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IMPACT OF COMPASSION FATIGUE AND EMOTIONAL INTELLIGENCE ON THE QUALITY OF CARE IN SKILLED NURSING FACILITIES

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IMPACT OF COMPASSION FATIGUE AND EMOTIONAL INTELLIGENCE ON THE QUALITY OF CARE IN SKILLED NURSING FACILITIES

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment of the Requirements for the Degree
Master of Social Work

by
John Simon S. Pangilinan

June 2018
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Approved by:

Professor Thomas Davis, Faculty Supervisor, Social Work
Professor Janet Chang, Research Coordinator
ABSTRACT

Staff in skilled nursing facilities (SNF) can experience physical and emotional strain via caregiving. The purpose of this study was to educate staff on the harm of compassion fatigue and a lack of emotional intelligence and provide steps that can be taken by administration to improve the quality of care provided. It was hypothesized for staff that having low compassion fatigue and high emotional intelligence would result in a higher quality of care. The study design utilized a quantitative approach and a purposive sample from a SNF. Participants were provided with The Professional Quality of Life 5 Scale (ProQoL 5), Wong & Law Emotional Intelligence Scale (WLEIS), and survey data received from Department of Public Health. A Multiple Regression test analyzed the relationship between compassion fatigue and emotional intelligence on the quality of care provided by staff members. The results of this study indicated that staff’s compassion fatigue was not indicative of quality of care; however, Self-Emotional Appraisal, a subscale of WLEIS, was found to predict the quality of care. This study assisted with informing SNF staff in recognizing how managing their emotions could be a useful tool to improve the quality of care they provide. Lastly, SNF administration could implement policies, procedures, and in-services to ensure that all staff members are educated in identifying emotions and practicing self-care.
ACKNOWLEDGEMENTS

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CHAPTER ONE
INTRODUCTION

Problem Formulation

Skilled nursing facilities (SNF) provide 24-hour care to older adults (residents) who cannot live independently at home or in assisted living facilities (Centers for Medicare and Medicaid Services [CMS], 2017). All workers in this setting serve as the residents’ communicator, advocator, and educator (Bassal et al., 2016; Sharma et al., 2016). However, this level of involvement with their patients can inflict both physical and emotional strain on the caregiver, thereby reducing the staff’s ability to provide the residents with the proper quality of care (Bassal et al., 2016).

Workers risk being overworked due to the increased risk for compassion fatigue (Böckerman & Ilmakunnas, 2008; Figley, 2006; Rai, 2010). Strict adherence to the residents’ care plans, combined with the symptomology exhibited by residents, can be particularly burdensome to the worker (Vernooij-Dassen et al., 2010; Smith et al., 2011). To alleviate this, identifying and reducing compassion fatigue can provide a variety of benefits for the worker, such as reduced stress, improved decision-making, stronger communication, and increased patient-to-nurse satisfaction (Potter et al., 2013).

Staff in a SNF are also expected to be emotionally intelligent—known as the ability to apply emotions effectively—and should also be able to regulate those emotions appropriately (Deshpande & Joseph, 2008; Neumann et al.,
2011). Resident-to-staff communication is essential in providing the proper
treatment and quality of life for the residents. Having high emotional intelligence
has been shown to reduce patients’ anxiety and depression, thereby improving
their overall quality of life (Bassal et al., 2016; Gutierrez & Mullen 2016).

The worker must utilize this understanding of emotions as a form of
therapy, coping with the emotional or physiological toll generated from witnessing
any suffering experienced by their residents (Neumann et al., 2011; Van Mol et
al., 2015). The inability for workers to comprehend a resident’s emotions would
prevent the detection of a resident in mental distress and/or physiological pain
(Fearon & Nicol, 2011; Gutierrez & Mullen, 2016). Furthermore, the lack of
emotional intelligence would contribute to burnout for both workers and their
informal (e.g., family) caregivers (Gutierrez & Mullen, 2016).

Purpose of the Study

The purpose of this research study was to assess the impact of
compassion fatigue and emotional intelligence on the quality of care in SNFs.
The Nursing Home Reform Act (NHRA) from the Omnibus Budget Reconciliation
Act of 1987 established federal regulations requiring that nursing homes provide
adequate staffing personnel on a 24-hour basis and to administer the necessary
care in accordance with patient care plans (CMS, 2003). Additionally, the NHRA
has allowed for facilities to be cited if they fail to provide proper medically-related
services.
A patient’s health would be jeopardized when the staff is unable to carry out their duty in providing appropriate levels of care. To address the concerns of compassion fatigue and emotional intelligence on the quality of care in SNFs, research needs to be conducted in determining how compassion fatigue and emotional intelligence affect staff performance. Reviewing both current and past literature could help guide SNFs in developing policies and procedures, requiring staff to prevent compassion fatigue while increasing emotional intelligence.

The overall research method used in this research study is quantitative in design. The study used a self-administered survey designed to collect data from a large group of people (SNF staff) at one point in time. This research design allows for appropriate data to be collected within the study’s limited time frame and also ensures that the researcher’s biases and values will not interfere with participants’ responses and the interpretation of data.

Significance of the Project for Social Work

The findings from this proposed study would impact social work practice in SNFs. Social workers have been required in multidisciplinary teams in SNFs (CMS, 2008). In the context of micro-practice, social workers would be able to recognize the importance of empathy in a resident’s individualized treatment plans (Qaseem et al., 2008). Additionally, in the context of macro-practice, policies, procedures, and training could encourage staff to practice self-care and utilize personal emotions as a tool to increase quality of care.
Social workers should demonstrate emotional competence and find methods that manage compassion fatigue. Not doing so leads to the inability to develop effective therapeutic relationships with the clients and is also a violation that prevents proper services to those clients (Guitierrez & Mullen, 2016; National Association of Social Workers, 2008). Moreover, the consequences for macro-social workers in SNFs include a lack of ethical responsibility from organizational leaders in protecting the well-being of workplace employees. Furthermore, the expectation of SNFs in providing the appropriate Quality of care for clients would not be met (Burton, 2010; CMS, 2003).

Substantial research has assessed the impact that compassion fatigue gives to quality of care (Potter et al., 2010; Rai, 2010; Wu et al, 2016; etc.). Similarly, emotional intelligence has been observed in the context of organizational and workplace improvement (Mikolajczak & Bellegem, 2017). However, there has not been any focus on the impact of compassion fatigue and emotional intelligence on the Quality of care in SNFs. To address the concern presented above, the present study will explore the following question: How do compassion fatigue and emotional intelligence affect the quality of care of skilled nursing facility staff?
CHAPTER TWO
LITERATURE REVIEW

Introduction

The literature relating the impact of compassion fatigue and emotional intelligence on the quality of care in SNFs was discussed. This included an overview of the effects of compassion fatigue and emotional intelligence on quality of care in healthcare settings. Moreover, this study addressed certain conflicting findings and methodical limitations from previous literature while reviewing the conceptualization models that impact quality of care in SNFs.

Compassion Fatigue

Compassion fatigue was defined by Figley (1995) as a secondary traumatic-stress disorder that results from the accumulated cost of caring (Figley, 1995; Showalter, 2010). Compassion fatigue contributed to feelings of guilt due to the inability of caregivers to fully and successfully aid the patient while dealing with the patient’s trauma (Bride, Radey, & Figley 2007).

Impact of Compassion Fatigue on the Worker

Compassion fatigue has been examined in helping professions. Service providers can internalize their patients’/clients’ adversity in social work (Adams, Figley, & Boscarino, 2008), medicine (Neumann et al., 2011), occupational health, human resources, counseling, hospice, and police (Alkema, Linton, &
Davies, 2008). For SNFs, compassion fatigue could contribute to feelings of job burnout among workers (Rai, 2010).

In SNFs that specialize in dementia care, there would be an additional detrimental effect on the well-being of workers due to the increased level of care needed to treat that population (Gaugler et al., 2009). Workers exhibited similar ailments in larger hospital settings (Gaugler et al., 2010; Boyle, 2011). However, this risk was considerably higher and more prevalent for SNF staff due to the long-term care needed from residents—i.e., workers have repeated exposure to the triggering of residents (Winfrey et al., 2016).

Compassion fatigue could be detrimental to the worker’s performance. For example, workers could experience reduced job satisfaction, decreased productivity (Potter et al., 2010), and an overall reduction in a worker’s skill level due to long-term absenteeism (Bökerman & Ilmakunnas, 2008). The combination of these factors would create an economic burden on the workplace due to the recovering worker’s reduced productivity. (Poggi, 2010).

Impact of Caregiver Compassion Fatigue on Patient

Patients are placed at risk when they are attended by caregivers with compassion fatigue, and have reported dissatisfaction with the level of care that was received (Austin et al., 2009; Bökerman & Ilmakunnas, 2008; Potter et al., 2010). In addition, patients reported feeling anxious when receiving care from workers unfit to work (Ford et al., 2011). Furthermore, consequences arise from residents with dementia, as they are more likely to be admitted to nursing homes
due to the increased medical needs (Gaugler et al, 2009). The increased workload would place workers at a higher risk for physiological impairments (e.g., sickness) and depressive symptoms (Gaugler et al., 2010).

**Compassion Fatigue for Informal Caregivers.** Informal caregivers (e.g, family caregivers) could exhibit symptoms of compassion fatigue similar to healthcare professionals (Perry, Dalton & Margaret, 2010). Informal caregivers could experience feelings of uselessness stemming from their inability to fulfill their role as either a proper caretaker or family member (Lynch & Lobo, 2012).

**Emotional Intelligence**

Mayer & Salovey (1990) defined emotional intelligence as the ability to recognize the meanings and contexts of emotions in order to enhance decision-making. The definition was broken into four criteria that reflect the individual’s capability to recognize, understand, apply, and adapt emotional information as a means to accomplish personal and social goals (Mayer et al., 2001).

**Effects of Emotional Intelligence**

Emotional intelligence has benefitted individuals in managing stress, controlling impulsivity (Mayer, Roberts, & Barsade, 2008), and attaining higher levels of life-satisfaction (Di Fabio & Saklofske, 2014). These benefits were seen in other professions such as physicians, human service workers, schoolteachers and principals, and business managers (Elfenbein et al., 2007; Guitierrez et al., 2016; Mayer, Roberts, & Barsade, 2008). From an organizational standpoint, Mikolajczak & Bellegem (2017) reported a 1% decrease in healthcare
expenditures for every 1% increase in intrapersonal emotional intelligence as measured on the Profile of Emotional Competence (Brasseur et al., 2013). The conclusion drawn from these findings has urged healthcare administrators to integrate emotional intelligence in customer service and human resources.

**Effects of Emotional Intelligence for Workers**

Emotional intelligence has helped nurses develop proper rapport with patients (Hefferman et al., 2010). Nurses that scored higher on emotional intelligence were reported to also perform better, have longer careers, and have better job retention than low-scoring nurses (Codier et al., 2009). This effect could be due to nurses being able to articulate, express, and negotiate their feelings successfully and appropriately to others (Elfenbein et al., 2007).

Additionally, workers that have made proper ethical decisions in their practice have scored significantly high on emotional intelligence. They have also been reported as having higher self-confidence, displaying instances of personal honesty, empathy, proper self-management, and a personal intuition of their strengths and weaknesses (Deshpande & Joseph, 2008). In addition to confirming the results of Deshpande & Joseph (2008)—Kaur, Sambasivan & Kumar (2013) have also noted improvements in a worker’s ability to care, reductions in burnout, and increased feelings of being in control.

**Effects of Worker Emotional Intelligence on Recipients**

Workers must satisfy the psychosocial needs of their patients (Deshpande & Joseph, 2008). Staff with low emotional intelligence have received low reviews
in SNF patient-satisfaction surveys (Bassal et al., 2016). Moreover, workers with low emotional intelligence were rated as being disrespectful, inactive listeners, and unable to recognize a patient-in-pain (Heffernan et al., 2010). In contrast to these detrimental attributes, staff with high emotional intelligence have displayed caring behaviors that have increased patient-satisfaction, patient and staff well-being, and have subsequently improved the healthcare organization’s performance (Kaur, Sambasivan, & Kumar, 2013).

Gaps in Literature

Quality of care requires the collaboration of multiple disciplines, such as social work or dietetics (CMS & DHHS, 2017), but many studies have only focused on nursing practice (Bassal et al., 2016; Boyle, 2011; Gaugler et al., 2010; etc.). Nevertheless, studies on quality of care have been conducted in hospital settings as opposed to SNFs (Bassal et al., 2016; Gutierrez & Mullen, 2016). Unlike hospitals, SNFs focus on assisting residents with their activities of daily living and maintenance care (e.g., eating, dressing, and/or bathing; Levinson, 2013). Therefore, the findings from this study would address these gaps by considering the quality of care from a multidisciplinary-team perspective within the context of SNFs.

Conflicting Findings

The use of high emotional intelligence is associated with less burnout and higher job satisfaction; however, these benefits can also be due to the multi-
dimensional nature of emotional intelligence (Weng et al., 2011b). Weng et al. (2011b) was unable to discern where and when emotional intelligence would influence the results. Moreover, Kaur, Sambasivan, & Kumar (2013) indicate that positive quality of care is a result of many factors in addition to emotional intelligence, such as burnout or psychological ownership. In these studies, personality traits might influence emotional intelligence scores, which in turn, impact the susceptibility to burnout or patient health status (Kaur, Sambasivan, & Kumar, 2013; Weng et al., 2011a; Weng et al., 2011b).

Methodological Limitations

There have been inconsistencies in previous literature regarding the definitions and operationalization of compassion fatigue and emotional intelligence. This study will address some limitations presented by the literature.

Distinguishing Compassion Fatigue from Burnout

Burnout was formerly synonymous with compassion fatigue (Yoder, 2010). However, burnout is a chronic physiological, psychological, and emotionally exhausting result from prolonged involvement in emotionally demanding situations (Boyle, 2011) and the inability to meet a goal (Maslach & Jackson, 1981). Burnout and compassion fatigue are similar in that they both require appropriate coping mechanisms and stress management (Boyle, 2011).

Ability-Based versus Trait-Based Emotional Intelligence

Emotional intelligence has two general definitions that are either trait-based or ability-based. The trait-model refers to the self-perceptions about
emotional abilities (Joseph & Newman, 2010). In contrast, the ability-model considers how emotions guide cognitive performance (Mayer et al., 2001; Wong & Law, 2002). Both definitions have been criticized for being neither valid nor consistent, because emotions do not remain the same even when exposed to similar external situations (Di Fabio & Saklofske, 2014).

Theories Guiding Conceptualization

The Diathesis-Stress Model by Monroe & Simons (1991) posited that the combination of stress and biological predispositions, such as genetics, contributes to mental and physiological disorders. Being predisposed to a combination of psychiatric disorders, as well as the onset of stressors from caregiving, could hasten the onset of detrimental ailments (Acabchuk et al., 2017). Protective factors—conditions or attributes that reduce risk and promote healthy development—helped create buffers and coping strategies that allow an individual to thrive even during stressful times (DHHS, 2016).

In SNFs, stress occurred from the worker’s struggle to balance the complex relationship between a patient’s demands, the worker’s emotional reactions to handle those demands, and the ethical standards of practice expected in caregiving (Boyle, 2011). A consequence of failing to deal with this accumulated stress would be for the worker to consider quitting, which would further reduce the number of workers available (Simons & Jankowski, 2008). SNF administrators and policy majors could prevent this potential job turnover by encouraging workers to practice proper stress management techniques.

11
In the discourse of SNFs, compassion fatigue and low emotional intelligence could take place at the staffing level, thereby preventing clients from having their needs met (Boyle, 2011). The social work General Systems Theory, or “Person-in-Environment” (PIE), emphasized the mutually influencing factors of the reciprocal relationships between the environment and individuals, groups, organizations, or communities (Bartlett & Saunders, 1970). Organizations could apply the PIE theory to potentially increase their quality of care by investing in training sessions that assist workers in identifying factors in their environment that contribute to their compassion fatigue.

The PIE trainings would increase the caregivers’ awareness to situations that alleviate or exacerbate a resident’s presented problem. Under the PIE perspective, an individual’s presented problems and strengths are assessed rather than focusing exclusively on the limitations of the individual’s problem. The practitioner is granted a wider gamut of interventions that addresses a person’s concerns both externally (e.g., social) and internally (e.g., behavioral).

Summary

This study attempted to address certain conflicting findings and methodical limitations discussed in the previous literature. Additionally, this study would provide new information concerning the effects of compassion fatigue and emotional intelligence on the quality of care within the setting of SNFs. The Diathesis-Stress Model and General Systems Theory could provide SNFs with a foundation to ensure caregivers are healthy and competent when treating
residents. Lastly, this study would be examined through the social work discourse by examining methods that improve healthcare provision.
CHAPTER THREE

METHODS

Introduction

This study described the effects that both compassion fatigue and emotional intelligence have on the quality of care in a SNF. This chapter detailed how this study was carried out. The sections include a discussion on the study design, sampling methods, data collection and instruments, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study was to examine how the staff’s compassion fatigue and emotional intelligence affected the quality of care they provide. This study was a descriptive research project due to the limited research on this topic from the perspective of social workers. This study was also quantitative, as surveys were used to collect data from subjects. Furthermore, a descriptive and quantitative approach allowed the researcher to explore the question imposed at the beginning: How do compassion fatigue and emotional intelligence affect the quality of care of SNF staff?

A modified version of the Professional Quality of Life Scale Version 5 (ProQoL 5) and the full version of the Wong and Law Emotional Intelligence Scale (WLEIS) were provided to participants. The participating SNF facility provided quality of care data received from their most recent survey on Life and
Safety. The surveys were administered to groups of participants to facilitate this study’s feasibility and time constraints.

Although the survey was appropriate to address this study’s question, there was the possibility of bias in respondent answers due to researcher comments, honesty of survey answers, or feelings of coercion to participate and complete the survey. Moreover, the ability to generalize to staff at other SNFs was compromised because this study considered staff at one SNF.

Sampling
This study utilized a purposive sample of all staff members that work in a Medicare-certified 99-bed SNF. All staff in a SNF are mandated reporters; that is, they are required by law to report reasonable suspicions of abuse (CMS, 2008). Therefore, all staff across all departments will be considered for the study as they are integral in resident safety. There was a total of 72 participants for the study.

Data Collection and Instruments
Quantitative data was collected from participants via two questionnaires that were provided in March 2018. Demographic information was collected and consisted of: employment status, department, gender, and ethnicity—all being nominal and categorical; and age being an ordinal data set (Appendix B).

The strengths of administering this survey include collecting data from a large participant group, a quick return of questionnaire results, low cost for
materials, multiple measurement of variables, and the ability to identify areas of concern related to the delivery of care for residents. Potential issues that could occur included participants having coerced feelings to volunteer, biased responses from participants for fear of retaliation, and participants’ reporting false responses on survey items. To encourage genuine responses from participants, the researcher emphasized the voluntary participation, the need for honest answers to avoid error in results, human resources consults, and how accurate results would assist the facility in improving resident care.

The researcher utilized two research instruments and one federal survey tool to collect data about participants. First, the ProQoL 5 developed by Stamm (2009) was used to assess compassion fatigue. The ProQoL 5 is a 30-item instrument designed to parse compassion fatigue from burnout with respect to culture and has been used in over 200 publications (Stamm, 2010). For this study, only 19 questions from the ProQoL 5 were used as they pertained exclusively to compassion fatigue as recommended in Hemsworth et al. (2018). The ProQoL 5 scale has an internal consistency reliability of Cronbach’s alpha of at least .7 and Pearson r ranging from .79 to .88 for measuring compassion fatigue and type of question (Hemsworth et al., 2018).

Secondly, the full version of the Wong and Law Emotional Intelligence Scale, or WLEIS, was used to measure emotional intelligence (Wong & Law, 2002). Each of the 16 items are answered on a 7-point Likert scale that ranges from 1 = strongly disagree to 7 = strongly agree. WLEIS was designed to parse
personality from emotional intelligence while being ability/application-based and culturally sensitive (LaPalme et al., 2016). The WLEIS has an internal consistency reliability ranging from Cronbach’s alpha of at least .81 and a Pearson’s $r$ ranging from .31 to .54 for the relationships between the type of questions and the application of emotional intelligence (Carvalho et al., 2016).

Lastly, the facility provided data from the California Department of Public Health (CDPH) Life and Safety Survey conducted the same month as this study (Appendix C; CMS, 2016). The complete and unaltered version of the tool was utilized by CDPH to gather data on the quality of care of the SNF staff; OoC scores were indicated by the number of deficiencies sorted by department. Medicare nursing home surveys are not perfect as there could be deficiencies related to false positives and false negatives (Woolley, 2010). To reduce erroneous results, the Agency for Healthcare Research and Quality from the Department of Health and Human Services advised that any personal changes made to the tool may affect the reliability and validity of the survey tool (Sorra et al., 2016). While there were no reported statistics to examine the internal consistency reliability of the federal tools, such as Cronbach’s alpha, the survey tools were endorsed by the National Quality Forum; therefore, the CMS survey tools were valid and reliable (CMS, 2014).

Procedures

The agency’s corporate and administrator were notified of the study to reserve the appropriate room, time, and date. Flyers were made that described
the purpose and goals of the study and were posted next to the areas that the staff frequents, such as the Nursing Station and Time Clocks. The flyers contained information such as location of the study: a large conference room designed to accommodate 90 people. Moreover, refreshments, such as snacks and drinks, were provided for participating and completing the survey. Participants were encouraged to volunteer and were able to RSVP by contacting the researcher via email or phone call.

The entire study took place across three days with the agency’s approval. The survey was provided during three shifts across two days: “Morning” (8:00 AM – 4:00 PM), “Afternoon” (4:00 PM – 12:00 AM), and “Night” (12:00 AM – 8:00 AM). The third day consisted the agency providing the results of the CDPH survey to the researcher. The survey results utilized for this study is before the facility’s plan of correction was implemented; therefore, the actual Quality of care score could differ from the results used in data analysis.

It must be noted that not all 72 participants were available at the same time due to the revolving shift. However, up to 45 participants will be available on the Morning shift. As participants arrived, each was asked to sign-in on an agency-specific sign-in sheet, as per request from the agency for accountability purposes from the agency’s policy. A brief introduction reiterated information from the flyer and thanked the participants for taking time to volunteer for the survey. Participants were provided a packet containing the demographic form (Appendix B) and Institutional Review Board-informed consent (Appendix A) to
read and fill out. Participants will then be provided the actual survey forms to complete (Appendix B). Upon completion and submission of the survey, participants were instructed to remain in their seat, but welcomed to the refreshments while waiting. After all participants completed the survey, the researcher provided a verbal and written debriefing of the survey (A). This survey was designed to take 20-25 minutes, be held in one-hour blocks during multiple shifts to maximize participation and allow workers time to address resident needs.

Protection of Human Subjects

The identity of the participants was kept confidential in data analysis. However, an agency-specific sign-in sheet (name-only) was kept with the agency for accountability purposes. The survey was completed in a private conference room behind closed doors. It was explained to participants that their confidentiality and anonymity was maintained throughout the data analysis section but limited due to the agency policy for the sign-in sheet. Each participant survey was assigned number for data analysis, so that there will be no information that identifies any participant. All documentation and data from the surveys was to be maintained in a password-encrypted USB drive, and be kept in a locked desk. The data and documentation will be securely destroyed and/or deleted one year after completion of the study.
Data Analysis

The two independent variables are caregivers’ compassion fatigue and emotional intelligence. Compassion fatigue is measured using the Stamm (2009) scale, and therefore, this variable is interval. Emotional intelligence is measured using WLEIS (2002) scale, this variable is also interval. The dependent variable is Quality of care as measured using the results from the CMS 2016 Life and Safety Workbook; this scale is interval. A Multiple Regression test was conducted on these variables. Descriptive analyses were conducted on the demographic data collected. Reliability analysis will also be conducted on the WLEIS subscales. Responses for all the data collected were entered into SPSS, and each variable will be analyzed to display tables for this study.

Summary

This study examined the effects that a caregiver’s compassion fatigue and emotional intelligence have the quality of care in nursing homes. The quantitative methods utilized in this study facilitated this process. The use of surveys and secondary data provided from the facility allowed for the researcher to gather many data in the limited period.
CHAPTER FOUR
RESULTS

Introduction
This chapter explains the results of the statistical analyses implemented. This chapter includes a description of sample from the demographic data and the analysis of the data using inferential statistics. The first section describes the demographics of the data with the inferential statistics in the following section.

Presentation of Findings

Descriptive Statistics
There was a total of 72 participants in this study; all demographic information was gathered from the questionnaires. All participants included in this study were employed by the SNF. As seen in Table 1, in the category of Age, 12 participants had not provided survey answers; the average age of the 60 participants was 39.62 years of age. Regarding Department, most of the staff at the SNF belonged to Nursing, \(N=24\) (33.3%), followed by Administration, \(N=11\) (15.3%), then by two departments Social Services and “Other,” \(N=6\) (8.3%), followed by four departments Dietary, Housekeeping, Maintenance, and Rehabilitation, \(N=5\) (6.9%), and lastly by Laundry, \(N=4\) (5.6%). Of the 72 respondents, women comprised of more than half of the sample, \(N=53\) (73.6%); men, \(N=19\) (26.4%). Ethnically, Latinos comprised of the majority of the staff, \(N=27\) (37.5%); Asians comprised of the second majority, \(N=20\) (27.8%),
Caucasian, N=14 (19.4%), “Other,” N=6 (8.3%), African American, N=4 (5.6%), and lastly one (N=1, 1.4%) person identified as Indian. 51 participants (70.8%) were working full time at the SNF with 20 participants (27.8%) working part-time; there was one participant (N=1, 1.4%) working on an on-call basis.

Table 1. Demographic Information

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Frequency</th>
<th>Mean (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
<td><strong>Frequency</strong></td>
<td><strong>N (%)</strong></td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td><strong>(if applicable)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td><strong>Submitted</strong></td>
<td>60 (83.3%)</td>
</tr>
<tr>
<td></td>
<td><strong>Not Answered</strong></td>
<td>12 (16.7%)</td>
</tr>
<tr>
<td><strong>Department</strong></td>
<td><strong>Administration</strong></td>
<td>11 (15.3%)</td>
</tr>
<tr>
<td></td>
<td><strong>Dietary</strong></td>
<td>5 (6.9%)</td>
</tr>
<tr>
<td></td>
<td><strong>Housekeeping</strong></td>
<td>5 (6.9%)</td>
</tr>
<tr>
<td></td>
<td><strong>Laundry</strong></td>
<td>4 (5.6%)</td>
</tr>
<tr>
<td></td>
<td><strong>Maintenance</strong></td>
<td>5 (6.9%)</td>
</tr>
<tr>
<td></td>
<td><strong>Nursing</strong></td>
<td>24 (33.3%)</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
<td>6 (8.3%)</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation</strong></td>
<td>5 (6.9%)</td>
</tr>
<tr>
<td></td>
<td><strong>Social Services</strong></td>
<td>6 (8.3%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td><strong>Female</strong></td>
<td>53 (73.6%)</td>
</tr>
<tr>
<td></td>
<td><strong>Male</strong></td>
<td>19 (26.4%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td><strong>African American</strong></td>
<td>4 (5.6%)</td>
</tr>
<tr>
<td></td>
<td><strong>Asian</strong></td>
<td>20 (27.8%)</td>
</tr>
<tr>
<td></td>
<td><strong>Caucasian</strong></td>
<td>14 (19.4%)</td>
</tr>
<tr>
<td></td>
<td><strong>Indian</strong></td>
<td>1 (1.4%)</td>
</tr>
<tr>
<td></td>
<td><strong>Latino</strong></td>
<td>27 (37.5%)</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
<td>6 (8.3%)</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td><strong>Full Time</strong></td>
<td>51 (70.8%)</td>
</tr>
<tr>
<td></td>
<td><strong>Part Time</strong></td>
<td>20 (27.8%)</td>
</tr>
<tr>
<td></td>
<td><strong>On-Call</strong></td>
<td>1 (1.4%)</td>
</tr>
</tbody>
</table>
Descriptive statistics were gathered on the scales used on the 72 participants. These results are provided in Table 2. The mean results gathered are as follows: CF = 34.61; EI = 86.50. For the subscales of WLEIS, the means are as follows: SEA = 21.89, OEA = 21.81, UOE = 21.06, and ROE = 21.75. The median scores for each scale was: CF = 33.50, EI = 85.00, SEA = 22.00, OEA = 22.00, UOE = 21.00, and ROE = 22.00. The standard deviation of the data was: CF = 5.94, EI = 8.56, SEA = 2.86, OEA = 2.73, UOE = 3.29, and ROE = 3.39.

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Mean</th>
<th>Median</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CF</td>
<td>34.61</td>
<td>33.50</td>
<td>5.94</td>
</tr>
<tr>
<td>EI</td>
<td>86.50</td>
<td>85.00</td>
<td>8.56</td>
</tr>
<tr>
<td>SEA</td>
<td>21.89</td>
<td>22.00</td>
<td>2.86</td>
</tr>
<tr>
<td>OEA</td>
<td>21.81</td>
<td>22.00</td>
<td>2.73</td>
</tr>
<tr>
<td>UOE</td>
<td>21.06</td>
<td>21.00</td>
<td>3.29</td>
</tr>
<tr>
<td>ROE</td>
<td>21.75</td>
<td>22.00</td>
<td>3.39</td>
</tr>
</tbody>
</table>

**Inferential Statistics**

Inferential Statistics were analyzed using IBM SPSS Statistics. This study replicated the procedures in previous studies, such as LaPalme et al. (2016) and Carvalho et al. (2016), by testing reliability measures of the WLEIS subscales.
Table 3 provides information on the reliability analyses of the WLEIS and its subscales. The Cronbach’s Alpha results for the data are as follows: Self-Emotional Appraisal (SEA) = .80; Other-Emotional Appraisal (OEA) = .74; Use of Emotion (UOE) = .68; and Regulation of Emotion (ROE) = .77. The Cronbach’s Alpha for the entire WLEIS (EI) scale was .64.

Table 3. Cronbach’s Alpha Results for WLEIS

<table>
<thead>
<tr>
<th>Emotional Intelligence Scale or Subset</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>WLEIS (EI)</td>
<td>.64</td>
</tr>
<tr>
<td>SEA</td>
<td>.80</td>
</tr>
<tr>
<td>OEA</td>
<td>.74</td>
</tr>
<tr>
<td>UOE</td>
<td>.68</td>
</tr>
<tr>
<td>ROE</td>
<td>.77</td>
</tr>
</tbody>
</table>

A multiple regression analysis was conducted to examine the relationship between Quality of Care and Emotional Intelligence and Compassion Fatigue. As can be seen in Table 4, quality of care (QOC) was not affected by compassion fatigue (CF) and emotional intelligence (EI); $F(2,69) = .18, p = .83$, with an $R^2$ of .01. Participants’ predicted QOC is equal to $2.58 + .00 \text{(CF)} – .02 \text{(EI)}$, where CF is coded by the summation of points across 19 questions, and EI is coded by the summation of SEA, OEA, UOE, and ROE on questions 1 – 16.
Table 4. Multiple Regression Analysis on Emotional Intelligence and Compassion Fatigue on Quality of Care

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>2.58</td>
<td>1.36</td>
<td>1.90</td>
<td>.06</td>
</tr>
<tr>
<td>EI</td>
<td>-.02</td>
<td>.01</td>
<td>-.20</td>
<td>-1.69</td>
</tr>
<tr>
<td>CF</td>
<td>.00</td>
<td>.02</td>
<td>.03</td>
<td>.21</td>
</tr>
</tbody>
</table>

A multiple regression analysis was conducted to examine the relationship between quality of care and the subsets of the WLEIS subscales: SEA, OEA, UOE, and ROE. Table 5 provides the statistical results of the analysis. There was only one significant result from the subscales, and that was SEA with $F(5,66) = 2.295, p < .01$, with an $R^2$ of .148.
Table 5. Multiple Regression Analysis between Compassion Fatigue and Wong and Law Emotional Intelligence Scale Subscales

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>3.32</td>
<td>2.602</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CF</td>
<td>-.04</td>
<td>.04</td>
<td>-.12</td>
<td>-1.01</td>
</tr>
<tr>
<td>SEA</td>
<td>-.24</td>
<td>.08</td>
<td>-.41</td>
<td>-3.08</td>
</tr>
<tr>
<td>OEA</td>
<td>.11</td>
<td>.8</td>
<td>-.18</td>
<td>1.37</td>
</tr>
<tr>
<td>UOE</td>
<td>.04</td>
<td>.7</td>
<td>.08</td>
<td>.60</td>
</tr>
<tr>
<td>ROE</td>
<td>.7</td>
<td>.6</td>
<td>.13</td>
<td>1.05</td>
</tr>
</tbody>
</table>

Upon further examination of the subscales of WLEIS, a significant regression equation was found with EI (F(2,69) = 5.24, p < .01). Table 6 shows the results of the multiple regression analysis conducted on EI and SEA on QOC. Participants’ predicted quality of care is equal to 1.86 – .29 (SEA) + 71 (EI) where SEA is coded by the 1 – 7 on a Likert Score for questions 1 – 4, and EI is coded by the summation of SEA, OEA, UOE, and ROE on questions 1 – 16. A further analysis was conducted on the subscales of WLEIS and a significant regression equation was found with SEA subset of the emotional intelligence scale (F(1,70) = 4.756, p < .05). Participants’ predicted quality of care is equal to 4.82 - .15 (SEA). Participants’ quality of care decreased .29 points in SEA for the total points seen in EI scores at .07.
Table 6. Multiple Regression Analysis of Emotional Intelligence and Self-Emotional Appraisal.

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>1.86</td>
<td>1.94</td>
<td>.96</td>
<td>.34</td>
</tr>
<tr>
<td>SEA</td>
<td>-.29</td>
<td>.08</td>
<td>-.50</td>
<td>-3.08</td>
</tr>
<tr>
<td>EI</td>
<td>.07</td>
<td>.03</td>
<td>-.36</td>
<td>2.33</td>
</tr>
</tbody>
</table>
CHAPTER FIVE

DISCUSSION

Introduction

This chapter elaborates on the significant results attained by this study by considering previous findings in this field of research. Moreover, the limitations of this study are discussed. Additionally, recommendations are provided for social work practice and policy. Consideration for future researchers in this area is mentioned. Lastly, a summary of this study’s findings and urgency related to compassion fatigue and emotional intelligence on quality of care was provided.

Discussion

The purpose of this research study was to assess the impact of compassion fatigue and emotional intelligence on the quality of care of SNF staff; specifically, to examine if lower levels of compassion fatigue and higher levels of emotional intelligence would result in an increased quality of care. The results of this study indicated that compassion fatigue and emotional intelligence does not impact quality of care, so this study failed to reject the null hypothesis.

In line with previous research (Carvalho et al. 2016; LaPalme et al., 2016), this study assessed the reliability of the WLEIS. It must be noted that there was no determinant score that distinguishes “high” from “low” emotional intelligence; however, previous researchers found that higher scores on the WLEIS generally meant higher levels of emotional intelligence. This study was able to verify those
previous studies by having similar reliability results; therefore, the WLEIS was still reliable at the time of this study.

The study’s main hypothesis was not supported by its findings; however, the results of this study might suggest that there may be another aspect that could impact the quality of care in a nursing home. Poghosyan et al. (2017) investigated how quality of care in hospital nurses could be impacted by burnout, long-term exhaustion, and diminished interest in work due to chronic occupational stress; their findings suggested that higher levels of burnout resulted in lower quality of care. Similarly, the findings from Wagaman et al. (2015) considered how empathy is required for social workers to work in multiple settings, and components of empathy could also be a tool that may reduce burnout and secondary traumatic stress while increasing compassion satisfaction and improving client engagement. The findings in these studies suggested that reducing burnout and increasing empathy might be effective strategies for improving the quality of care in a variety of settings.

**Additional Findings**

Although this study’s main hypothesis was not supported by its findings, this study identified significant findings regarding WLEIS and its subscale Self-Emotional Appraisal on the quality of care in SNFs. For reference, the subscales of WLEIS are as follows: Self-emotional appraisal (SEA) refers to the individual's ability to understand their emotions whereas other's emotional appraisal (OEA) is the ability for the individual to recognize and understand other people's emotions;
use of emotion (UOE) is the tendency for individuals to motivate oneself to apply their emotions to enhance performance, and regulation of emotion (ROE) assesses the individual’s ability to regulate their own emotions (Fukuda et al., 2011). As stated, Wagaman et al. (2015) considered how empathy could be used as a tool to improve the social workers’ engagement of clients by encouraging social workers to be aware and mindful of the emotions between themselves and others to maintain professional boundaries. The findings from this study reflected the self-awareness of emotions indicated by Wagaman et al. (2015). The results from this study should encourage SNFs to provide trainings to not only social workers, but to all workers in this setting. These trainings would encourage workers to have self-awareness of their emotions in their everyday practice to prevent decision-making patterns that reflect poor boundary setting and maintenance.

Acknowledging Compassion Fatigue

It must be noted that while compassion fatigue was considered as an entire category for this study, it is a summation of burnout and secondary traumatic stress, as measured by the ProQoL 5 (Hemsworth et al., 2018; Stamm, 2010). Therefore, facility would score “low” for compassion fatigue. In reiteration, the findings in this study were unable to identify an impact of compassion fatigue and emotional intelligence on the quality of care provided in SNFs.
Regarding compassion fatigue specifically, the results of this study could establish a dangerous precedent for healthcare facilities in that the findings from this study could entice facilities to neglect their employees due to the perceived lack of an impact compassion fatigue on the quality of care. As reported in the previous literature, facilities must be mindful of the reported negative experiences related to compassion fatigue that could be detrimental to facilities and organizations (Bökerman & Ilmakunnas, 2008). Moreover, compassion fatigue is the summative result of burnout and secondary traumatic stress, the latter of the two defined as the indirect exposure to the trauma and stressors experienced by victims (Hemsworth et al., 2018). Workers experiencing burnout would be less likely to express dedication, commitment, and loyalty to their workplace; furthermore, the worker's decision-making abilities would be jeopardized, thereby potentially endangering residents in SNF settings (Rai, 2010). Stamm (2010) acknowledged that the occurrence of secondary traumatic stress would be rare, but symptoms are defined by sudden feelings of fear, anxiety, insomnia, and mental reminders of the event that pop into the mind; furthermore, the rare occurrence does not eliminate the possibility that it does not happen.

Working with suffering individuals is an unavoidable aspect in healthcare settings (Decker et al., 2015). The findings in this study should not discount the experiences of compassion fatigue experienced by workers in these settings. When compassion fatigue is considered individually, previous studies reported an improvement in the quality of care for healthcare facilities that addressed the
compassion fatigue of their workers (Potter et al., 2013; Vernooij-Dasser et al., 2010; Smith et al., 2011). As stated, compassion fatigue cannot be examined without considering burnout and secondary traumatic stress, and in the context of this study, the facility was considered as having “low” experiences of compassion fatigue; however, this categorization is arbitrary, and, as stated, the facility should continue its current policies and procedures in addressing compassion fatigue and should not rely on chance that the risks would not occur. SNFs should also continue encouraging workers to be proactive in reducing their compassion fatigue to be in better health to maintain the continuity of care they provide.

Importance of the Emotional Intelligence Subscales

This study did not identify any significant results regarding OEA, UOE, and ROE; however, findings from previous literature supported the importance of these WLEIS subscales to quality of care. Therefore, the findings of this study did not discount the importance of the emotional intelligence subscales presented by OEA, UOE, and ROE. These aspects of emotional intelligence have been a necessity for all healthcare workers in the context of hospital settings (Birks, McKendree, & Watt, 2009; Mayer, Salovey, & Caruso, 2008; Smith, Profetto-McGrath, & Cummings, 2009). The combination of all emotional aspects would allow the healthcare worker to moderate their emotions based on the context, environment, situation to validate the emotions of others in the room; that is, in the event of a patient experiencing trauma, the healthcare worker would be able to identify, acknowledge, and validate the anxiety of the family.
members at the patient’s bedside, and this would be in addition to the healthcare worker modifying their own emotions match the appropriateness of the situation (Mayer, Salovey, & Caruso, 2008; Smith, Profetto-McGrath, & Cummings, 2009).

In addition to the above, previous research has found that emotional intelligence subscales would help to reduce psychological distress among healthcare professionals; thereby indirectly improving the quality of care provided (Bassal et al., 2015; Kaur, Sambasivan, & Kumar, 2013). Similarly, for social work practice, the ability of the social worker to attain competencies in the emotional intelligence subscales would improve their well-being in addition to preventing the various aspects of compassion fatigue and stress (Kinman & Grant, 2011). For other healthcare worker, the subscales provide an entire picture that would assist the worker in listening, building empathy, and in identifying and understanding the effects of non-verbal communication—e.g., recognizing a patient in pain or experiencing fear (Morrison, 2007). Despite this study’s insignificant findings related to OEA, UOE, and ROE, the findings in previous studies would suggest that reducing burnout and increasing empathy might be effective strategies for improving the quality of care in a variety of settings, but more importantly, to attain these benefits, a healthcare practitioner must not neglect the emotional intelligence and competencies from the OEA, UOE, and ROE subscales.
Limitations

A limitation of this study was in its descriptive design. This design could only describe a set of observations from the data collected; therefore, causal relationships cannot be drawn from the sample. Thus, it could neither be said that SEA, compassion fatigue, nor emotional intelligence impacted quality of care with absolute certainty. Instead, the findings of this study suggested that there would not be a relationship between compassion fatigue and emotional intelligence on the quality of care in a SNF.

Another limitation of this study is the purposive sampling; this study conducted its survey from one SNF; this affects its ability to generalize its findings to other SNFs and similar settings. Moreover, most of the sample were Latino or Asian, this could affect this study’s generalizability due to the lack of ethnic diversity and/or minority representation. Furthermore, the sample had six social workers at the SNF, this could impact the generalizability to other social workers in similar settings. The generalizability of this study could also be impacted due to the disproportionate number of females outnumbering men of about three females to one male.

This researcher would recommend that future studies sample multiple providers in SNFs for the sample to be more representative of social workers practicing in the field. Future studies should benefit this increased sample size due to the increased generalizability of having more facilities involved, but more importantly, the samples from each department would increase and become
more representative; that is, there would be a larger and more representative pool of participants in departments with limited staff.

The last limitation of this study was regarding the type of scale used to measure emotional intelligence that was limited by time and resources. As reported, the WLEIS has been a popular choice, and the scale has still been widely used to assess emotional intelligence due to the combination of its ease of distribution and its focus on being ability-based (Carvalho et al., 2016; LaPalme et al., 2016). However, there are more comprehensive, albeit paid, tests offered such as the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer et al., 2001) that could reveal additional findings beyond what the WLEIS could provide. Despite this potential improvement in scale, this study considered the requirement of a payment to use the scale in addition to the minimum amount of time needed to be invested to take the MSCEIT—at the least 50 minutes. Due to the nature of SNFs and the requirement of workers to meet the needs of residents, the MSCEIT was costly and impractical in respect of the workers’ time and their duties to provide the continuity of care.

Recommendations for Social Work Practice, Policy, and Research

CMS (2008) has required that social workers be included in a multidisciplinary team in SNFs. Though this study's results could not conclude a significant finding regarding compassion fatigue and emotional intelligence, this does not devalue the need for healthcare workers, especially social workers, to continue practicing techniques that reduce compassion fatigue to prevent
burnout (Wagaman et al., 2015). When these factors were considered separately, quality of care and performance is improved when healthcare workers reduced compassion fatigue (Ford et al., 2011; Gaugler et al., 2009) or improved emotional intelligence (Elfenbein et al., 2007; Guitierrez et al., 2016; Mayer, Roberts, & Barsade, 2008). Furthermore, compassion fatigue did not warrant any significant results in this study; however, research warrants that social workers that fail to practice proper self-care techniques experienced higher rates of compassion fatigue and burnout due to the accumulation of psychological distress when working with trauma victims (Adams, Figley, & Boscarino, 2008). These findings further support the notion that social workers and other healthcare workers would need to be aware of compassion fatigue impacting their workplace performance.

While this section pertains to social workers in SNF settings, the recommendations provided here can transcend across different disciplines, such as nursing; therefore, recommendations presented here could assist healthcare workers in their practice. In the context of micro social work practice, the WLEIS subscale of SEA was the only significant result impacting quality of care, but as mentioned above, previous studies demonstrated the requirement of all aspects of emotional intelligence to be an effective and empathetic practitioner. Emotional intelligence has been applicable to micro practice by assisting social workers in the following areas: assessment through risk identification; advocacy by which the social worker can identify abuse, neglect, and pain; and in crisis
intervention whereby the social worker would need to manage the anxiety generated by the traumatic and stressful situation.

From an administration and macro social work standpoint, a discussion of how policy dictates actions must be addressed. This notion becomes imperative when considering the concerns that arise in fields that employs social workers. Previous research reported that there are no specific policies regarding practicing self-care (Adams, Figley, & Boscarino, 2008; Kim & Stoner, 2008; CMS, 2008); instead, policies are in place that lay the expectations of what is to be accomplished in the workday. That is, there are no policies in place that state how social workers and their colleagues must practice self-care, and it is the responsibility of the social worker themselves to manage the stress from the job (Kim & Stoner, 2008). Kim and Stoner (2008) recommended that organizations redesign the work environment to provide social workers with more job autonomy and social support. Lastly, organizations that provided workplace support reduced the risk of psychological stressors among social workers and reduced the staff turnover rate (Hombrados-Mendieta & Cosano-Rivas, 2011).

Future Research

Future studies examining this area of research should consider burnout and job satisfaction in addition to the compassion fatigue and emotional intelligence presented in this study. This idea would consider additional factors that might contribute to workplace stress. Furthermore, for respect of time, this study utilized a modified ProQoL 5 that looked specifically at compassion fatigue.
However, future studies should consider using the entire questionnaire to account for the additional factors given they have the additional time and resources to analyze those factors. This could be due to Stamm (2010) having noted how burnout, compassion fatigue, and job satisfaction are interrelated; all the factors must be considered. Regarding emotional intelligence, this study relied on the WLEIS due to the ease of distribution and availability of the scale and materials. Future studies that are granted ample time and resources should consider the more comprehensive tests, such as the MSCEIT (Mayer et al., 2001), to further parse emotional intelligence and the corresponding subscales listed in the WLEIS. In addition to the above, future studies should address the limitations presented by this study; that is, they should seek an increased sample size that is inclusive of more SNFs, a more balanced gender ratio, and greater ethnic diversity to improve generalization.

Conclusion

This study did not find a relationship between compassion fatigue and emotional intelligence impacting the quality of care in SNFs. However, this study identified a possible impact on quality of care by considering the staff’s Self-Emotional Appraisal. Additionally, the data collected could support previous research regarding compassion fatigue, emotional intelligence, and quality of care in SNFs. Despite this study’s failed attempt to reject its null hypothesis, current rules and regulations established by federal and facility guidelines places could foster high stress environments for social workers and their colleagues.
Therefore, it would be in the worker’s best interest to continue to reduce compassion fatigue and increase emotional intelligence to continue providing appropriate levels of quality of care. Additionally, previous research has continued to stress the need for future research in this area to continue acknowledging the need for addressing the prevalence of possible conflict or harm due to compassion fatigue and low emotional intelligence (Mikolajczak & Bellegem, 2017; Potter et al., 2010). In addition to the previous studies, the findings from this study will continue to assist social workers and other professionals in this field to consider reducing compassion fatigue while improving their emotional intelligence to perform better.
APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL FORM, INFORMED CONSENT,
AND DEBRIEFING STATEMENT
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s) John Simon S. Pangilinan

Proposal Title Impact of Compassion Fatigue and Emotional Intelligence on the Quality of Care in Skilled Nursing Facilities

# SW18-7

Your proposal has been reviewed by the School of Social Work Sub-Committee of the Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

✓ approved

☐ to be resubmitted with revisions listed below

☐ to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

☐ faculty signature missing

☐ missing informed consent ☐ debriefing statement

☐ revisions needed in informed consent ☐ debriefing

☐ data collection instruments missing

☐ agency approval letter missing

☐ CITI missing

☐ revisions in design needed (specified below)


Committee Chair Signature James [Signature]

Date 1/17/2018

Distribution: White-Coordinator; Yellow-Supervisor; Pink-Student
The study in which you are asked to participate is designed to examine various emotions of staff members working in a skilled nursing facility (SNF). The study is being conducted by John Pangilinan, a graduate student, under the supervision of Dr. Thomas Davis, Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board Social Work Sub-committee at CSUSB.

PURPOSE: The purpose of the study is to examine various emotions of staff members working in a SNF.

DESCRIPTION: Participants will be asked questions on their current emotional state via a survey and be asked some demographic information, and be evaluated by the observer.

PARTICIPATION: Your participation in this study is completely voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential, and data collected will have identifying information—i.e., name—removed.

DURATION: It will take 20-30 minutes to complete the survey.

RISKS: Minor risk associated with feeling uncomfortable answering survey questions. This study is voluntary, and participants may withdraw at any time without any consequences.

BENEFITS: There may be an improvement in the quality of care provided by staff, pending the results of this study.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Thomas Davis at (909) 537-3839.

RESULTS: Results of this study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after July 2018.

This is to certify that I read the above, and I am 18 years or older.

Please place an "X" here __________________________ Date __________________________
STUDY OF EFFECTS OF COMPASSION FATIGUE AND EMOTIONAL INTELLIGENCE ON THE QUALITY OF CARE IN SKILLED NURSING FACILITIES

The study you have just completed was designed to examine the effects of compassion fatigue and emotional intelligence on the quality of care provided by staff in a skilled nursing facility. We are particularly interested in the relationship between these two variables to see whether experiencing compassion fatigue and a lack of emotional intelligence affects the quality of care that staff members provide to residents. Should you feel the need to discuss any concerns regarding your job performance, please contact [redacted], and/or [redacted].

Thank you for your participation and for not discussing the contents of the study with other staff members. If you have any questions about the study, please feel free to contact John Pangilinan or Dr. Thomas Davis at (909) 537-3839. If you would like to obtain a copy of the results of this study, please contact Dr. Thomas Davis at (909) 537-3839 or tomdavis@csusb.edu at the end of July 2018.
APPENDIX B

DATA COLLECTION INSTRUMENTS
The above is was made by the author to gather demographic information.
The above is the modified ProQoL 5 from Hemsworth (2018) used for this study.
For each item, please rate the following items using the scale below: 7 being "STRONGLY AGREE", 4 being "NEITHER AGREE NOR DISAGREE," and 1 being "STRONGLY DISAGREE:

<table>
<thead>
<tr>
<th></th>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>SOMEWHAT DISAGREE</th>
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1. I have a good sense of why I have certain feelings most of the time.
2. I have good understanding of my own emotions.
3. I really understand what I feel.
4. I always know whether or not I am happy.
5. I always know my friends' emotions from their behavior.
6. I am a good observer of other's emotions.
7. I am sensitive to the feelings and emotions of others.
8. I have a good understanding of the emotions of people around me.
9. I always set goals for myself and then try my best to achieve them.
10. I always tell myself I am a competent person.
11. I am a self-motivated person.
12. I would always encourage myself to try my best.
13. I am able to control my temper and handle difficulties rationally.
14. I am quite capable of controlling my own emotions.
15. I can always calm down quickly when I am very angry.
16. I have good control of my own emotions.

The above is adapted from Wong and Law (2002) used for this study.
APPENDIX C

LIFE AND SAFETY SURVEY DATA
The above is from the CMS (2016) Life and Safety Survey used for this study.
REFERENCES


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