

International Journal of Nursing and Health Care Science

Review Article

Wilkinson M and Buckley A. *Int J Nurs & Health Car Scie* 04: 2024-321

Stroke Rehabilitation Nursing and Compassion Fatigue - A Literature Review and Research Proposal

Mark Wilkinson, RN, BA (Hons), ProfDip, PGCert, MSc, PhD.#, A. Buckley, RN, BA (Hons), MSc.

Submission Date: 17 March, 2024

Accepted Date: 30 March, 2024

Published Online: 03 April, 2024

#Liverpool University Hospitals NHS Trust, UK

#Corresponding author: Mark Wilkinson, RN, BA (Hons), ProfDip, PGCert, MSc, PhD., Stroke nurse consultant, Liverpool University Hospitals NHS Trust, Prescot Street, Liverpool, Merseyside, L7 8XP, UK

How to cite this article: Wilkinson M and Buckley A (2024) Stroke Rehabilitation Nursing and Compassion Fatigue - A Literature Review and Research Proposal. *Int J Nurs & Health Car Scie* 04(04): 2024-321.

Introduction

Compassion fatigue (CF) has been defined as the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized or suffering person [1]. CF significantly impacts on nursing practice and performance, patient satisfaction and organizational negative implications [2]. Nurses working in stroke services at a specialist level have been found to experience CF due to patients presenting with acute and often unpredictable illness, increased mortality, interaction with relatives, moral distress and competing service demands [3]. Nurses working in stroke rehabilitation units may be subject to similar stressors. However, the evidence related to the emotional impact on their practice is sparse. This article aims to present the current evidence related to CF in nursing. This will serve as part of the justification for further interrogation of stroke rehabilitation nurses' feelings of CF encountered in caring for patients in their practice.

Keywords: Compassion fatigue; Nurse; Rehabilitation; Stroke

Background

Compassion fatigue (CF) is characterized by the negative aspects of providing care to those who have experienced extreme or traumatic stressors. It has been referred to as the innate ensuing comportment and feelings on acknowledgment of a traumatic occurrence involving another individual [1]. In effect, the distress occasioned by another is projected onto the person who wants to function as their helper. Negative responses are characterized by preoccupation with the traumatized individual, re-experiencing their trauma, feeling ensnared, and adopting avoiding behaviours [4]. This can result in sleeplessness, depression, and an inability to separate one's personal and professional life [5]. CF has significant organisational issues for healthcare providers, with nurse retention, patient satisfaction and patients' safety impacted [6]. Care institutions need to develop strategies for the investigation and reduction of CF due to the ramifications for staff, patients, relatives, and services [7].

CF has previously been investigated in both acute and longer-term nursing [8-11]. However, the evidence relating to rehabilitation nursing staff, is scant. Nurses practicing in long term care or rehabilitation are at risk of CF from prolonged or repeat exposure to patient's suffering and their extended patient engagement [12]. Moderate levels of CF as evident among nurses caring for people with chronic disease [13]. Cardile, et al. [14] have reported elevated levels of CF in neurological rehabilitation workers citing efforts disproportionate to the outcome as a responsible factor. Dadoosh and Al - Fayed [15] reported CF among 63% of its sample (n = 131) of nurses working in neurological wards, postulating exposure to the suffering of acute neurological conditions as contributory. Furthermore, prolonged exposure to collaborating with patients and families over considerable periods can gestate CF to the detriment of person centered rehabilitation [15].

These articles report the prevalence of CF in long term care and rehabilitation. However, they offer no appreciation of their subjects lived experience of the origins of their CF. Nurses working on stroke rehabilitation units may develop CF due to recurrent proximity and engagement with patients traumatized by stroke. The researchers have experience in working in the area of stroke rehabilitation and an interest in the nurses who populate this area. The researchers therefore propose that the cause of these nurses' lived experiences of CF is investigated.

Search Strategy

Literature searching and the subsequent reviews of the captured papers, enable the researcher to reflect on current evidence to determine the key concepts to address the elements arising from the area of interest and informs decisions on the research question and the methods employed to answer it [16]. The strategy for evidence searching requires a systematic approach, with the criteria being made explicit [17]. Page and Moher [18] advocated the PRISMA guideline for conducting literature searching as a robust and reproducible means to minimise bias. These guidelines followed when conducting this literature search.

Mohamed Shafriil, et al. [19] advises a search of appropriate databases, websites and other sources depending on the type of evidence sought. An electronic literature search was undertaken, with the MEDLINE, EMBASE, CINAHL and PsycINFO, BNI, EMCARE databases being accessed. This researcher argues that the databases accessed were apposite to the reviews' aim. McGowan, et al. [20] have documented the critical use of search terms in the process of identifying the relevant literature. Bettany - Saltikov and McSherry [21] advocate the use of the PEO framework in undertaking qualitative literature reviews. It is frequently employed as a tool for structuring questions to develop search terms [22]. The framework was influential for this researchers' considerations on the applied search, MeSH, and Boolean terminology (Table 1). (Table 2) reveals the search terms used to meet the researcher's primary area of interest. The inclusion and exclusion criterion (Table 3) were proposed to locate the studies relevant to the topic. The search was conducted within the dates from 2015 to the present date. The year 2015 was selected as a starting point given that this was when the researcher originally started their work on the topic. Primary research articles from peer reviewed journals were selected for review. Allowing for the linguistic dominance of English within medical and health sciences [23] only articles in the English language were selected for review. Studies relating to (registered) adult nursing with an emphasis on rehabilitation were selected for review. The core aim of this review was to gain an appreciation of stroke rehabilitation nurses' lived experience of CF, therefore studies that referred to quantitative findings were excluded from selection. Articles using mixed methods were considered if there were demonstrable qualitative findings. Figure 1 details the process outcome. While the principal search method chose medicine and health related bibliographic databases that offered access to a large volume of scientific journals [24], the titles and abstracts of the identified articles being examined for relevance to the area of interest, reference and citations were also checked for any unidentified studies.

Population	Qualified nursing staff – adult nursing.
Exposure	Stroke rehabilitation.
Outcome	Compassion fatigue.

Table 1: The applied PEO framework.

1. Compassion Fatigue.
2. Nurse.
3. 1 AND 2.
4. Stroke rehabilitation
5. 3 AND 4.
6. Qualitative.
7. 5 AND 6.

Table 2: The Search Terms.

Inclusion:	
	Primary studies in the English language.
	Peer reviewed articles dating from 2015 to the present date.
	Studies involving qualified adult nurses caring for people undergoing stroke rehabilitation.
	Qualitative methodology and results.
Exclusion:	
	Articles not in the English language.
	Articles from non-peer reviewed journals predating 2015.
	Studies involving non-qualified nursing staff/ not working with adults.
	No qualitative methodology/ result.

Table 3: The inclusion/ exclusion criteria.

Majid and Vanstone [25] commented on the diverse compendium of quality assessment tools when assessing the merits of qualitative studies. This researcher adopted the CASP tool to appraise the quality of the located studies. This strategy allowed confidence in the article's findings and appropriateness to this researcher's area of inquiry [26].

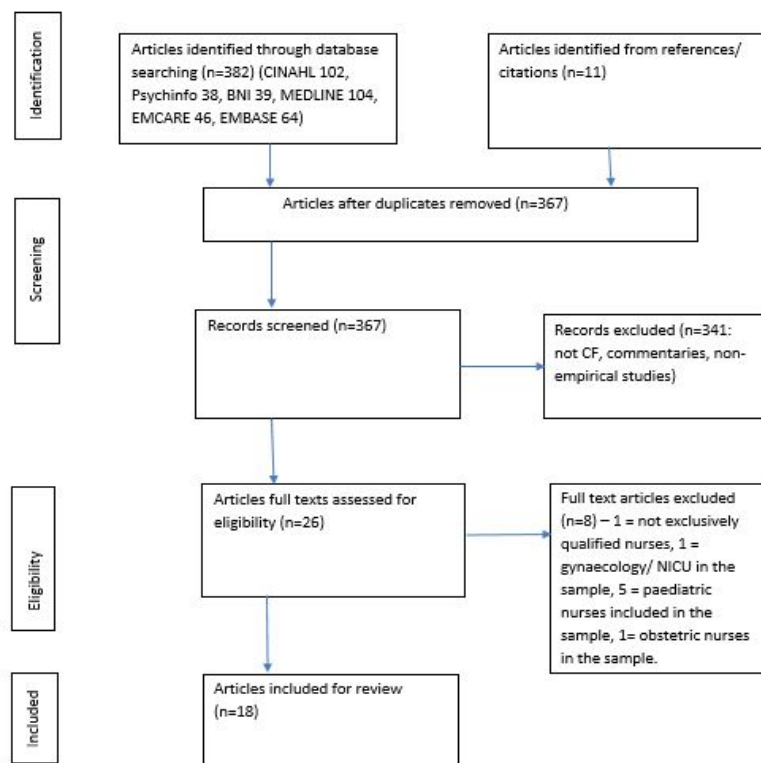


Figure 1: Study identification and inclusion utilising PRISMA criteria.

Study Characteristics

The literature search realized 17 articles for inclusion in this review (appendix A. Appendix B details the qualitative studies not selected for the final review). The studies originated in Australia (1), Iran (1), Japan (1), Malta (1), South Africa (2), Spain (1), Turkey (2), the UK (3) and the USA (4). The study populations were adult nurses working in oncology (7), general medicine (acute/ primary care (3), HIV care (1), long term care (1) and stroke (1). No studies reported on findings of CF in rehabilitation nurses. Three studies were of mixed methods [27-29], with remainder being exclusively qualitative in their conduct. Two studies referenced narrative [3,28], two referred to grounded theory [30,31], three referred to using focus groups [32-34], one study used an embedded case study design [35], the remainder being descriptive (6) and interpretive phenomenology (3) using semi structured interviews. Participants ranged in number from three to 55. All studies described ethical considerations, the participants and recruitment process. All articles offered examples of qualitative responses from their participants.

Findings

The articles were submitted to repeated scrutiny to identify their inherent comparable and contrasting tropes [36]. The immersive experience of attending to suffering people was articulated across these articles. Several studies linked this to acute presentations of critical illness with fluctuating clinical courses [3,30]. However, most of the articles referred to descriptions of chronic illness and suffering. Despite the underlying pathology, these nurses' depictions of CF are argued as the result of exposure to the triumvirate of suffering in terms of prolongation, accumulation, and the inability to afford alleviation [37]. Furthermore, CF is contended as being the result of empathic engagement [33,38]. Although the participants referred to suffering across all age ranges, CF was most keenly felt when caring for young people [3,30,39]. This had resonance where the situation forced reminders of the nurses' own personal experience - age/ family/ loss being cited. The studies by Dowdell, et al. [32] and Tellie, et al. [35] are however interesting in that the experience of CF was related to repetitive exposure but empathy was lost through patient non-compliance and the feeling that time and effort had been wasted. CF was aggravated in situations of treatment without benefit [40]. This can be explained in two dimensions - having to see it and being made complicit in its prosecution, the result being despair, anger and inter collegial dispute [27].

These articles referred to cultures punctuated by acrimony resulting in the situation of care being jeopardized. Jackimowicz, et al. [31] sample referred to the inequalities posed by healthcare cultures that were medically led. This led to situations of hostility rather than collaboration [41], the disconnect being most appreciated by nurses feeling that their opinions were not listened to or respected [42]. Nurses' CF feelings were exacerbated where there was disagreement with physicians when they felt that care was not in the patient's best interests or where the nurses' values were rendered vulnerable [40]. Furthermore, CF can be linked to these nurses' frustrations at not being to live up to their own professional standards [29,37], with the care they aspire to deliver relegated to that of a basic level [28].

Nurses' distress was heightened when having to contend with perceived disrespect from patients [32]. This study reported on have disrespected provoked negative emotional responses. This is further exacerbated by the demands patients made of their nurses, particularly where they were deemed as unattainable or unrealistic [28]. Interestingly, Fukumori, et al. [39] also reported a source of nurses' distress as seeing discord arising in the form of patients' disagreements with their own relatives over treatment.

Family interactions were also seen to precipitate reports of CF. The effect of nurses seeing relatives in distress was disquieting [38]. Furthermore, nurses' distress was compounded by developing attachment behaviours with relatives [34]. Wentzel, et al. [43] referring to overinvestment of empathy and involvement with relatives as giving all to people who had become like family. However, the emotional investment was at the eventual cost of becoming perturbed. This can be contrasted with the findings of Omran and Callis [33] who have referred to nurses' distress resulting from disagreement with family members. The focus of this disharmony is rooted in relatives' unrealistic expectations, particularly regarding outcomes [31].

The articles referred to CF germinated by atmospheres of division and restriction. Poor collaboration, and understaffing was chasmic for collegial relationships with some nurses labelled as uncaring [28]. The team disconnect was most acute where targets were prioritised over patient care [29]. Increasing workload demands escalated distress [30]. The increased burden of workload and responsibility led to evident disillusionment, prompting one participant to state resentment for nursing [31]. Resource constraint in terms of staff, time, equipment, and environment left nurses feeling physically and emotionally exhausted [44]. This was exacerbated by unsupportive management [28].

Considerations and the Research Question

While the search strategy was apposite [45], it does have limitations. The researcher is cognisant that the inclusion and exclusion criteria used could have been prohibitive for potential evidence outside the English language, published before 2015, from journals that were not peer reviewed and unpublished works [46]. Furthermore, given the wide populations studied, there is a degree of difficulty when considering the components of generalisability and transferability [47].

This review has resonance with that of McGrath, et al. [48] who found no papers related to predictors of CF in providers of rehabilitation services. Similarly, this researcher has located no studies that investigated nurses' experience of CF when caring for people in the rehabilitation setting, including people with stroke.

This researcher, however, argues the merit of this literature's review when considering the proposed area of investigation, contending that the findings of these articles could resonate with the experience of CF in rehabilitation services. It is argued that the suffering described in these studies, particularly when considering the longer-term presentations, may be comparable when considering chronic disability and the complications arising from stroke. There is the opportunity to examine the dynamic between nurses and physicians, but the often-competing interests of the multidisciplinary approach in rehabilitation. Furthermore, it is possible to debate the similarities found in these studies and the potential for conflict when dealing with rehabilitation patients' and families demands and expectations. This researcher also suggests that the elements of environment and resources will find resonance with the nurses working in rehabilitation.

This gap in the evidence base requires redress. This researcher opines that this innovative proposed study would add to the appreciation of rehabilitation nurses lived experiences and the knowledge of trauma reactions in this unique group. This researcher proposes consideration of the following research question:

Under what circumstances could nurses working in stroke rehabilitation units experience compassion fatigue?

There are multiple qualitative methodologies that could inform the basis of explorations of this topic [49]. Al - Ababneh [50] has referred to the philosophical underpinnings of ontology - what constitutes reality and epistemology - how that reality is arrived at and understood. The philosophical basis of this research is situated in a critical realist ontology and an interpretivist epistemology. These considerations are important in justifying the choice of methodology, methods, data collection, analysis, and interpretation [51]. This researcher proposes an interpretive Hermeneutic phenomenological methodology as appropriate to the conduct of this investigation [52] as it affords a broader understanding of the phenomenon with its situation and context - including environment, time, body, relationships, and culture, what it means to the individual, and how it impacts and alters their being [53]. This methodology may therefore grant an appreciation of the context of how these elements may influence the development and impact of compassion fatigue among stroke rehabilitation nurses [54-59].

Conclusion

Nurses working in the theatre of stroke rehabilitation may be exposed to several situations whereby they may experience the development of compassion fatigue. Compassion fatigue has previously been studied in many areas of nursing practice, with multiple reasons for its development being offered. However, there is a paucity of evidence related to the experience of compassion fatigue in nurses working in the field of rehabilitation. No studies have been undertaken with specific reference to compassion fatigue in nurses whose work is dedicated to that of stroke rehabilitation. The researchers suggest that this gap in the knowledge base is addressed and propose a qualitative approach to understanding these nurses' lived experiences.

References

1. Figley CR (1995) Compassion fatigue as secondary traumatic stress disorder: an overview. In: *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatised*.
2. Cohen-Katz J, Wiley SD, Capuano T, et al. (2004) The effects of mindfulness-based stress reduction on nurse stress and burnout: a quantitative and qualitative study. *Holist Nurs Pract* 18: 302-308.
3. Wilkinson M, Cox N, Witham G, et al. (2022) Hyperacute stroke and the specialist nursing impact: exploring the cause and context of feelings of secondary traumatic stress-a qualitative inquiry. *Journal of Research in Nursing* 27: 343-354.
4. Cavanagh N, Cockett G, Heinrich C, et al. (2020) Compassion fatigue in healthcare providers: a systematic review and meta-analysis. *Nursing Ethics* 27: 639-665.
5. Alharbi J, Jackson D, Usher K (2019) Personal characteristics, coping strategies, and resilience impact on compassion fatigue in critical care nurses: A cross-sectional study. *Nursing & Health Science* 22: 20-27.
6. Peters E (2018) Compassion fatigue in nursing: A concept analysis. *Nursing Forum* 53: 466-480.
7. Xie W, Chen L, Feng F, et al. (2021) The prevalence of compassion satisfaction and compassion fatigue among nurses: A systematic review and meta-analysis, *International Journal of Nursing Studies* Volume 120: 103973.
8. Ratrouf H, Hamdan-Mansour A (2017) Factors Associated with Secondary Traumatic Stress among Emergency Nurses: An Integrative Review. *Open Journal of Nursing* 7: 1209-1226.
9. Salimi S, Pakpour V, Rahmani A, et al. (2020) Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Among Critical Care Nurses in Iran. *Journal of Transcultural Nursing* 31:59-66.
10. Christodoulou-Fella M, Middleton N, Papathanassoglou EDE, et al. (2017) Exploration of the Association between Nurses' Moral Distress and Secondary Traumatic Stress Syndrome: Implications for Patient Safety in Mental Health Services. *BioMed Research International* 19.
11. Arimon-Pagès E, Torres-Puig-Gros J, Fernández-Ortega P, et al. (2019) Emotional impact and compassion fatigue in oncology nurses: Results of a multicentre study. *European Journal of Oncology Nursing* 43: 101666.
12. Lin LC, Huang Y C, Carter P, et al. (2021) Resilience among nurses in long term care and rehabilitation settings. *Applied Nursing Research* 62: 151518.
13. Yakar HK, Oguz S, Bulut B, et al. (2023) Compassion fatigue in nurses caring for chronic diseases. *International Journal of Occupational Safety and Ergonomics* 29: 109-114.
14. Cardile D, Corallo F, Ielo A, et al. (2023) Coping and Quality of Life Differences between Emergency and Rehabilitation Healthcare Workers. *Healthcare* 11: 2235.
15. Dadoosh KA, AL-Fayyed S (2022) Compassion Fatigue among Nursing Staff Practicing at Neurological Wards. *ResMilitaris* 12: 4614-4623.
16. Bramer WM, Rethlefsen ML, Kleijnen J, et al. (2017) Optimal database combinations for literature searches in systematic reviews: a prospective exploratory study. *Systematic Reviews* 6: 245.
17. Snyder H (2019) Literature review as a research methodology: An overview and guidelines. *Journal of Business Research* 104: 333-339.
18. Page MJ, Moher D (2017) Evaluations of the uptake and impact of the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) Statement and extensions: a scoping review. *Systematic Reviews* 6: 263.
19. Mohamed Shaffril HA, Samsuddin SF, Abu Samah A (2021) The ABC of systematic literature review: the basic methodological guidance for beginners. *Quality and Quantity* 55: 1319-1346.
20. McGowan J, Sampson M, Salzwedel DM, et al. (2016) PRESS Peer review of electronic search strategies: 2015 guideline statement. *Journal of Clinical Epidemiology* 75:40-46.
21. Bettany-Saltikov J, McSherry R (2016) *How to do a Systematic Literature Review in Nursing: A step-by-step guide*. Second Edition. Open University Press.
22. Kabir R, Hayhoe R, Bai A C M, et al. (2023) The systematic literature review process: a simple guide for public health and allied health students. *International Journal of Research in Medical Sciences* 11: 3498-3506.
23. Cooper C, Booth A, Varley-Campbell J, et al. (2018) Defining the process to literature searching in systematic reviews: a literature review of guidance and supporting studies. *BMC Med Res Methodology* 18: 85.
24. Briscoe S (2018) A review of the reporting of web searching to identify studies for Cochrane systematic reviews. *Research Synthesis Methods* 9: 89-99.
25. Majid U, Vanstone M (2018) Appraising Qualitative Research for Evidence Syntheses: A Compendium of Quality Appraisal Tools. *Qualitative Health Research* 28: 2115-2131.
26. Long HA, French DP, Brooks JM (2020) Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*1: 31-42.
27. Giarelli E, Denigris J, Fisher K, et al. (2016) Perceived quality of work life and risk for compassion fatigue among oncology nurses: A mixed methods study. *Oncology Nursing Forum*, 43: E121-E131.
28. Upton KV (2018) An investigation into compassion fatigue and self-compassion in acute medical care hospital nurses: a mixed methods study. *Journal of Compassionate Health Care*, 5: 7.
29. Francis-Wenger H (2023) Exploring compassion satisfaction and compassion fatigue in emergency nurses: a mixed-methods study. *Emergency Nurse*.
30. Taşdemir Hİ, Aydın R, Dursun Ergezen F, et al. (2023) Unveiling the burden of compassion fatigue in nurses. *Nursing Ethics* 0(0).
31. Jackimowicz S, Perry L, Lewis J (2018) Insights on compassion and patient-centered nursing in intensive care: A constructivist grounded theory. *Journal of Clinical Nursing* 27: 7-8, 1599-1611.

32. Dowdell EB, Alderman SE, Foushee N, et al. (2022) Expressions of Compassion Fatigue by Emergency Department Nurses Caring for Patients with Opioid and Substance Use Disorders. *Journal of Emergency Nursing* 48: 688-697.
33. Omran T, Callis AM (2021) Bereavement needs of critical care nurses. A qualitative study. *Dimensions of Critical Care Nursing* 40: 83-91.
34. Pérez-García E, Ortega-Galán AM, Ibáñez-Masero O, et al. (2021) Qualitative study on the causes and consequences of compassion fatigue from the perspective of nurses. *International Journal of Mental Health Nursing* 30: 469-478.
35. Tellie M, Leech R, Van Wyk N (2020) Compassion fatigue among nurses: the cost of having a relationship with HIV-positive patients. *Africa Journal of Nursing and Midwifery* 22: 2.
36. Castleberry A, Nolen A (2018) Thematic analysis of qualitative research data: Is it as easy as it sounds? *Currents in Pharmacy Teaching and Learning* 10: 807-813.
37. Akbarian-Rokni M, Mardani-Hamooleh M, Abbasi M, et al (2023) Nurses' perceptions of the challenges involved in providing of end-of-life care to people with heart failure: a context-based study. *BMC Palliative Care* 22: 180.
38. Bilgic S, Pamuk-Cebeci S (2022) Compassion fatigue in oncology nurses in Turkey. A qualitative study. *Holistic Nursing Practice. The International Science of Health and Healing* 36: 304-310.
39. Fukumori T, Miyazaki A, Takaba C, et al. (2020) Traumatic events among cancer patients that lead to compassion fatigue in nurses: A qualitative study. *Journal of Pain and Symptom Management* 59: 254-260.
40. Grech A, Depares J, Scerri J (2018) Being on the frontline. Nurses' experiences providing end-of-life care to adults with haematologic malignancies. *Journal of Hospice & Palliative Nursing* 20: 237-244.
41. Phillips CS, Volker DL (2020) Riding the rollercoaster. A qualitative study of oncology nurses' emotional experiences in caring for patients and their families. *Cancer Nursing* July 29.
42. Finley BA, Sheppard KG (2017) Compassion Fatigue: Exploring Early-Career Oncology Nurses' Experiences. *Clin J Oncol Nurs* 21: E61-E66.
43. Wentzel S, Collins A, Brysiewicz P (2019) Describing compassion fatigue from the perspective of oncology nurses in Durban, South Africa. *Health SA Gesondheid* 24: a1279.
44. Steinheiser MM, Crist JD, Shea KD (2020) Compassion fatigue in RNs working in skilled nursing facilities. *Research in Gerontological Nursing* 13: 320-328.
45. Liberati L, Altman DG, Tetzlaff J, et al. (2009) The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies That Evaluate Health Care Interventions: Explanation and Elaboration. *Annals of Internal Medicine* 151: W-65-W-94.
46. Rethlefsen ML, Kirtley S, Waffenschmidt S, et al. (2021) PRISMA-S: an extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews. *Systematic Reviews* 10: 39.
47. Leung L (2015) Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care* 4: 324-7.
48. McGrath K, Matthews LR, Heard R (2022) Predictors of compassion satisfaction and compassion fatigue in health care workers providing health and rehabilitation services in rural and remote locations: A scoping review. *Australian Journal of Rural Health* 30: 264-280.
49. Dyar KL (2022) Qualitative inquiry in nursing: creating rigor. *Nursing Forum*, 1: 197-200.
50. Al-Ababneh M (2020) Linking Ontology, Epistemology and Research Methodology *Science & Philosophy* 8: 75-91.
51. Cuthbertson LM, Robb YA, Blair S (2020) Theory and application of research principles and philosophical underpinning for a study utilising interpretive phenomenological analysis. *Radiography* 26: e94-e102.
52. Burns M, Peacock S (2019) Interpretive phenomenological methodologists in nursing: A critical analysis and comparison. *Nursing Inquiry* 2: e12280.
53. Matua GA (2015) Choosing phenomenology as a guiding philosophy for nursing research. *Nurse Researcher* 22: 30-34.
54. Matua GA, Van Der Wal DM (2015) Differentiating between descriptive and interpretive phenomenological approaches. *Nurse Researcher* 22: 22-27.
55. Findley BA, Sheppard K (2017) Compassion Fatigue. Exploring early-career oncology nurses' experiences. *Clinical Journal of Oncology Nursing* 21: E61-E66.
56. Jahner S, Penz K, Stewart, et al. (2019) Psychological impact of traumatic events in rural nursing practice: An integrative review. *Online Journal of Rural Nursing and Health Care* 19: 105-135.
57. Kayes NM, Papadimitriou C (2023) Reflecting on challenges and opportunities for the practice of person-centred rehabilitation. *Clinical Rehabilitation* 37:1026-1040.
58. Morrison LE, Joy JP (2016) Secondary traumatic stress in the emergency department. *Journal of Advanced Nursing* 72: 2894-2906.
59. Pautasso M (2019) The Structure and Conduct of a Narrative Literature Review. In: *A Guide to the Scientific Career*. Shoja M, et al. (Editors).