JONA
Volume 49, Number 9, pp 404-410

THE JOURNAL OF NURSING ADMINISTRATION

Nurse Leader Burnout, Satisfaction, and Work-Life Balance

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OBJECTIVE: To examine and report burnout, secondary trauma, and compassion satisfaction in acute care nurse leaders through a large mixed-methods research study.

BACKGROUND: Although nurse leaders are removed from daily patient care activities, the pervasive challenges in the work environment create conditions for professional burnout. Nurse leaders must garner compassion satisfaction from different sources, including peer and staff interactions.

METHODS: The Professional Quality of Life scale was given to nurse leaders at 29 hospitals in 1 health system. Sixteen leaders from 2 hospitals participated in qualitative interviews.

RESULTS: Six hundred seventy-two nurse leaders from 29 hospitals reported similar levels of burnout across frontline, midlevel, and director-level leadership. Directors demonstrated higher levels of compassion satisfaction and lower levels of work-life balance. Four themes emerged representing areas of professional life that potentiate and alleviate compassion fatigue.

CONCLUSIONS: All levels of nurse leaders must address the risk of burnout and can do so through individual and organizational resiliency strategies.

Acceptable professional quality of life for healthcare professionals requires minimizing compassion fatigue and optimizing compassion satisfaction. Compassion fatigue is described as a high level of burnout and secondary traumatic stress that can result in the inability for a caregiver to foster compassionate and caring interactions.[1,2] Burnout is a prolonged response to chronic emotional and interpersonal stressors and is characterized by hopelessness and apathy.[2,3] Secondary traumatic stress can result through the exposure of caring for patients who have experienced a traumatic or stressful event, resulting in affective symptoms or distress for the caregiver.[2] The strain of compassion fatigue is counterbalanced with compassion satisfaction derived from work, or the pleasure and gratitude developed from a position.[2,4]

Compassion fatigue research and interventions in nursing have predominantly addressed bedside caregivers, as they experience continuous, intense interactions with patients that may both positively and negatively impact their professional quality of life. Evidence has clearly linked the association between burnout in the healthcare workforce and poor outcomes for patient safety.[3,4]

Although much of the work in this area has emphasized direct care nurses, burnout and secondary traumatic stress can also negatively affect nurse leaders. Research in the nurse leader population indicates this group experiences burnout,[5] likely contributing to decreased job satisfaction and intention to leave their positions.[6] Nurse leaders manage multiple, complex and competing priorities, such as workforce engagement, clinical outcomes, and fiscal productivity. As the risk of burnout increases, decision-making effectiveness

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This study was funded in part by the American Organization of Nurse Executives small grants program.

The authors declare no conflicts of interest.

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Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jonajournal.com).

DOI: 10.1097/NNA.0000000000000784

and emotional intelligence may decrease, making leadership effectiveness a greater challenge.[7]

Factors contributing to leaders' burnout are complex. Competent clinicians may be promoted into leadership roles without evaluation of adequate leadership skills, knowledge, and training. Underdeveloped leaders are challenged to meet organizational demands while struggling with work-life balance in an environment that may be overwhelmingly stressful.[8] Additionally, the leadership role is embedded in the same high-intensity hospital environment in which clinical nurses practice; however, the accountability for dealing with these issues is complicated. Nurse leaders are subject to the same emotional and traumatic situations that occur for direct care nurses when interacting with patients, family, and other providers, and they also, at times, are responsible for decisions that have put nurses at the point of service at risk of traumatic stress.

Studies acknowledge nurse leaders' burnout and potential contributing factors,[5,6] but these studies have not directly measured burnout or compassion fatigue in the nurse leader population, and little is known about the risk of secondary traumatic stress. In an organizational environment where leaders report heavy workload, strained resources, and inability to ensure consistent quality of care, greater levels of burnout among leaders are reported.[9] Additionally, work environments defined by poor leadership and ongoing lack of autonomy have been noted to increase burnout.[10] Conversely, nurse leaders are motivated by meaningful recognition and are disheartened by inequity in rewards and acknowledgment.[11,12]

Because there is a need to better understand compassion fatigue and compassion satisfaction, including the sources and symptoms in nurse leaders, we conducted a multihospital study to examine these factors. This study reports burnout, secondary traumatic stress, and compassion satisfaction in 3 hierarchal levels of nurse leaders and explores how these leaders recognize compassion fatigue and promote compassion satisfaction.

Methods

A mixed-methods study was conducted, with quantitative survey data to measure burnout, secondary trauma, and compassion satisfaction in nurse leaders, along with qualitative data to understand how leaders garner compassion satisfaction. Institutional review board approval was obtained by Arizona State University.

Setting

Data were collected from 29 hospitals within a single nonprofit health system. Ten of the hospitals are in rural geographic locations within the Western region of the United States, whereas the remaining 19 are in urban settings. All of the rural hospitals are considered small (<50 beds), whereas the urban hospitals range from 50 to approximately 700 staffed beds. Four of the participating hospitals possess Magnet® or Pathway to Excellence® designation. All 29 hospitals were included in the quantitative data collection; from those hospitals, 1 rural and 1 urban hospital were selected to participate in the qualitative portion of the study. Selection for the qualitative portion was based on support from their executive leadership and for diversity in short- and long-term leaders.

Sample

The invited sample included a total of 1118 RN leaders who held titles in the organizations as either clinical managers (CMs, 806 eligible), senior CMs (SCMs, 202 eligible), or directors (110 eligible). Similar to a charge nurse role, CMs support bedside staff and patients on a shift-by-shift basis; SCMs provide leadership of clinical, financial, and personnel management of assigned areas; and directors provide strategic leadership and administration over service lines and multiple units. Participants were excluded if they were in a nonnursing, education, or direct clinical care position. From the 2 hospitals selected for the qualitative component, purposive sampling of 16 nurse leaders consisted of 6 CMs, 6 SCMs, and 4 directors.

Measures

A 3-part electronic survey was used for quantitative data collection measuring: 1) demographics; 2) burnout, secondary traumatic stress, and compassion satisfaction; and 3) 4 single-item work-related satisfaction questions.

Demographic Measures

Demographic information included title, race, certification, professional membership organizations, tenure, and years of experience as a nurse and as a nurse leader. Participants were also asked if they intend to be in their current position in 1 year. Because of an error of omission, the question asking participant's age and educational level was inadvertently not included on the survey.

Professional Quality of Life

The Professional Quality of Life (ProQOL)[2] scale was used to measure burnout, secondary traumatic stress, and compassion satisfaction. The ProQOL has been used extensively in burnout research and deemed reliable in the nursing population.[2,13] The 30-item questionnaire asks respondents to rate items on a 5-point Likert scale ranging from 1 (never) to 5 (very often). Responses are divided into 3 subscales (burnout, secondary traumatic stress, and compassion satisfaction). The subscale items are totaled (some items reversed),

and raw subscale scores cannot be combined to create a total score.

Nurse Leader Satisfaction

Nurse leaders were asked 4 researcher-derived questions addressing their organizational satisfaction, similar to previous acute care research,[5] including overall satisfaction and satisfaction with their work-life balance, recognition they receive, and perceived level of collaboration in their work. The rating scale ranged from 1 (very dissatisfied) to 5 (very satisfied).

Data Collection

The email invitation to participate was sent from the executive nurse leader in each facility to eligible nurse leaders. The survey was open for 1 month with reminder emails sent at 1-week intervals for 3 weeks. An iPad was raffled as an incentive for participation.

Recruitment for the qualitative portion of the study occurred at leadership meetings and through the nurse executives at the 2 designated facilities. Nurse leaders were invited to schedule through e-mail a 1-on-1 phone interview with the coinvestigator. Interviews began with the coinvestigator reading the recruitment invitation, reinforcing confidentiality and stating the research purpose. A series of scripted questions were used as a guide (Table 1), with follow-up questions as needed. Each interview lasted approximately 30 minutes, and nurses received a $20 gift card for participation.

Data Analysis

Data analysis was conducted using SPSS version 23 (Armonk, New York). Cases with more than 10% of the data missing were deleted (n = 23 [3%]). For cases with random data missing, mean imputation was used for the outcome variables only (n = 121 [18%]). Frequencies and means were calculated to describe burnout, secondary trauma, and compassion satisfaction, and an analysis of variance was conducted to test differences between groups. Because of unequal group sizes, a Welch test and Tamhane post hoc analysis were used to test differences between group satisfaction responses. Generalized linear regression modeling was also used to analyze the effects of individual variables on leaders' burnout, secondary trauma, and compassion satisfaction. Significance to assess differences was evaluated at $P < .05$.

Content analysis was used to uncover themes, cognitions, and attributions associated with compassion satisfaction and compassion fatigue and objectively categorize them. Each interview consisted of 8 questions designed to identify links between nurse leader perceptions of meaningful recognition and feedback from one's peers, direct reports, and supervisor and to describe the role these interactions played in decreasing compassion fatigue and increasing compassion satisfaction.

Responses to the interview questions were documented by hand during the interview. Responses were read back to the interviewee to ensure accuracy. All identifiers except job title and facility type were removed from the interview notes, and the documents were numbered. Within 24 hours of the initial call, the interview responses were electronically transcribed. Content analysis was done by 2 experts in organizational psychology and healthcare. Analysis began with independently reviewing 3 randomly selected interviews and identifying emerging themes. Following the independent analysis, the 2 coders discussed their findings, reached consensus, and then utilized the themes and coding process to analyze the remaining 13 interviews.

Table 1. *Interview Questions*

What on the job depletes your emotional energy?
What on the job restores your emotional energy?
How do you know when a peer interaction is successful?
How do you know when a direct report interaction is successful?
How have you been recognized in a meaningful way for your contributions by your organization?
How do peers within your organization recognize one another for their expertise?
Provide an example(s) of direct report feedback you have received that best describes the impact of your leadership style on your team.
As a nurse leader, how does what you do now to restore your emotional energy differ from the ways you restored that emotional energy when you were a staff nurse?

Results

A total of 672 nurse leaders (60% overall response rate) participated in the survey, including 430 CMs (53% response), 142 SCMs (70% response), and 100 directors (91% response). Demographic frequencies are presented in Table 2. Approximately 15% of the nurse leader population reported their race as nonwhite. Professional certification and organization membership status were lowest in the frontline CM, at 36% and 41%, respectively. Years of experience increased as role responsibilities increased; however, the lowest tenure was in the nurse director position.

Levels of burnout, secondary traumatic stress, and compassion satisfaction are reported in Table 3. No significant differences existed between groups on burnout or secondary traumatic stress; post hoc analysis demonstrated significantly higher reports of compassion satisfaction in the director group compared with CMs ($F_{2,613} = 4.24$, $P = .012$).

Table 2. Demographic Characteristics of Nurse Leaders

	CMs (n = 427)	SCMs (n = 141)	Directors (n = 99)	All Nurse Leaders (n = 667)
Female[a]	390 (91.3)	123 (87.2)	87 (87.9)	600 (89.9)
Nonwhite race[a]	74 (17.3)	14 (9.9)	14 (14.1)	102 (15.3)
Certified[a]	152 (35.6)	63 (44.7)	43 (43.4)	258 (38.7)
Member of professional organization[a]	175 (41.0)	87 (61.7)	70 (70.7)	332 (49.8)
	CMs (n = 426)	SCMs (n = 141)	Directors (n = 99)	All Nurse Leaders (n = 666)
Total years of experience as RN[b]	15.35 (9.78)	19.38 (10.33)	22.27 (9.75)	17.24 (10.26)
Years of experience as RN leader[b]	5.30 (5.80)	8.65 (6.82)	12.03 (7.75)	7.06 (6.93)
Years of experience in current position[b]	3.91 (4.47)	3.71 (8.32)	2.50 (2.92)	3.66 (5.37)

Response rates vary by item as demographic questions were not required.
[a]Reported as n (%).
[b]Reported as mean (SD).

Perceived satisfaction is reported in Table 4. Overall satisfaction with work significantly increased with each level of leadership ($F_{2,662} = 5.35$, $P = .002$). Clinical managers reported significantly higher levels of satisfaction with work-life balance than SCM and director-level leaders ($F_{2,664} = 12.29$, $P < .001$). However, CMs reported lower satisfaction with collaboration in their work than their middle and senior leadership counterparts ($F_{2,669} = 4.82$, $P = .009$) and lower satisfaction with recognition ($F_{2,667} = 3.15$, $P = .045$).

Regression modeling demonstrated higher burnout in nurse leaders was predicted by less experience in leadership ($\beta = .0.35$, $P = .022$) (Supplemental Digital Content 1, http://links.lww.com/JONA/A707). Additionally, higher nurse leader overall satisfaction and satisfaction with work-life balance significantly predicted lower burnout. While high collaboration was not a significant predictor of decreased burnout, low collaboration satisfaction scores significantly predicted higher burnout ($\beta = 3.15$, $P = .035$). Lower scores on the secondary trauma scale were predicted by increased overall satisfaction and higher work-life satisfaction (Supplemental Digital Content 2, http://links.lww.com/JONA/A708). A higher level of compassion satisfaction was predicted by greater number of years of experience ($\beta = .05$, $P = .003$), as well as membership in a professional nursing organization ($\beta = .88$, $P = .013$). Nurse leaders with increased overall satisfaction and higher work-life balance also reported higher compassion satisfaction (Supplemental Digital Content 3, http://links.lww.com/JONA/A709). Multicollinearity was assessed on models; whereas correlations between satisfaction questions and compassion satisfaction ranged from 0.400 to 0.583, multicollinearity diagnostics did not demonstrate variance inflation factor values higher than 2.05.

Qualitative Findings

Synthesis of the qualitative content analysis revealed 4 emerging themes: 1) Emotional Drain; 2) Every Interaction Tells a Story; 3) Managing One's Psychological Capital; and 4) Work-Life Balance Juggle (WLBJ).

Emotional Drain represented feelings leaders experience as they carry out challenging tasks associated with managing people. Providing an example, one leader explained that "supporting the hospital even when I don't agree with the process/practice" created emotional drain. Describing another situation and experience associated with this theme, a different leader shared that "the balance: how long and how hard you keep coaching performance" before you terminate an individual was also a source of emotional depletion. Regardless of title, emotional drain was the common thread associated with managing people through various difficult situations and appeared to possess a

Table 3. ProQOL Outcomes Variables

	CMs (n = 430)	SCMs (n = 142)	Directors (n = 100)	All Nurse Leaders (n = 672)
Burnout[a]	23.29 (5.70)	23.42 (5.77)	23.19 (5.56)	23.30 (5.69)
Secondary trauma stress[b]	20.47 (5.36)	21.62 (4.88)	20.73 (5.22)	20.73 (5.22)
Compassion satisfaction[c]	38.90 (5.81)	39.69 (5.76)	40.89 (5.85)[d]	39.44 (5.83)

[a]Potential score range for sample, 10 to 39.
[b]Potential score range for sample, 10 to 40.
[c]Potential score range for sample, 18 to 50.
[d]Significant at $P = .012$ compared with CMs.

Table 4. Welch F Test Results for Satisfaction Outcomes

Group	n	Mean	SD	Tamhane T2 Comparisons	
				CM	SCM
Overall satisfaction					
CM	425	3.74	0.93		
SCM	141	3.97	0.79	0.024	
Director	99	4.00	0.81	0.035	0.983
Satisfaction with work-life balance					
CM	426	3.49	1.04		
SCM	141	3.05	1.18	<0.001	
Director	100	3.06	1.11	0.001	1.00
Satisfaction with recognition					
CM	428	3.43	1.17		
SCM	142	3.59	1.05	0.449	
Director	100	3.71	0.96	0.049	0.670
Satisfaction with level of collaboration					
CM	430	3.74	1.01		
SCM	142	3.99	0.89	0.022	
Director	100	3.98	0.93	0.090	0.999

Satisfaction assessed from 1 = very dissatisfied to 5 = very satisfied; significance assessed at $P < .05$.

cumulative nature potentially leading to compassion fatigue.

The theme Every Interaction Tells a Story revealed how peer, direct-report, and supervisor nonverbal feedback is used to assess another's engagement and serves as a powerful form of positive reinforcement. Describing the nonverbal feedback and engagement link, 1 nurse leader explained, "If I can see acknowledgment on their face, nodding and listening, eye contact—that does not mean they agree, but are listening." Other nurse leaders articulating how these nonverbal interactions served as a form of recognition explained, "You see something in that nurse, a spark," whereas another stated, "You feel that synergy or energy between you."

The 3rd theme, Managing One's Psychological Capital, contained 2 components: the challenges leaders encounter as they navigate motivational barriers of others and the emotional restoration they experience when this navigation is successful. Describing the navigation aspect, 1 leader shared the barrier of "trying to get staff to move in directions and dealing with 20% of the staff who say I've always done it this way." Another leader, explaining how tangible requirements of their role can exacerbate these barriers, stated, "Trying to juggle the paperwork of the job and trying to be there emotionally for my staff, but the other stuff has to be done, and they don't understand." The emotional restoration component of this theme emerged when successful navigation of motivational barriers occurs or, as 1 leader explained, "When we are actually able to push change through for the better and staff are able to see it." Describing the emotional restoration impact another leader explained, "When you see a patient actively engage with staff, you know the information you communicated to the staff is making its way to the patients." The interwoven nature of these 2 themes provided insight regarding how emotional restoration refuels compassion satisfaction; thus, refueling is an outcome occurring from successful barrier navigation. Embedded in this theme are explanations about navigating motivational barriers accompanied by descriptions of emotional restoration occurring from one's perceived success.

The final theme represents the dual role WLBJ plays in fostering both compassion fatigue and compassion satisfaction. Unique to this theme was an evolutionary component, where some of the leaders recognized that self-care was a part of effective leadership, while others were still trying to figure out how to integrate downtime into their lives. Part of this evolution involved descriptions about the transition from staff nurse to leadership, as 1 nurse explained, "(When I was a staff nurse) I had a narrower focus than I do as a leader. As a staff nurse, if I didn't kill anybody, that was a good day." Another nurse leader, reflecting on the impact of a leader's expanded scope, explained, "There are always emails and that's stressful. When I am off for a few days, there are hundreds of emails I have to deal with when I come back."

Recognizing the pitfalls associated with lack of WLBJ, this theme also encompassed accepting that effective leadership requires WLBJ and not viewing this as a weakness, as 1 leader explained, "Saying this is a priority and I have to do it taking care of me (is important)." Of interest was the descriptions of this growth and the conviction in the interviewee's voice/tone when recounting the moment he/she recognized that

allowing time to replenish was a strength, as 1 leader shared, "As a leader I carry more of an ownership, I have to be really intentional to self-care and have downtime. I try to be intentional and not let things get to me."

Discussion

While compassion fatigue has been discussed in the staff nurse population, burnout in nurse leaders has yet to be measured in a large-scale study, and this research contributes knowledge about nurse leader burnout, secondary traumatic stress, and compassion satisfaction. Extending the quantitative portion of this research, the inductive-inquiry approach provided an opportunity to explore how nurse leaders utilized feedback to recognize their contributions, promote compassion satisfaction, and buffer compassion fatigue.

In better understanding compassion fatigue, we discovered that quantitatively leaders demonstrated similar levels of burnout and secondary traumatic stress, with directors in this sample showing significantly higher levels of compassion satisfaction, or joy in their work. This finding could suggest that the broader scope and influence associated with the role responsibilities are more satisfying to leaders. In addition, nurses' years of experience can be a predictor of compassion satisfaction, with more years of experience associated with higher compassion satisfaction. This may be related to professional maturation that is inherent to greater experience.

However, the stress and emotional strain of leaders and their organizational responsibilities at various levels came through clearly. The tenure of directors was lower than other leadership positions, similar to that of executive level positions.[14] While frontline nurse leaders reported the highest satisfaction with their work-life balance, indicators of the stressors contributing to burnout were evident. Clinical managers reported overall less satisfaction and satisfaction with collaboration, as well as the highest intent to leave. Additionally, results align with previous research indicating that inexperienced/younger nurses are experiencing the highest burnout.[15] As leadership positions become increasingly harder to fill, the need for succession planning and supporting nurse leader well-being will be critical to support leadership tenure.[14,16]

Of concern, pervasive in both the findings of the survey and the interviews, were the reoccurrence and asserted theme of WLBJ and Emotional Drain. Our interviews indicated that leadership of those responsible for human life is a daunting scope. This scope, coupled with the complexity of healthcare leadership, creates a challenge to one's self-care. While the interviews noted WLBJ struggles as people moved from staff to leadership positions, the survey identified further strain in the higher-level leadership facing the most significant challenges with their work-life balance satisfaction. Burnout from organizational stress results from lack of barriers and an inability to "turn off" the work at the end of the day. Contributing factors can include technology, lack of executive leadership support, lack of peer support for coverage, and insufficient resources.[16] In turn, recognition of those situations where Managing One's Psychological Capital occurred and asking leaders who have achieved WLBJ success to mentor others may offer opportunities to promote emotional energy restoration and compassion satisfaction. Conversely, achieving some degree of work-life balance may increase one's compassion satisfaction and diminish burnout.[1]

Implications

Recognizing the pervasive nature of burnout in all levels of leadership and a fostered sense of compassion satisfaction at higher levels of leaders, the goal of organizations should be to continue to focus on supporting joy in work, in addition to continuous work environment improvements. An example of this type of work includes the Institute for Healthcare Improvement's framework for improving "joy at work," a term used to not merely describe the absence of burnout but the potential for happiness, meaning, and purpose with one's work.[17] The framework offers beneficial core strategies for increasing job satisfaction and preventing burnout, including autonomy, recognition, teamwork, and wellness and resilience activities. In addition to foster compassion satisfaction, the framework relies on managers and core leaders supporting individuals, with reinforcement by senior leaders. The role identity for leaders helps set boundaries to identify the needs for support at different levels of leadership.

In addition to identifying support for leaders at different levels, leaders' risk of burnout should continue to be assessed. Leaders with large spans of control, committee overload, and unreasonable expectations to be accessible 24/7 are at risk of burnout. Creating smaller spans of control, developing mechanisms to address organizational workload, and helping leaders set boundaries around accessibility expectations can diminish burnout and promote well-being. Tactics to promote compassion satisfaction, engagement, work-life balance, and leader retention include peer coverage so leaders can be "off technology," condensed work weeks (ie, 9 days every 2 weeks or a 4-day work week), allowing more downtime; and

strategic management of committee responsibilities with end dates; and succession planning.[16]

Limitations

While the results of this study highlight differences among leadership levels in relation to compassion satisfaction, they do not increase understanding related to burnout and secondary traumatic stress among leadership levels. It is possible that social desirability response bias or the limitation of 1 healthcare system influenced results at the director level, an inherently smaller group than frontline managers. Further, comparisons to staff nurse levels of compassion fatigue and satisfaction are not available with this study design. Future studies may benefit from assessing these trends among facilities across the country including supervising nurses, as well as innovations in decreasing burnout and fostering compassion satisfaction. Addressing burnout at this level could benefit organizational objectives, the thousands of staff members they will lead, and the millions of patients and families they will serve.

Conclusion

Preventing, identifying, addressing, and monitoring clinician burnout in the workplace are important nursing leadership functions. Leaders at all levels experience their own emotional depletion, work-life balance struggles, and the inability to restore their energy. As one of the most significant driving forces for supporting joy in the work environment, building personal resilience and supporting their own well-being must be a priority for nurse leaders as a strategy for achieving national goals for workforce development and healthcare reform.

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