were also identified out of the nine qualified papers extracted from six databases, using the meta-ethnographic approach detailed by Noblit and Hare. These themes included: physical ("just plain worn out") and emotional symptoms ("walking on a tightrope"), triggering factors ("an unbearable weight on shoulders" and "alone in a crowded room"), and measures to overcome/prevent ("who has my back?") (Nolte et.al., 2017). A study among 650 Oncology Nurses in the United States and Canada using a quantitative, descriptive non-experimental design with similar variables, reported comparable levels of compassion fatigue, burnout, and compassion satisfaction (Wu et.al., 2016). Younger American nurses classified 40 years old and below were more likely to experience moderate to high level of secondary traumatic stress. Nurses with longer hospital experiences were found to have the least secondary traumatic stress which suggest that these populations are the least candidate for compassion fatigue (Wu et.al., 2016) Whereas in a study in community hospital in USA with 139 license and non-licensed employees, it was been reported that there was lesser compassion fatigue among

critical care workers in contrast with most of the reports from several researches (Smart et.al., 2014)

In a non-experimental study, descriptive, predictive study, amongst 1,000 emergency nurses in the USA, the results revealed overall low to average levels of compassion fatigue and burnout and generally average to high levels of compassion satisfaction (Hunsaker et.al., 2015).

In one of the studies conducted in India, about Professional quality of Life in Neonatal Intensive Care Unit, most of the respondents out of 129 nurses from nine NICU across the city, perceived burnout and secondary traumatic stress disorder which comprises Compassion fatigue, was negatively correlated with Compassion satisfaction (Amee et.al, 2014). In another study in Central India among 30 government hospitals, there was high prevalence of burnout noted among Nurses in clinical areas than those in Nursing Administration (Divinakumar, 2014).

In a qualitative study of 10 Filipino service care providers who were raised in the Philippines but found work in residential care facilities in the United States, they experience more compassion satisfaction than compassion fatigue which they attribute to Filipino cultural values of caring for elders, self-care strategies, ability to cope with job stressors, and supportive working environment (Cerezo-Pann, 2018). In a study in the Philippines, conducted in Philippine Heart Center, a government owned but corporate controlled hospital, level of compassion fatigue was associated with nurses' age, gender, length of direct patient care, unit assignment, stress level, job fulfilment and compassion satisfaction. With a total sample of 262, they determined that the higher the level of work stress, the higher was the probability of having secondary traumatic stress a component of compassion fatigue, amongst their nurses

(Candano & Mancuyas, 2015). In a study in Philippine General Hospital, oncology nurses revealed a moderate compassion satisfaction, burnout, and secondary traumatic stress, both a component of compassion fatigue (Tamayo et.al., 2016). In a retrospective study by Kutney-Lee (2013), it was identified that positive working environment is associated with lower nurse burn out and dissatisfaction. In another study from Philippine General Hospital, a cross sectional study of 246 nurses, organizational role stress and age have been identified to be independent and most significant predictors of burnout (Lu, 2008).

Several studies had recognized nursing as one of stressful profession (Chana 2015). According to one statement, “Nursing is, by its very nature, an occupation subject to a high degree of stress. Every day the nurse confronts stark suffering, grief, and death as few other people do. Many tasks are mundane and unrewarding. Many are, by normal standards, distasteful, even disgusting, others are often degrading; some are simply frightening” (Hingey, 1984). Being exposed to this environment on a daily basis does not only affect the nurses’ wellbeing negatively (Rudman et al., 2012) but also the patient outcomes, (Cimiotti et al., 2012), and patient’s safety (Smart et al., 2014).

Resilience

Stress seemed to be an inherent phenomenon common to nurses’ environment but a unique positive trait, mitigates its’ effects, which is known in the literature as resilience.

Resilience is defined as an individual ability to maintain relatively stable, health levels of psychological and physical functioning across time and possess the ability to generate new experience and positive emotions, despite of being exposed to trauma

and loss (Bonnano, 2008). But there were several definitions that are being associated with resilience, some theorist suggests resilience as a trait, others propose it as an outcome and others assume it as a process (Prince-Embury, 2013). Resilience originated on the Broaden and Build theory of positive psychology (Isgett & Fredrickson, 2015). This theory predicts that positive emotion broadens one's cognition and attention, which leads toward high emotional wellbeing. According to the Broaden and Build theory (Fredrickson, 1998), some individuals use protective factors such as positive affect as a resource to bounce back and even thrive. Through positive emotions, they are able to find positive meaning from stressful situations (Tugade & Fredrickson, 2004). Being resilient acts as a buffer to the relationship between stressors and negative affective responses to stressors (Ong, Bergeman, Bisconti, & Wallace, 2006), potentially reducing behavioral and physical strains such as turnover intentions, reduced job satisfaction, and injuries. In a synthesis of systematic literature search of electronic databases (PsycINFO, CINAHL and PubMed), Resilience emerged as a central concept through-out the llfespan closely linked to health and well-being (Caldeira & Timmins, 2016). In the Philippines, inspired by Roy's adaptation theory, Reburon (2016) came up with a Warrior resilience theory about adaptation and personal and professional resilience of nurses, combining both military and nursing concept. He underscored that having Warrior resilience is both a skill and a process enabling a person to confront the adversity without reaching a breaking point and recognizing it as an opportunity to mature (Reburon 2016).

In a survey among Australian Physicians, only 14% of physicians reported burnout using a single-item scale, and 10% were found to be highly resilient. Resilience was found to be linked to lower burnout (Cooke et al., 2013). In a study among Australian sample of 735 OR nurses, the study findings concluded that age,

years of OR experience and education contributed to resilience in this group (Gillespie, 2009). A study in Canada, critical care nurses experience burnout; however, resilience showed promise as a potential solution to burnout (Jackson, 2018). A study in Poland, among nurses working in palliative care confirmed a negative relationship between resilience and Secondary Traumatic Stress. Psychological resilience is considered a significant factor to protect a person from exposure to secondary trauma to combat development of Secondary Traumatic stress (Ogińska-Bulik, 2018). In a study with 313 nurses working in a psychiatric hospital in Japan, nurses with high level of resilience had lower level of depression and emotional exhaustion (Ogata as cited by ÇAM & BÜYÜKBAYRAM, 2017). A 1061 participant in China attributed moderate level of resilience to positive coping style and self-efficacy (Guo, 2017). In a study among Oncology Nurses, a quasi-experimental research examined the effect of an intervention program, Resilience to Professional Quality of life, which showed negative significant relationship between intervention and control groups on Compassion fatigue and Compassion satisfaction (Jakel et.al., 2016). In a cross-sectional study of nurses assigned at burn unit, plastic surgery ward, and reconstructive microsurgery unit, caring for dust explosion patients in Taiwan, the study findings demonstrated significant relationships between work stress, burnout, and secondary traumatic stress (Tseng et.al., 2018). Resilience alleviated the effects of Secondary traumatic stress among the participants (Tseng et.al., 2018). In a descriptive qualitative study in Singapore regarding nurse's perception of resilience, four themes were generated (a) resilience is still performing nursing duties despite adversities; (b) resilience is a constantly changing process that develops over time; (c) religion and faith help build resilience; and (d) support of others is important in overcoming work-related stress.

(Ang et.al., 2019). In a study in China among 22 hospitals, data showed a relationship between burnout and resilience among transplant nurses (Yang, 2018).

Synthesis

Compassion fatigue and compassion satisfaction is a common finding in the nursing profession, it is somehow interesting how some Filipino nurses, stays resilient in the profession despite of the challenges they face as a health care provider. As described by several foreigners, the Filipino's have a water-proof spirit when the Philippines was devastated by eight tropical depressions yet still managed to maintain a cheerful disposition (Gulf news, 2012). Filipino resilience also manifested in their capacity to rise above adversities, especially during calamities (Asian News monitor, 2014), and even during the recent war in Libya where they chose to stay and serve rather than leave and be in a safer place (Cobus, 2015).

One of the busiest units of the hospital includes maternal and child areas though these are not fully represented in the literature. One of the NHS hospital in United Kingdom, attributed about 30% chance of the maternity hospitals to turn down mother's in labor which according to the Jon Skewes, Royal College of Midwives director for policy, said: "There is a cocktail of a historically high birth-rate, increasingly complex births and staff shortages that lead to units closing temporarily" (Donnelly, 2017). In a newly opened maternity unit in Khost Afghanistan, from 1,670 births in 2016, their census went up to 2,300 births in 2017 in addition to 1,650 newborns admitted in the Neonatology unit during 2017. All in all, they already had catered to more than 100,000 births since they opened in 2012 (Neyret, 2018). In one of the hospital in the Philippines described to be as baby factory in the country (Narang, 2015), an average of 60 babies are delivered everyday (Ward, 2018), keeping the

delivery room, maternal wards and NICU busy especially when there are complex cases that requires further observation and intervention. Unlike other hospitals, who turndown patients, this particular hospital in the Philippines accommodate patients to the point of placing four post-partum mothers in double beds along with their neonates. (Narang, 2015). A census of 60 deliveries implies a double number of patients at the minimum since not only the mother becomes the patient but also the baby. It further adds up if the mother is having multiple pregnancies.

This study hence wishes to explore resilience and professional quality of life of Nurses in a Maternal and child hospital, which is one of high intensity areas of the hospital yet was not well represented in the literature especially in the Philippine setting.

Theoretical Framework

This study focused on the Transactional theory of stress and coping (Lazarus & Folk man, 1984) which emphasizes as a result of transaction between a person and his/her environment. Stress as a transaction was emphasized when Dr. Susan Kobasa, first used the word “hardiness” to refer to traits that sets resilient people apart from those who develop problems when exposed to stresses and pressure (Kobasa, 1979 as cited in Walinga 2014). Stress takes place when the demand exceeds the resources or our ability to cope (Lazarus &Folkman, 1984). Personal, social, and environmental influence are being taken into consideration, in identifying the nature, degree, and impact of stress. According to this theory, the person’s reaction to stress depends on his/her respective appraisal of the problem which will dictate the coping mechanism (Lazarus & Folkman, 1984). Primary appraisal includes evaluation of the stressor and its degree. The stressor is identified whether it is positive or negative and

further broken down as to whether it is harmful, challenging or a threat. Secondary appraisal evaluates the coping capability in response to the stressor, then followed by re-appraisal which includes pacing and learning. It is a dynamic type of model of stress where the person can change his/her appraisal and one's response (Lazarus & Folkman, 1984).

Conceptual Framework

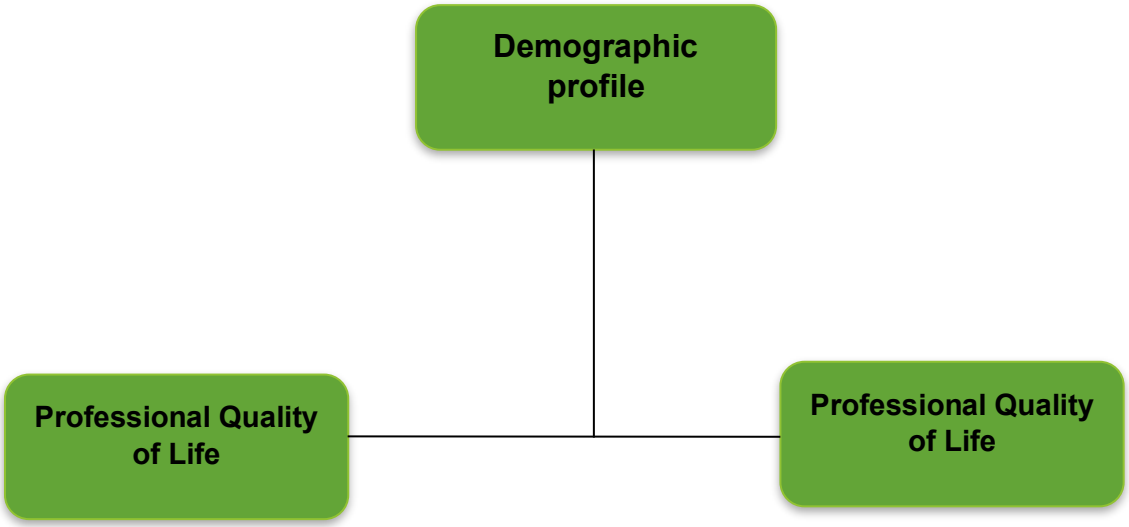


Figure 1. Professional Quality of life, Demographic profile and Resilience in a Maternal and Child Hospital

Nursing is one of highly demanding professions in the health care industry. Farrington described nursing culture in the 1990's typically encapsulates the notions of stress and burnout for being synonymous with the rigors of nursing (Farrington, 1995) which still seems to be evident to this date. Being constantly exposed to stressful environment especially in the hospital setting may somehow increase ones' tolerance to stress, as it becomes part of their everyday reality. But reaction varied individually depending on ones' perception of stress and their complex environment. Even the toughest professionals like nurses can get affected, the question however is how far it can affect them. According to Transactional theory of stress and coping (Lazarus &

Folkman, 1984) stress was identified a result of interaction between a person and his/her environment. A person can appraise the category of stress and react to it based on one's evaluation of the stressor and possible coping mechanism which can be influenced by identified independent variables. In this model, age, sex, length of experience, area of assignment, nursing position and resilience are considered as independent variables, whereas the dependent variables identified are compassion fatigue (secondary traumatic stress, burnout) and compassion satisfaction which are all dimensions of professional quality of life. Responses varies from one person to another depending on their appraisal of the problem which may significantly be influenced by aforementioned independent variables hence this study proposes relationship with the Professional Quality of Life outcomes of the respondents.

Operational Definition of Terms

Professional Quality of Life - refers to the quality one feels in relation to their work as nurses. This is composed by the positive aspect of caring known as Compassion Satisfaction and negative aspect of caring known as Compassion Fatigue. Professional Quality of Life will be measured through Professional Quality of Life instrument version V or PROQOL V.

Compassion Fatigue - refers to the negative aspect of caring. It is characterized by gradual decline of Compassion over time common with individuals working directly with trauma victims or anyone who helps others out due to progressive and cumulative result of prolonged, continuous, and intense contact with patients, and exposure to stress. It is. It has two components, Burnout and Secondary traumatic stress. Burnout refers to a type of psychological stress, characterized by exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness, and may have the dimension

of frustration or cynicism, and as a result reduced efficacy within the workplace. Secondary traumatic stress (STS) refers to physical, emotional and/or mental pain or suffering experienced by individuals or groups, in response to their indirect exposure to traumatic events, such as living or working in close proximity and/or close relationship with people who have undergone direct traumatic exposure. STS and Burnout will be measured using Professional Quality of Life V instrument (ProQol V) as part of Compassion fatigue construct.

Compassion Satisfaction - is attributed to the positive feeling they obtained from helping others, the positive aspect of caring that will be measured through using Professional Quality of Life V instrument (ProQol V).

Resilience – An individual's ability to maintain relatively stable, health levels of psychological and physical functioning across time and possess the ability to generate new experience and positive emotions despite of being exposed to trauma and loss. This will be measured using Resilience (RS-14) tool by Wagnild and Young.

Full Time - Working 40 hours a week.

Nurse I and Nurse II - refers to nurses who exclusively renders direct patient bedside care.

General Areas - refers to clinical areas such as the Out-patient department, and clinical wards.

Specialty Areas - refers to specialized units such as the Operating room, Delivery room, Neonatal Intensive care unit, Paediatric Intensive Care Unit, Emergency room.

CHAPTER III

RESEARCH METHODOLODY

Research design

This research used a non-experimental, correlational design to address the objective of the study. The investigator wished to study the relationship between compassion fatigue, compassion satisfaction and resilience amongst nurses in a Maternal and Child Hospital. In this study, a non-experimental correlational design is appropriate since its' purpose is to assess the prevalence and relationship between variables particularly for this topic which may had been long existing but may not be completely understood and acknowledged amongst this population especially in a public hospital setting which are consistently challenged by high patient ratio. While experimental studies are mostly preferred, this design seems to be more appropriate based on the purpose especially in investigating and establishing its' prevalence in the population.

The research was conducted in two weeks, no sampling was used since all nurses currently employed in the hospital of choice, who met the inclusion criteria were included. Data were gathered through accomplished research questionnaire by the nurses. Resilience scale RS-14, ProQOL V for compassion fatigue, compassion satisfaction and Demographic data at the end of the questionnaire to minimize bias).

Sample

The target participants were all the nurse I and nurse II employees who were employed in one of the tertiary government hospitals of interest. No sampling was done, as all staff nurses who met the inclusion criteria and who consented to

participate in the study were included. There were 245 Nurse I and Nurse II staff in this institution. The research was conducted within two weeks' period.

The inclusion criteria were (a) nurses who were employed in a tertiary government hospital holding a regular employment status (fulltime) (b) with direct patient care assignment and who had given consent to participate in the study. These were Staff nurse I and II assigned at the General ward and Specialty areas of the hospital. Nurses in administrative, managerial, and supervisory position (Nurse III and above) were excluded.

Setting

The study was conducted in a 700-bed capacity tertiary maternity hospital. An ISO accredited, government hospital, operating as a teaching and training hospital. It has slower turnover of nursing personnel compared to private institution. They have 245 Nurse I and Nurse II who had responded to the study.

Data Collection

Stage I: Choosing the subjects

The population of interest in this study included Nurse I and Nurse II, with direct patient care interaction, working full time (40 hours per week) in one of maternal and child hospital in the Philippines. All these nurses who met the inclusion criteria and gave their consent to participate were included in the study. The Nursing service department determine qualified participants based on the given criteria.

Stage II: Data Gathering

Approval from the UP Open University (UPOU) Ethics review board was sought before proceeding with the study. Permission from the Institutional Review Board and

Chief Nursing Officer of the hospital was like wise requested. Since all eligible participants of the targeted population were included in the survey, the assistance of the Nursing Service Department was sought in the recruitment of the participants through their Nursing Education and Research Office and Nurse Managers of each unit. Participants were invited to participate during their Nursing assembly with a Psychologist on standby in case of a need for referral. Nurses who were not able to attend the assembly, received one-on-one briefings from the Principal investigator (PI) during work hours. Upon the signature of the consent form, participants were asked to complete the questionnaire which consisted of socio-demographic profile, Professional Quality of Life scale version V and Resilience scale. Two weeks was allotted for the entire duration of the data collection.

Research Instruments

The study utilized two research instruments to measure the variables of interest: Professional Quality of Life scale (version 5) to measure Compassion fatigue, Compassion satisfaction and Resilience Scale (RS 14). The questionnaire was divided into three parts. The first portion included the 30 items Professional Quality of Life scale; the second part was the resilience scale scale questionnaire composed of 14 items scale. and the third part was the demographic data.

Professional Quality of Life scale (ProQOL 5 version 5) is a tool that measured compassion fatigue and compassion satisfaction nurses experience as they cared for individuals who experienced suffering or trauma. It was previously known as compassion fatigue self-test developed by Figley in 1980's (Stamm, 2010). It was further revised through the collaborative effort of Figley and Stamm and later named as Compassion satisfaction and Fatigue test (Stamm, 2010). The tool was renamed

as Professional Quality of Life scale by Stamm in late 90's (Stamm, 2010). ProQOL V was the latest version of the tool that was used in the study which is composed of 30-item questions using five-point Likert scale responses from never, rarely, sometimes, often, and very often. These responses were further defined, to establish a collective understanding between the scales. It is comprised with three subscales: Compassion satisfaction, burnout, and secondary traumatic stress with the latter two constituting compassion fatigue, whereas compassion satisfaction acts as a stand-alone measure. There were 10 items assigned per subscale. Items 1, 4, 8, 10, 15. 17, 19, 21, 26, 29 were included in the Burnout scale. Items 2, 5, 7, 9, 11, 13, 14, 23, 25, 28 were included in Secondary Traumatic Stress scale. Whereas items 3, 6, 12, 16, 18, 20, 22, 24, 27, 30 comprised the Compassion Satisfaction scale. Previous tests had produced acceptable level of internal consistency reliability, Cronbach alpha for Compassion Satisfaction is alpha 0.88; Burnout is alpha = 0.75; Secondary Traumatic Stress is alpha = 0.81 (Stamm, 2010). Being used in more than 200 published papers and more than 100,000 articles on the internet, gives good construct validity (Stamm, 2010). It has also been comprehensively tested and has been found to be reliable and valid (Hooper et al., 2010). As suggested by Stamm, selected items from the tool may also be modified to suit the respondents like the term help and helper will be substituted with care and caregiver and the trauma victims will be replaced with patients. Permission to use the ProQOL.org was granted by the Author of the research tool, Beth Hudnall Stamm, PhD. This test may be freely copied if (a) author is credited, (b) no changes are made, and (c) it is not sold.

Resilience scale (RS-14), this tool measured nurses' level of resilience. It was formerly a 25 item self-report questionnaire made by Wagnild and Young in 1993 but was further reduced by the same author in 2010 to a shorter 14-item version

questionnaire. The tool was answered through a 7 Likert-scale with varying response from 1 (strongly agree) to 7 (strongly disagree). The higher the score, equals to higher resilience. The Chronbach's alpha coefficient for the resilience scale ranges from 0.85 to 0.94. The internal consistency for the RS-14 ranges from 0.91 to 0.94 in four reported studies. It has also exhibited good construct, concurrent, convergent and discriminant validity (Wagnild, 2010). Since 2006, more than 6,000 Researchers, clinicians, organizations have requested to use the Resilience scale. Permission to use the Resilience scale was granted by the Author of the research tool, Gail Wagnild and Heather Young through intellectual property license agreement which states that is shall not be modified, abridged, condensed, re-casted or transformed (Wagnild, 2009).

Demographic profile is placed in the last part of the questionnaire and sought to answer data from the respondents i.e., Age, sex, length of hospital experience in the hospital, nursing position and area of assignment.

Procedure for Data Collection

After securing permission from the authors of the chosen research tools, approval of the Institution Review Board of the hospital, and approval of Ethics Review board of the Academe, the Researcher proceeded with data collection by coordinating first and foremost with the Nursing service through their Nursing Education and Research office of the hospital where the intent of the study was explained in detail. Their assistance was sought in choosing eligible participants and in distribution of the questionnaire. Participants were invited to participate during their assembly's and the one who were not able to attend received one on one briefings. Pretesting of the questionnaires was initially done for 20 nurses to see how long it would take them to

answer the tools and to clarify any confusion with these instruments. Before distribution of the questionnaires, the respondents were reminded that their identity and answers will be strictly kept confidential and there would be no sanctions that will be imposed should they decide not to continue, however it was pointed out how their participation will help in addressing the research questions that might help nurses in the future. After that, they were asked to complete the consent form and the questionnaires. During the time of data collection, a psychologist was on standby for immediate referral of any untoward or negative effects the participants may experience as they answer the survey tools, as the Secondary Traumatic Stress construct involves remembering traumatic experiences with patients. After completion of the questionnaires, each one was checked for completeness. Only surveys with complete data were included in the analysis. Questionnaires were scored by identifying the mean per item based on their scoring on the Likert-scale per response with consideration on the guidelines per tools. Each answered tool were tabulated using Microsoft excel and sent to a Statistician for data analysis.

Data Management

The study collected and record respondents' demographic profile and responses in Resilience scale and Professional Quality of Life scale which has been converted to tables. These data include age, sex, nursing positon, area of assignment, length of hospital experience and resilience as independent variables and Professional Quality of Life as dependent variables (Compassion fatigue, Compassion Satisfaction). Raw data was collected from a total of 215 questionnaires which were encoded in Microsoft excel file and was forwarded to the Statistician for data analysis. Intended repository will be the academe where findings can be used as reference with proper citation observed.

Ethical Considerations

Approval from the UPOU (University of the Philippines Open University) Ethics Review Board was secured first after the research proposal was approved. Approval from the Institutional Review Board of the hospital was secured before initiating the study. Names and data of the respondents were with utmost confidentiality to protect their privacy and anonymity and only group patterns were analyzed for its' intended purpose. Documents were stored in a locked cabinet, accessible to the Primary Investigator only and disposed of, after extraction of the collective data needed after a month and was shredded thereafter. This study followed all the provisions of the Data Privacy Act of 2012. Their participation in the study was completely voluntary and can be withdrawn at any point of data collection with no negative implications should they decide not to join or withdraw in the study. There was a psychological risk associated with participation in the study as some questions may bring emotional distress. A psychologist was on standby for respondents who got emotionally or psychologically affected while answering the questionnaire or those who had feelings of depression or burn-out from work. A written consent form was completed first before answering the research tool and Principles of Beneficence and Non-maleficence were ensured to protect the welfare of the respondents by ensuring the study brought about good and rendered no harm to the research participants physically, psychologically and socially.

Data Analysis

Descriptive statistics was calculated using Statistical software (SPSS Statistics 21) to describe the variables and samples of the study. The demographic profile of nurses: age, length of service, and area of assignment, was measured by frequency

and percentage per identified range. Whereas the prevalence of resilience, compassion fatigue, and compassion satisfaction was treated with weighted mean and standard deviation. The correlation between resilience and compassion fatigue was measured by Pearson's r using the summarized score per subscale. The correlation between Resilience and compassion satisfaction was measured by Pearson's r as well. The correlation between resilience, compassion fatigue, compassion satisfaction and demographic profile of nurses (age, length of experience, area of assignment) were also measured using the same statistical test as they were converted to interval variables.

Table 1. Different statistical test to be used for each dependent and independent variable.

Independent variable	***Level of Measurement***	***Statistical test to be used***
Resilience	Interval	Pearson's r correlation
Age	Interval	Pearson's r correlation
Area of assignment	Interval	Pearson's r correlation
Length of experience	Interval	Pearson's r correlation
Dependent Variable	***Level of Measurement***	***Statistical test to be used***
Compassion fatigue (STSS and BO)	Interval	Pearson's r correlation
Compassion satisfaction	Interval	Pearson's r correlation

CHAPTER 4

RESULTS and DISCUSSION

Demographic Profile

Table 2. Frequency Distribution of socio-demographic profile of the Respondent Nurses (n=215)

Characteristics	Frequency	Percentage
Sex		
Male	119	55.35%
Female	96	44.65%
Age		
21 – 35 years old	177	82.33%
36 - 50 years old	36	16.74%
51 years old and above	2	0.93%
Nursing position		
Nurse 1	98	45.58%
Nurse 2	117	54.42%
Specialty	115	53.49%
General	100	46.51%
5 - 10 years	188	87.44%
11 - 20 years	24	11.16%
21 years and above	3	1.40%

Study participants were described using frequency distribution. Majority of participants were males n=119 (55.35%) in contrast to number of females n=96 (44.65 %).

Majority of participants were nurses in 21-35 years old category n=177 (82.33 %), followed by nurses between ages 36-50 n=36 (16.74 %), followed last by nurses 51 years old and above n=2 (0.93 %).

Nurse II constitute most of the respondents with n=117 (54.42 %), whereas Nurse I composed of n=98 (45.58 %) of the total participants.

Nurses assigned in the Specialty areas composed most of the respondents n=115 (53.49 %) while those assigned in the General areas represents n=100 (46.51 %) of the total population.

Nurses with 5-10 years' experience composed most of the respondents n= 188 (87.44 %), whereas nurses with 11-20 years' experience comes second n=24 (11.16 %) while nurses with longest experience have the least respondents=3 (1.40 %).

Professional Quality of Life

Compassion Fatigue

Table 3. Burn-out

INDICATORS	MEAN RESPONSE	STD. DEVIATION
1. I am happy.	4.58	0.642
4. I feel connected to others.	4.52	0.669
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I*[help]*.	1.05	0.302
10. I feel trapped by my job as a *[helper]*.	2.67	1.494
15. I have beliefs that sustain me.	4.64	0.766
17. I am the person I always wanted to be.	4.17	0.433
19. I feel worn out because of my work as a*[helper]*	4.03	1.223
21. I feel overwhelmed because my case [work] load seems endless.	4.40	1.041
26. I feel "bogged down" by the system.	3.63	1.176
29. I am a very caring person.	4.83	0.374
WEIGHTED MEAN RESPONSE	**3.85**	**0.813**

	PARAMETERS
(3.68 – 5.00)	High
(2.34 – 3.67)	Moderate
(1.00 – 2.33)	Low

The overall response of the respondents in relation to burnout was high. Despite high response in positive questions such as "*I am happy, I have beliefs that sustain me, I am a very caring person"*; the response to the other questions such as *"I feel worn out, I feel overwhelmed"* were also high. There were also moderate responses with questions like "*I feel trapped by my job as helper, I feel bogged down by the system*". There were low standard deviations on majority of responses from positive questions which means that responses were close to the mean; there were small variation with responses which reflect similarity in the outlook of the respondents. Whereas negative questions like I feel trapped, I felt overwhelmed, I feel bogged down, showed a slight higher standard deviation from the rest which reflect that responses were slightly far from the mean, showing a slight spread implying that there were more but slim variability's in the response and difference in the perception of the respondents of these negative questions.

High burnout may had been influenced by constant high patient ratio, since the setting of this research has the reputation of being a "baby factory" for consistently getting the highest birth rates among the rest of the hospitals in the Philippines (Narang, 2015). Sometimes four to five mothers with their neonates shared in one bed just to be accommodated (Narang, 2015). With this kind of scenario, the staff would likely become overworked as their patients get to be multiplied as one delivery is equal to a mother and baby tandem which could be more if the case is a multiple pregnancy. The staff also needed to conduct health teachings before sending the patients home which can be more challenging if the patient is a first time mother who needs further education on how to feed, to bathe and, to take care of their young. Since the setting is one of the most affordable, expert providers of maternity care, with

good location to boast, it became one of the most sought hospital for most patients especially those with marginal income justifying it consistent high patient census

Table 4. Secondary Traumatic stress

INDICATORS	MEAN RESPONSE	STD. DEVIATION
2. I am preoccupied with more than one person I*[help]*.	3.63	0.933
5. I jump or am startled by unexpected sounds.	1.06	0.239
7. I find it difficult to separate my personal life from my life as a*[helper]*.	3.06	1.075
9. I think that I might have been affected by the traumatic stress of those I*[help]*.	4.20	1.006
11. Because of my *[helping]*, I have felt "on edge" about various things.	3.44	1.515
13. I feel depressed because of the traumatic experiences of the people I*[help].*	2.40	0.625
14. I feel as though I am experiencing the trauma of someone I have*[helped]*.	2.33	0.669
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I*[help]*.	2.50	0.603
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.	2.26	0.741
28. I can't recall important parts of my work with trauma victims.	1.09	0.349
WEIGHTED MEAN RESPONSE	**2.60**	**0.775**

	PARAMETERS
(3.68 – 5.00)	High
(2.34 – 3.67)	Moderate
(1.00 – 2.33)	Low

Whereas the overall weighted mean response resulted to moderate Secondary Traumatic Stress (STS) result. The question “I think I might have been affected by Traumatic stress of those I help got the highest rating; while other questions, like I am preoccupied with more than one person I*[help],* I find it difficult to separate my personal

life from my life as a*[helper],* I have felt "on edge" about various things, I feel depressed because of the traumatic experiences of the people I*[help],* I avoid certain activities or situations got moderate response. The standard deviation showed that most of the answers were close to the mean except for items stating that they might be affected by Traumatic stress of those they help, difficulty on separating personal life and felt “on edge” about various things which showed greater spread but slight difference in their point of view in respect to these aspects. While majority of responses in the questions showed minimal difference in their opinions.

Secondary Traumatic Stress and Burnout according to studies have strong association (Cieslak et. al., 2013) similar to the findings of this current research. Common denominator for both is the high patient ratio of the hospital which exposes them to handle more patients than they can. One thing to consider is also the nature of the hospital as a birthing institution. Pregnant women giving birth experience labor/birth pains that may show great deal of distress which could also affect nurses especially those who are either new in the hospital or unfamiliar with giving birth such as males.

Table 5. Compassion Satisfaction

INDICATORS	MEAN RESPONSE	STD. DEVIATION
3. I get satisfaction from being able to *[help]*people	4.71	0.466
6. I feel invigorated after working with those I*[help]*.	4.64	0.510
12. I like my work as a*[helper]*.	4.66	0.486
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.	4.65	0.489
18. My work makes me feel satisfied.	4.67	0.483
20. I have happy thoughts and feelings about those I *[help]* and how I could help them	4.67	0.480
22. I believe I can make a difference through my work.	4.64	0.490

24. I am proud of what I can do to*[help]*.	4.89	0.466
27. I have thoughts that I am a "success" as a*[helper]*	4.67	0.480
30. I am happy that I chose to do this work.	4.65	0.533
WEIGHTED MEAN RESPONSE	**4.68**	**0.488**

	PARAMETERS
(3.68 – 5.00)	High
(2.34 – 3.67)	Moderate
(1.00 – 1.33)	Low

Filipinos are also known as hospitable people. This is a huge part of Filipino culture; hence they usually offer help. This is reflected with their responses in the CS scale which resulted to high compassion satisfaction. All questions resulted to high response. There were little differences in the opinion of the group as it reflected very small standard deviation which may give us hint on the characteristic and general and positive outlook of the respondents. The latter may be high because despite of being one of the busiest maternal and child hospitals in the country, the staff may have found a sense of purpose and fulfillment in their work. They may have many patients but the fact that they were able to help, impart their knowledge, and gave effort to serve the underprivileged population might had made all the difference. The nature of the research setting as Maternal and Child hospital may also have influenced compassion satisfaction status, since you can see the result of care being rendered as soon as the pregnant women gives birth. This is also a positive reason to be admitted in a hospital, frequently thought of as a momentous occasion and happy event being celebrated in contrast to being confined due to an illness.

Level of resilience among nurses in maternal and child hospital

Table 6. Level of resilience

INDICATORS	MEAN RESPONSE	STD. DEVIATION
I usually manage one way or another.	6.32	0.877
I feel proud that I have accomplished things in my life.	6.09	0.948
I usually take things in stride.	5.99	1.009
I am friends with myself.	5.75	0.838
I feel that I can handle many things at a time.	5.67	0.955
I am determined.	5.62	0.882
I can get through difficult times because I've experienced difficulty before.	5.73	0.896
I have self-discipline.	5.47	0.926
I keep interested in things.	5.45	0.920
I can usually find something to laugh about.	5.51	0.916
My belief in myself gets me through hard times.	5.47	0.985
In an emergency, I'm someone people can generally rely on.	5.50	0.911
My life has meaning.	5.61	0.920
When I'm in a difficult situation, I can usually find my way out of it.	5.52	0.971
WEIGHTED MEAN RESPONSE	**5.69**	**0.925**

	PARAMETERS
(5.01 – 7.00)	High
(3.01 – 5.00)	Moderate
(1.00 – 3.00)	Low

Overall resilience score was high. The mean response in the Resilience scale per item also showed high results with all the questions reflecting that Filipinos have positive outlook in life. Standard deviation showed that most of the responses were

close to the mean showing little variability is giving us an idea of the general characteristic of the respondents based on their responses. Only the item: *I usually take things in stride* showed slightly higher variability in responses yet still close to the mean. High resilience, may be a unique characteristics of Filipinos, that despite of negative experiences, they were able to turn things around to their advantage by becoming more resilient that is why even if the nurses felt high burnout due to the hospital settings, they still exhibited high resilience. The result is also consistent with what President Duterte said that Filipino resilience can be attributed to their strong faith with God (Manila Bulletin, 2019) which may have something to do with them being one of the Christian nations in Asia. Lastly, Filipinos have strong family ties, they also find family among their friends even if they do not share the same blood. This maybe why Filipinos were described to have “waterproof spirit” (Gulf news, 2012) as they have have proven their resiliency at the time of war (Cobus, 2015), tropical depression (Gulf news, 2012), Disasters (Asia news Monitor, 2013) and others.

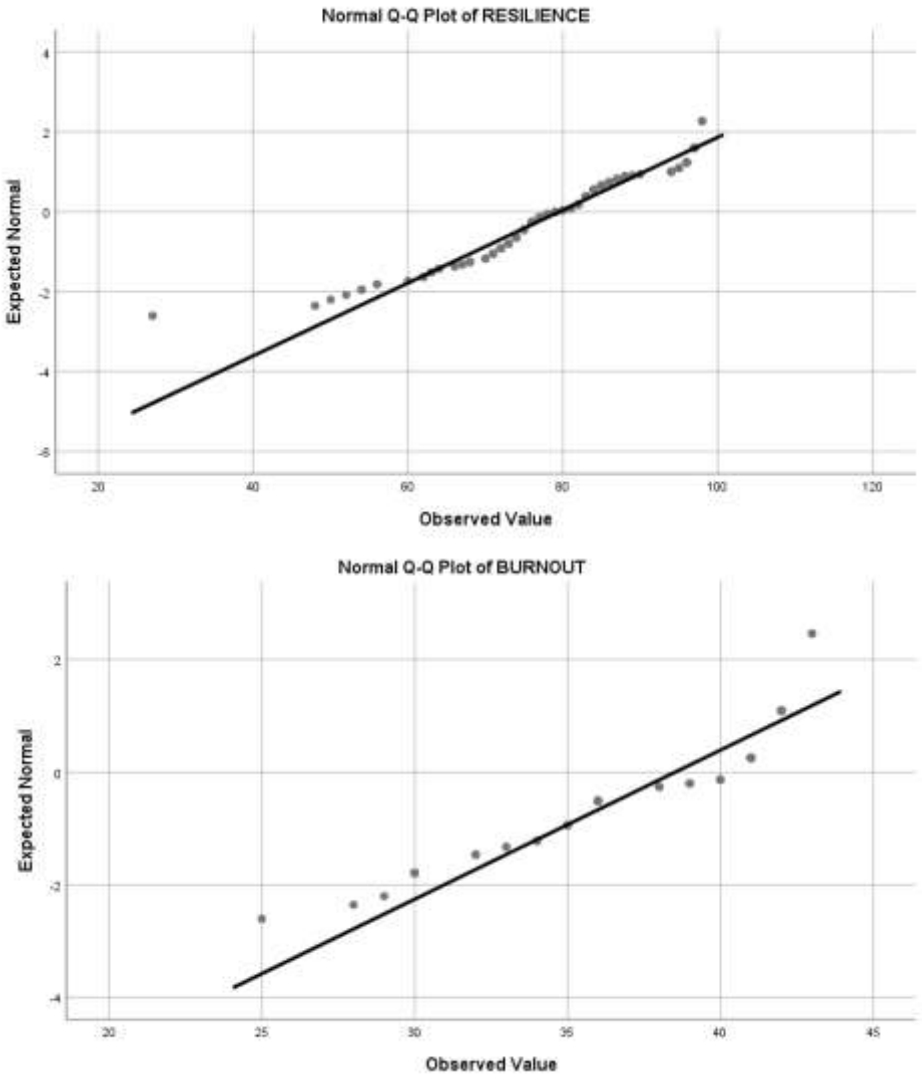
Relationship between Professional Quality of Life and resilience among nurses in a maternal and child hospital

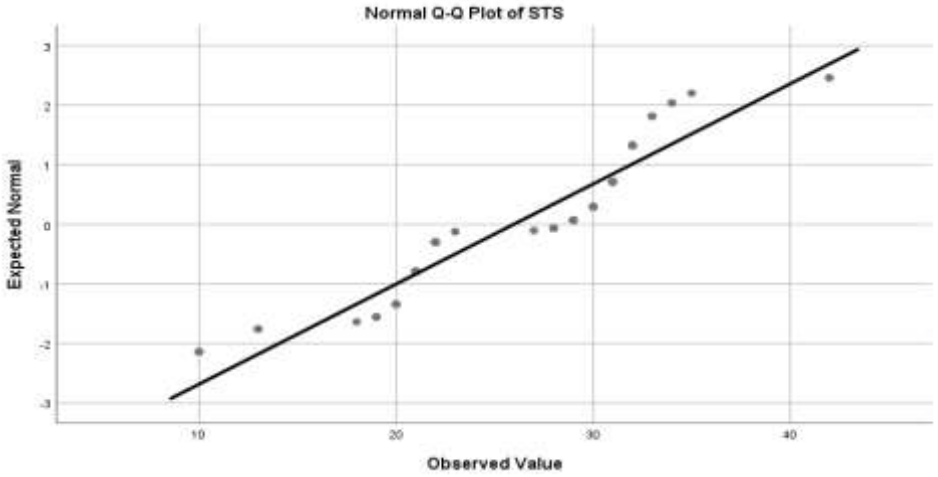
First, test of Normality was used. The table below presents the results from two well-known tests of normality, namely the Kolmogorov-Smirnov Test and the Shapiro-Wilk Test. The Shapiro-Wilk Test is more appropriate for small sample sizes (< 50 samples) but can also handle sample sizes as large as 2000. For this reason, Shapiro-Wilk test was used as the numerical means of assessing normality.It can be seen from the table below that "Burnout", "Compassion Satisfaction", “Resilience” and "Secondary Traumatic Stress" were all normally distributed since the Sig. value of the Shapiro-Walk Test is greater than 0.05, which showed that the the data is normal. If it is below 0.05, the data significantly deviate from a normal distribution.

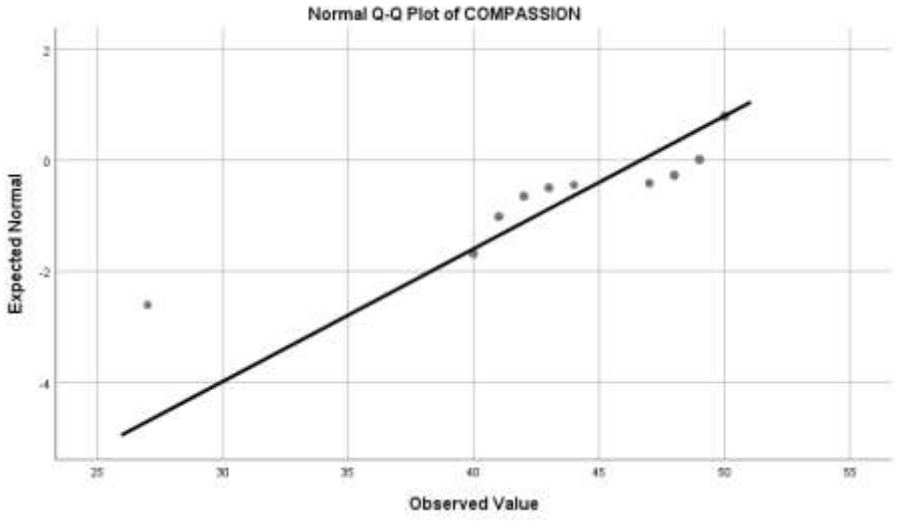
Table 7. Test of Normality

	Kolmogorov-Smirnov[a]			**Shapiro-Wilk**		
	Statistic	df	Sig.	**Statistic**	**df**	**Sig.**
BURNOUT	.284	215	.200	**.835**	**215**	**.827**
COMPASSION SATISFACTION	.277	215	.200	**.736**	**215**	**.882**
RESILIENCE	.092	215	.200	**.943**	**215**	**.837**
SECONDARY TRAUMATIS STRESS	.206	215	.200	**.880**	**215**	**.865**

Figure 2. Q-Q Plot for Resilience, Burnout, STS, and Compassion Satisfaction







In order to determine normality graphically, output of a normal Q-Q Plot can be used. If the data are normally distributed, the data points will be close to the diagonal line. If the data points stray from the line in an obvious non-linear fashion, the data are not normally distributed. As we can see from the normal Q-Q plot above, the data is normally distributed.

Hence assuming normality of data, Pearson's r was used as a parametric test to measure strength and direction between two interval variable.

Table 8. Professional Quality of life and Resilience

Resilience vs	Pearson- r	p- value
Burnout	.575	.000
Secondary Traumatic Stress	-.711	.000
Compassion fatigue	-.188	.006
Compassion Satisfaction	.571	.000

The tables above showed the correlation coefficient and the p-value.

Alternative Hypothesis 1: There is a significant relationship between Professional Quality of life and Resilience among nurses in maternal and child hospital

Interpretation: At 5% level of significance there is sufficient evidence to conclude that there is a significant relationship between Professional Quality of Life and Resilience of nurses in maternal and child hospital. Since P value is less than 0.05, we accept the alternative hypothesis. The Pearson's r correlation showed a strong uphill linear relationship with Burnout and Compassion satisfaction, which means that as Resilience goes up, Compassion Satisfaction and Burnout may go up as well. Whereas Resilience showed negative relationship with STS and weak negative correlation with Compassion fatigue like the findings among US Nurses (Hunsaker, 2015) and Australian nurses (Hegney et.al., 2015), and other nurses Ogińska-Bulik (2018). In a research by Harvey et.al., (2015), it was found that resilience was positively correlated with compassion satisfaction and high burnout score were strongly associated with lower resilience score and slightly lower

Compassion Satisfaction. In another study, resilience was found to be linked to lower burnout (Cooke et al., 2013) contrary to the result.

The respondents revealed high level of resilience, compassion satisfaction and burnout, and moderate STS which is almost similar to the research findings done in Philippine General Hospital (PGH) (Positive relationship with the variables), where the study revealed a moderate level of compassion satisfaction, burnout and secondary traumatic stress (Tamayo et.al, 2016). Both findings may have similarities as PGH and the research locale of this study both have highly dense patient population since PGH is the ultimate referral hospital and the other is the center of over population crisis in the Philippines.

The findings of this study align with the conceptual framework of the study suggesting relationship between Professional Quality of Life and Resilience. In contrast with other studies, nurses experiencing burnout are still resilient people. This is one of the interesting findings of this study as resilience is positive and burnout is a negative construct, but they co-exist. This finding may mean that resilience has no role in reducing prevalence of burnout hence training to increase Resilience will not address burnout, instead, the source should be identified and properly addressed. This finding is consistent with research done by midwives (Eaves, 2019) and doctors (McCain et.al., 2018) which was further underscored by Professor Leiter in his address in the APS congress 2018 as he emphasized the limitation of resilience in preventing burnout.

Relationship between Demographic profile and Professional Quality of Life among nurses in a maternal and child hospital

Alternative Hypothesis2: There is a significant relationship between demographic variables with Professional Quality of Life and Resilience

Table 9. Demographic Profile and Professional Quality of Life

	Burnout vs		**Pearson- r**	**p- value**
	Age		.278	.000
Sex	Mean score		.589	.000
	M	F		
	20.0588	26.7188		
	Length of Service		.228	.000
Area of	Mean score		.609	.000
Assignment	General	Specialty		
	26.7000	19.8435		
Nursing	Mean score		.763	.000
Position	Nurse I	Nurse II		
	18.3469	26.9573		

	Secondary Traumatic Stress vs		**Pearson- r**	**p- value**
	Age		-.387	.000
Sex	Mean score		-.844	.000
	M	F		
	30.6891	20.1250		
	Length of Service		-.302	.000

Area of Assignment	Mean score General Specialty 20.3300 30.8783	-.886	.000
Nursing Position	Mean score Nurse I Nurse II 31.0000 21.7607	-.775	.000

Compassion Satisfaction vs		**Pearson- r**	**p- value**
Age		.344	.000
Sex	Mean score Male Female 44.2941 49.5938	.631	.000
Length of Service		.276	.000
Area of Assignment	Mean score General Specialty 49.5400 44.1565	.644	.000
Nursing Position	Mean score Nurse I Nurse II 44.5204 48.4530	.469	.000

Compassion Fatigue vs	**Pearson- r**	**p- value**
Age	-.139	.042
Sex	-.367	.000

Length of Service	-.096	.159
Area of Assignment	-.348	.000
Nursing Position	-.059	.387

Assuming normality as computed with Shapiro-Wilk and graphed and plot using Q-Q graph, Pearson-r correlation was used as parametric test to establish relationship between two interval variables. The tables above showed the correlation coefficient and the p-value.

Interpretation: At 5% level of significance there is sufficient evidence to conclude that there is a significant relationship between Burnout, Secondary Traumatic Stress, Compassion Satisfaction between Demographic variables of the respondents. However, with STS and Burnout combined as Compassion Fatigue, length of service and Nursing position were found to be non- significant. Burnout was identified to have significant positive but weak relationship with age, and length of service. Burnout may go up as the age, length of service and higher nursing position arises. STS were identified more common in Male, like the study findings in Philippine Heart Center where males were identified more vulnerable (Candano & Mancuyas, 2015). STS is also more common among Nurse I may be because they are still getting competency as a Nurse in Specialty areas since most of the trauma of the patients happen in this area i.e., operations, giving birth. STS is inversely related with Age and length of experience. STS goes down as the nurse ages or gains longer hospital experience maybe because of maturity and as they become more acquainted with the kind of patients and cases they handle in the hospital.

High compassion satisfaction also increases with age, length of experience, Higher position. This may suggest that the older a person gets and the longer they stay at work empowers them more to help. Female nurses and those assigned in general areas were also correlated with High CS. The findings of the study showed relationship between Demographic data and Professional Quality of Life as proposed in the conceptual framework.

Relationship between demographic profile and resilience among nurses in a maternal and child hospital.

Alternative Hypothesis 2: There is a significant relationship between ***demographic variables*** *with Professional Quality of Life and* ***Resilience***

Table 10. Demographic profile and Resilience

Resilience vs			**Pearson- r**	**p- value**
Age			.670	.000
Sex	Mean score		.756	.000
	Male	Female		
	72.1261	88.7604		
Length of Service			.542	.000
Area of Assignment	Mean score		.756	.000
	General	Specialty		
	88.4300	71.8348		
Nursing Position	Mean score		.707	.000
	Nurse I	Nurse 2		
	71.1020	86.6325		

Interpretation: At 5% level of significance there is sufficient evidence to conclude that there is a significant relationship between demographic profile and resilience among nurses in a maternal and child hospital.

The Pearson's r correlation showed a positive strong relationship of demographic variables and resilience. Increase in age, length of service, higher nursing position (Nurse II), general Area of assignment (area with the highest mean) and female (sex with highest mean) correlated with increase in resilience. This may suggest that personal and work maturity plays a big factor in equipping nurses to cope well. Female nurses and those assigned in general areas were also correlated with high resiliency. This maybe attributed to females being more efficient in expressing their emotions and the general area to be a lesser toxic area of assignment than specialty units. In other studies, age and working experience was noted to be associated with higher resilience level (Ang et.al., 2018) In a study among Australian sample of 735 OR nurses, the study findings concluded that age, years of OR experience contributed to resilience in this group (Gillespie, 2009) which are similar findings in the study. The findings of this study are consistent with the conceptual framework of the research showing relationship between demographic data and resilience.

CHAPTER V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This study examined the correlation between Professional Quality of life and its' subscale Compassion fatigue (Burn-out and Secondary Traumatic Stress), Compassion satisfaction between Resilience and demographic profiles of the Nurses employed in a Maternal and Child hospital. This chapter provides summary of findings, conclusion, and suggestions for future research studies.

Summary of Findings

Resilience, compassion satisfaction, and burnout demonstrated a significant strong positive relationship. Resilience also increases with age, length of experience, higher position. Resilience is also higher among female nurses and those assigned in general areas. Similar to resilience, compassion satisfaction increases with age, length of experience and higher position and also common among women and among those assigned in general areas. Burnout also increases with age and length of service, and higher position. This is also more common among females and those assigned in general areas, in this study. Secondary traumatic stress on the other hand was negatively correlated with CS, resilience and burnout. When these variables rise, STS decreases. STS were identified more common in male, entry level nurses (Nurse I) and those assigned in specialty areas. STS is inversely related with age and length of experience. STS goes down as the nurse ages or gains longer hospital experience.

Conclusion

The present study contributed necessary discussion in the literature about Resilience and Professional Quality of Life of nurses assigned in maternal and child setting, in the Philippines.

The study results provided insights on the level of resilience amongst these nurses and their level of compassion satisfaction and compassion fatigue. The study outcome confirmed that Filipino nurses, also experienced compassion fatigue as their results reflected high burnout and moderate secondary traumatic stress. However, the results do not support the findings of other studies abroad, that resilience is inversely related to burnout, as it showed a perfect positive association with each other inferring that as resilience goes up, burnout also goes up. By understanding this, the hospitals should not entirely focus on building resilience to their staff but also on solving the source of burnout for their nurses. Cognizant of the relationship of demographic factors, resilience and Professional Quality of Life variables will aid in periodic assessment, and easier identification of population at risk of negative effects of caring (i.e., Male with shorter hospital experience for STS and Senior Nurses with longer hospital experience for Burnout).

This study provided a basis for further research to understand the relationship of Resilience and elements of Professional Quality of Life that may be used in other setting and nationality. Further investigation into these issues is crucial to ensure that patients are being cared by compassionate and highly resilient nurses' despite being exposed to potential hazards in the profession like compassion fatigue.

Recommendations

Future Research

The baseline data may inspire further studies regarding possible interventions that are directed towards promotion of holistic wellbeing of nurses, resilience, compassion satisfaction and prevention and early identification of incidence of compassion fatigue: STS and burnout. This will help ensure that nurses are on their optimum wellbeing to provide care which will benefit our patients the most. Different tools may be used such as rewards and meaningful recognition, and variety of activities i.e., teambuilding which may be utilized to promote overall wellbeing of the staff. Resiliency seminars may not help in preventing burn-out, so the source of Burnout should be identified and addressed as needed. Root cause analysis of burnout may be done in the future through thorough organizational and personal root cause analysis that may produce a more in-depth validated burn-out instrument that can further give cues on how to specifically address its causes.

With the characteristics of the population studied, other solutions may be explored. Positive and negative coping mechanism, strategies on managing workloads may also be studied in relation to resilience. The sample for this study only included nurses employed in a government hospital, so future studies including nurses in a private sector may be considered. Though this study has included nurses assigned in general and specialty areas, the study findings was generated from an exclusive maternal and child hospital, so other specialty hospital may also be studied in the future (i.e., orthopedic, kidney) to establish any diversity in the experiences among subspecialties with larger scale of population. Studies with randomization across other large-scale specialty hospital may be done in choosing the respondents

in future research. A prospective study may also be done, as cross-sectional study such as this one, might just a represent a bad day at work.

Education

Cognizance regarding compassion fatigue, compassion satisfaction and resilience should be instilled not only among newly hired nurses but also with nursing interns in their nursing curriculum. Programs should also be conducted regularly, not only to inform but to equip the present and future nurses in adapting healthy and effective coping mechanism.

Practice

The organization should likewise acknowledge the importance of promotion and prevention of this occupational hazard not only for the nurses but for the patients' welfare as well. Raising cognizance and acceptance in the organizational level will empower the management to come up with sound and effective plans that will be part and parcel of prevention and interventional strategies for risk reduction and risk management plan of the institution that will ensure wellbeing of nurses. A 360° feedback mechanism may also be employed for early detection and referral of compassion fatigue on a periodic basis and as needed as to not only focus on the employees of lower ranks but may extend to the leaders as well who likewise may experience the incidences of the variables being discussed.

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Appendix A

Consent form

Informed Consent

University of the Philippines Open University

This Informed Consent Form is for Nurse I and Nurse II employed in a maternal and Child Hospital, who we are inviting to participate in research study entitled "Professional Quality of Life and Resilience among Nurses in a Maternal and Child hospital"

Name of Principal Investigator -Mary Grace L. Rivera, RN

Name of Organization: University of the Philippines, Open University

Name of Project: Thesis N300

This Informed Consent Form has two parts:

Information Sheet (to share information about the study with you)

Certificate of Consent (for signatures if you choose to participate)

PART I: Information Sheet

Introduction

I am Mary Grace Lanzanas-Rivera, taking Master's Degree in Nursing. I am doing research on Professional Quality of life and Resilience among Nurses in a Maternal and Child Hospital. I am inviting you to be part of this research, but you can talk to anyone you feel comfortable with about the research before you decide to participate or not. Should you feel confuse with some concepts, you may reach me through the number indicated below.

Purpose of the research

This research aims to contribute to the knowledge on Professional Quality of Life (Compassion Fatigue and Compassion Satisfaction) and Resilience among Nurses in Maternal and Child Hospital. According to the literature, these variables are common among helping professionals across the globe including nurses. Though these has been established as common phenomenon, not all Filipino nurses experience were alike. There are some, who despite of the challenges in work, remains in the profession and thrives. This study aims to describe then the professional quality of life and resiliency of the Filipino nurses in a maternal and child hospital and determine its' correlation that might become a basis with future risk management programs in the institution.

Participant Selection

You are being invited to take part of this research because you are qualified based on inclusion and exclusion criteria of the study which will give us data on the Professional Quality of life and Resilience among Nurses in a Maternal and Child Hospital.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not and you may withdraw at any point in time. No sanctions will be given should you or should you not choose to participate in the study.

Procedure

If you agree to participate in the study, a consent form shall be signed prior to responding to the questionnaire. The survey form consists of three parts. First is the Professional Quality of Life (PROQOL V), second part is the Resiliency questionnaire and the third and last part is the demographic questionnaire. Participants may choose

to withhold their names, but we request that you complete the rest of the questionnaires to gather thorough information that are vital for valid output of the study.

Duration

Estimated time of answering the survey is twenty to thirty minutes only which will be administered within your hospital.

Benefits

There will be no direct benefits from participation in the study but the anticipated benefit of your participation will likely help our nurses and the future generation of Nurses, through the information that will be generated that can become a basis to formulate strategies promoting resiliency, positive effects of caring and preventing negative effects of the latter. This will not only benefit the nurses but also the patients and as a result, our society as a whole. This will also contribute to the existing scientific body of information that may be beneficial to other future researches related to the study.

Confidentiality

The information that we collect from this research project will be kept confidential. Information about you that will be collected during the research will be put away and no-one, but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except [name who will have access to the information, such as research sponsors, DSMB board, your clinician, etcetera].) Patient codes will be used to maintain privacy and confidentiality. This research will follow the Data Privacy Act of 2012)

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so and choosing to participate will not affect health care delivery. You may stop participating in the intervention, but I will give you an opportunity at the end of the program to review your remarks.

Risks

There is psychological risk associated with participation in the study as some questions may bring emotional distress. A Psychologist may attend to respondents who will get emotionally or psychologically affected while answering the questionnaire or those who have feelings of depression or burn-out from work.

Who to Contact

If you have any questions, you may contact the Investigator: [Mary Grace Rivera, University of the Philippines, Open University, 55 C. P Garcia Ave, Diliman, Quezon City, 1101, Metro Manila Philippines/0917-150-7628/marygrace.rivera@upou.edu.ph]).

Part II: Certificate of Consent

I have been invited to participate in research about Professional Quality of Life and Resilience among Nurses in a Maternal and Child hospital.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked to have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant: _____

Signature of Participant: _____

Date: _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. A consent to participate in the study will be secured prior to participation in the study.

2. A respondent will have to answer the Professional Quality of Life Scale (ProQOL) and Resiliency questionnaire, which could take about 30 minutes of their time.

3. A Psychologist may attend to respondents who will get emotionally or psychologically affected while answering the questionnaire or those who have feelings of depression or burn-out from work.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to

the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/month/year

Appendix B

Professional Quality of Life Scale (ProQOL V)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

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

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

Legend:

Never- Zero experience in 30 days

Rarely- Experienced 1-2 times in 30 days

Sometimes- Experience 3-4 times in 30 days

Often- Experienced 5 to 10 times in 30 days

Very often- Experienced 11 times and beyond in 30 days

____ 1. I am happy.

_____2. I am preoccupied with more than one person I[help].

_____ 3. I get satisfaction from being able to [help]people

_____4. I feel connected to others.

_____5. I jump or am startled by unexpected sounds.

_____6. I feel invigorated after working with those I[help].

_____7. I find it difficult to separate my personal life from my life as a[helper].

_____8. I am not as productive at work because I am losing sleep over traumatic experiences

of a person I[help].

_____9. I think that I might have been affected by the traumatic stress of those I[help].

_____10. I feel trapped by my job as a[helper].

_____11. Because of my [helping], I have felt "on edge" about various things.

_____12. I like my work as a[helper].

_____13. I feel depressed because of the traumatic experiences of the people I[help].

_____14. I feel as though I am experiencing the trauma of someone I have[helped].

_____15. I have beliefs that sustain me.

_____16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

_____17. I am the person I always wanted to be.

_____18. My work makes me feel satisfied.

_____19. I feel worn out because of my work as a[helper].

_____20. I have happy thoughts and feelings about those I [help] and how I could help them

_____21. I feel overwhelmed because my case [work] load seems endless.

_____22. I believe I can make a difference through my work.

_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I[help].

_____24. I am proud of what I can do to[help].

_____25. As a result of my [helping], I have intrusive, frightening thoughts

_____26. I feel "bogged down" by the system

_____27. I have thoughts that I am a "success" as a[helper]

_____ 28. I can't recall important parts of my work with trauma victims.

_____29. I am a very caring person.

_____30. I am happy that I chose to do this work.

Appendix C

14-ITEM Resilience Scale (RS-14)

Date_____

Please read each statement and circle the number to the right of each statement that best indicates your feelings about the statement. Respond to all statements.

Circle the number in the appropriate column	Strongly Disagree						Strongly Agree
1. I usually manage one way or another.	1	2	3	4	5	6	7
2. I feel proud that I have accomplished things in my life.	1	2	3	4	5	6	7
3. I usually take things in stride.	1	2	3	4	5	6	7
4. I am friends with myself.	1	2	3	4	5	6	7
5. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
6. I am determined.	1	2	3	4	5	6	7
7. I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
8. I have self-discipline.	1	2	3	4	5	6	7
9. I keep interested in things.	1	2	3	4	5	6	7
10. I can usually find something to laugh about.	1	2	3	4	5	6	7
11. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
12. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7

13. My life has meaning.	1	2	3	4	5	6	7
14. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7

Name: _____
(Optional)

Direction: Kindly input your answer or tick the space corresponding to your answer.

Age as of last birthday: _____

Length of hospital experience (in the institution): _____

Nursing position

_____Nurse I _____Nurse II_____

Current area of Assignment

_____Clinical Area (e.g., OPD, Clinical wards)

_____Specialty areas (e.g., OR, DR, ICU and others)

MARY GRACE L. RIVERA, RN
215 C Hillcrest Circle Oranbo Pasig City
+63 998 530 9518
mgracerivera@gmail.com

QUALIFICATIONS SUMMARY

- Registered Nurse with fourteen (14) years of hospital experience
- Currently employed in Rizal Medical Center, DOH (Department of Health) retained, 500-bed capacity tertiary government hospital with Phil-health, and ISO 9001-2015 accreditation.
- Philippines Registered Nurse, with board rating of 80.20% US Registered Nurse with license number r65741 (New Mexico State)
- Currently pursuing Master of Arts in Nursing at the University of the Philippines-Open University, on thesis completion.
- Given a commendation for invaluable service to the Nursing Division for exceptional work as the Unit Manager of Operating Room and Post-Anesthesia Care Unit-October 30, 2019
- Member of the hospital's ISO Internal Audit team.
- Technical working group member for PGS accreditation (Performance Governance System.
- Technical Working group member of Bid's and Awards Committee for 2019.
- Member, Sigma Theta Tau International Honor Society of Nursing, PSI Beta chapter, (member number 1937126)
- Lifetime member of Operating Room Nurses of the Philippines (ORNAP)
- Member of Association of Nursing Service Administrators of the Philippines (ANSAP)
- Member of Philippines Nurses Association
- BLS, ACLS certified
- Prepared the ISO core process of the Operating room, Post Anesthesia Care Unit, and Delivery Room (Rizal Medical Center).
- Former Overall Chairman for the Nurses week 2017
- Former President Rizal Medical Center, Nursing Association 2017-2018
- Former member of the Bids and Awards committee of the hospital for the year 2017 and 2018.

EMPLOYMENT HISTORY

❖ **NURSE MANAGER/NURSE IN CHARGE** – July 03, 2017 to present

- Employer : **Rizal Medical Center**
- Unit/Area : **OR-PACU Complex**

❖ **NURSE MANAGER** – (Nurse III) September 14, 2016 to June 30, 2017

(9 months)

- Employer : **Rizal Medical Center**
- Unit/Area : **OPD- Specialty areas**

(Eye Training and Facilities Center: Ambulatory Ophthalmic OR, Ancillary Diagnostic section, Eye OPD, ENT-HNS clinic, Minor Operating room)

❖ **NURSE MANAGER** - (Nurse III): November 15, 2015 to September 13, 2016

(10 months)

- Employer : **Rizal Medical Center**
- Unit/Area : **OPD- General clinics and Special areas**

(Eye Training and Facilities Center: Ambulatory Ophthalmic OR, Ancillary Diagnostic section, Eye OPD, ENT-HNS clinic, Minor Operating room, Surgery Clinic, OB-Gyne Clinic, Tumor Clinic, TB-DOTS, Medicine clinic, Pediatric Clinic, Medicine-Specialty clinics, Dental Clinics, Mental Hygiene)

❖ **Ophthalmic OR Nurse** - (Staff Nurse II) June 09, 2015 – November 14, 2015

(5 months)

- Employer : **Rizal Medical Center**
- Unit/Area : **Eye Center OR**

❖ **General OR Nurse** (Staff Nurse II) February 01, 2009 to June 09, 2015

(6 years and 4 months)

- Employer : **Rizal Medical Center**
- Unit/Area : **Main/General Operating room**

❖ **Obstetric Nurse** (Staff Nurse I) November 01, 2007 to January 31, 2009

(1 year and 2 months)

- Employer : **Rizal Medical Center**

- Unit/Area : **OB-ER, Delivery room complex**

❖ **NICU Nurse** (Staff Nurse I) December 01, 2006- October 31, 2007
(10 months)

- Employer : **Rizal Medical Center**
- Unit/Area : **NICU (Neonatal Intensive Care Unit)**

❖ **ER Nurse** (Staff Nurse I) November 07, 2005 – November 31, 2006
(1 year)

- Employer **: Rizal Medical Center**
- Unit/Area : **Emergency room**

PROFESSIONAL QUALIFICATIONS

Education

❖ **30 out of 36 units Master's of Arts in Nursing- 2012 to present**

University of the Philippines, Open University (currently completing thesis)
Los Banos, Laguna, 4031, Calabarzon Region, Philippines

❖ **Bachelor of Science in Nursing (2002-2005)**

Metropolitan Hospital College of Nursing (now Metropolitan Medical Center - College of Arts, Science and Technology)

1357 G. Masangkay Street Sta. Cruz, Manila, 1002 NCR, Philippines

❖ **99 Units in Accountancy (2000- 2002)**

Philippine School of Business Administration
1029, Aurora Boulevard, Quezon City, 1109 NCR, Philippines

❖ **Secondary level (1996 to 2000)**

Kid's of the King Christian Academy
Sitio Patnubay 3, Brgy. San Luis Antipolo City, 1870 Antipolo Rizal, Region IV-A, Phlippines

❖ **Primary level (1990-1996)**

Bagong Nayon III Elementary School

Brgy. Dela Paz, Cogeo Antipolo City, Region IV-A, Philippines

PERSONAL INFORMATION

- Age : 36 years' old
- Date of Birth : July 19, 1983
- Civil status : Married
- Marital status : Married
- Religion : Christian

CHARACTER REFERENCE

Cecilia Sub, RN (RMC- General Operating room) +63 977 005 0940

Heriberto Guballa, MD (RMC- Eye Training and Facilities Center) +63 928 599 3200

Edilinda Patac, MD. (RMC-Out Patient Department) (02) 865-8400 loc. 189