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Research Article

Compassion Satisfaction and Compassion Fatigue: Experiences of Rehabilitation Healthcare Workers in Rural and Remote Locations in Australia

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Purpose. This study sought to gain an understanding of rural and remote rehabilitation healthcare workers' perceptions and experiences of compassion satisfaction and compassion fatigue. *Method*. Sixteen rehabilitation workers from four national providers of rehabilitation services to rural and remote communities participated in semistructured interviews conducted by telephone over a four-month period in 2018-2019. Braun and Clarke's six-phase framework guided the thematic analysis. *Findings*. Quality of work life, organisational and workplace culture, and organisational management practices, particularly key performance indicators (KPIs), were reported as impacting compassion satisfaction and compassion fatigue. Sources of compassion satisfaction were also common to the development of compassion fatigue, suggesting that it is unlikely for compassion satisfaction to be experienced without risk of compassion fatigue. *Conclusion*. Although there are similarities in experiences of compassion satisfaction and compassion fatigue with other remote healthcare workers, for rehabilitation workers, KPIs were a unique concern, mainly due to their uniformity regardless of geographic location. Participants' concerns about meeting KPIs increased their work-related pressures, normalised unsafe work practices, and were a cause of recruitment and retention concerns. These perceived influences suggest that rehabilitation workers have a lower likelihood of developing and maintaining compassion satisfaction and a heightened risk of developing compassion fatigue than other rural or remote healthcare workers.

1. Introduction

Healthcare is associated with being a caring, fulfilling, and meaningful career; however, it is also demanding and stressful and presents an ever-changing work environment, which may influence the professional quality of life [1, 2]. The professional quality of life of healthcare workers is positively and negatively shaped by factors including workplace relationships, management, workload, and care recipient interactions [3]. Professional quality of life refers to the positive (compassion satisfaction) and negative (compassion fatigue) thoughts, feelings, and emotions when working in a care provision role, such as healthcare [4].

Compassion satisfaction and compassion fatigue are concepts associated with healthcare workers and workers in other caregiving professions, with the concepts guided, and most commonly measured by Stamm's professional quality of life measure (ProQOL) [5]. Professional quality of life outcomes are determined by the relationships between work and personal life, work environment, job role and tasks, remuneration and benefits, organisational culture, and administrative systems [6]. However, as the ProQOL measure does not have reference to rurality or remoteness, it is unclear whether the ProQOL measure was developed with consideration to rurality. Thus, we do not know if the ProQOL measure is in fact relevant to rural and remote healthcare workers.

Approximately 7 million (28%) Australians reside in rural and remote locations [7]. Due to ongoing shortages and decline in the healthcare workforce across all specialisations in rural and remote locations, Australians living outside urban areas face poorer health outcomes and significant barriers to healthcare accessibility [7].

Professional quality of work life of healthcare workers has been well documented, particularly amongst healthcare workers in urban locations. Urban practicing rehabilitation healthcare workers have a high risk of exposure to compassion fatigue with contributing factors including unreasonable time constraints, high work demands, administrative burden, critical decision making, poor work-life balance, suboptimal organisational governance, and feeling underappreciated at work [8]. Urban healthcare workers have a very high potential for developing and maintaining compassion satisfaction when they are satisfied with their work content, have positive working relationships, and are provided with flexible working arrangements. Those in management positions were also more likely to report compassion satisfaction due to their ability to influence organisational culture and have greater autonomy in their role [8].

A recent review identified that there is very little research available on the experiences of compassion satisfaction and compassion fatigue in rural and remote settings outside the occupations of medicine and nursing [9]. Within these two professions, contributions to greater compassion fatigue and lower compassion satisfaction have been identified for rural and remote workers. Nurses working in very remote areas of Australia were at risk of compassion fatigue due to high levels of emotional exhaustion, stress, and burnout, with moderate levels of job satisfaction due to the need to work beyond the scope of what would be expected in urban nursing practice [10]. Similarly, medical practitioners faced additional stressors compared to their urban colleagues. These stressors included limited healthcare resources, limited referral services, excessive travel, and greater generalist practitioner expectations, all of which may increase the risk of burnout, which is an element of compassion fatigue [11, 12]. Psychosocial support from family and friends was identified as a protective factor against the development of occupational stress and burnout in rural and remotely practicing medical practitioners [11]. While unique compassion satisfaction experiences and compassion fatigue-related challenges faced by rural and remotely practicing medical practitioners and nurses have been explored somewhat, there appears to be no exploration of the compassion satisfaction and compassion fatigue experiences of rural and remote rehabilitation sector of the healthcare workforce.

Rehabilitation healthcare workers are allied health professionals representing a growing workforce in Australia and internationally [13, 14]. Rehabilitation healthcare comprises disability management, occupational rehabilitation, medical rehabilitation, and injury management and prevention [15]. Rehabilitation healthcare is provided by multidisciplinary teams, encompassing medical and allied health professionals, with the aim of improving patient functionality, facilitating community engagement and participation in the workforce following injury or illness. Services are frequently provided through schemes such as workers' compensation, life insurance, and the Australian National Disability Insurance Scheme (NDIS).

Rehabilitation healthcare differs from medically orientated healthcare in that it is often provided within home and community settings and focuses on optimising functionality and independence of the individual to ensure a meaningful and better quality of life when undertaking activities such as work, education, and community participation [15]. Given that the role of rehabilitation healthcare workers differs from medical and nursing roles, it is not clear whether compassion satisfaction and compassion fatigue-related experiences are similar.

Investigating compassion satisfaction and compassion fatigue in rural and remotely practicing rehabilitation healthcare workers will help provide insight into issues they perceive as influencing employment attraction and retention and identify risks and protections which may have an impact on their professional quality of life. These insights could help maximise rehabilitation healthcare worker retention and, by doing so, support more positive health outcomes for the 28% of Australians residing in rural and remote locations [7].

In summary, rehabilitation healthcare workers are a growing part of the Australian healthcare workforce [16]. There is however clear evidence of high turnover and difficulties recruiting rehabilitation healthcare workers in rural and remote areas [17, 18]. We know that compassion satisfaction and compassion fatigue impact upon retention within nursing and medical professions. It is likely that this is the case for rehabilitation healthcare workers as well. To date however, there has not been an exploration of rehabilitation healthcare workers experiences of compassion satisfaction and compassion fatigue therefore we do not know if aspects are consistent with the more medically oriented professions of nursing and medicine or if they differ. Thus, the focus of the current study is to develop an understanding of rural and remotely practicing rehabilitation healthcare workers' perceptions and experiences of compassion satisfaction and compassion fatigue. The study's research question was what experiences or situations do rehabilitation healthcare workers in rural and remote Australia describe as influencing their compassion satisfaction and compassion fatigue?

2. Methods

2.1. Study Design. A qualitative approach was used to explore the perceptions and experiences of compassion satisfaction and compassion fatigue of individuals currently employed as rehabilitation healthcare workers in rural or remote locations in Australia. A qualitative methodology was chosen given the limited current understanding of the research topic [19]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guide our reporting of the study methods [20].

2.2. Participants. Sixteen rehabilitation healthcare workers from four national occupational rehabilitation companies that provide rehabilitation services to rural and remote communities participated in this study. Except for one participant (6%) employed by one of the companies as a vocational consultant to assist ill and injured workers with return-to-work planning, all participants were university-

educated allied health professionals: occupational therapist ($n = 6$, 37%), rehabilitation counsellor ($n = 3$, 19%), exercise physiologist ($n = 2$, 13%), psychologist ($n = 2$, 13%), and social worker ($n = 2$, 13%). Participants were distributed between management/supervisory roles ($n = 8$, 50%) and rehabilitation consultant positions ($n = 7$, 44%), with one vocational consultant ($n = 1$, 6%). All participants in management/supervisory roles were also actively engaged in rehabilitation care provision, with their own caseload to manage. Most were female ($n = 12$, 75%) (which reflects the dominance of females working in rehabilitation healthcare), in a partner/spouse relationship ($n = 10$, 63%), and working full time ($n = 14$, 88%) in New South Wales ($n = 9$, 56%). Other areas represented were Victoria ($n = 4$, 25%), Queensland ($n = 2$, 13%), and Western Australia ($n = 1$, 6%). Based on the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard (ASGS) Edition 3, four participants (25%) worked within inner regional Australia, nine participants (56%) worked within both inner and outer regional Australia, with three participants (19%) working in both remote and very remote Australia (Australian states are very large, with NSW > 800,000 square kilometres, which is larger than the United Kingdom and France combined). Four (25%) had non-work-related carer responsibilities. The average years of work experience as a rehabilitation healthcare worker was 3.21 years (range 0.5–13 years).

2.3. Procedure. The study's protocol was approved by the University of Sydney's Human Research Ethics Committee (Project No: 2018/524). Recruitment involved purposive sampling. Employers of the four organisations emailed an invitation to participate in the study to all of their rehabilitation healthcare workers in rural and remote locations (approximately $n = 100$). The study's participant information sheet and consent form were included in the invitation. Participants were requested to contact the researcher directly if they had any questions or wished to participate. All workers who contacted the researcher expressed interest in participating and were provided with an interview time. All provided written consent to participate and for the interview to be audio-recorded. Participants were interviewed from October 2018 to January 2019, a period preceding any COVID-19 restrictions, in Australia.

Interviews were conducted by the first author, a female Masters' level qualified rehabilitation counsellor with extensive experience working in the rehabilitation healthcare sector, including time working in rural and remote locations. The participant information sheet provided participants with information about the interviewer, which enabled participants to make an informed decision about whether they felt comfortable participating.

The interview guide was first "piloted" using three rehabilitation healthcare workers known to the first author as former colleagues. There was no ongoing working relationship with these participants, nor was there any personal relationship with them. To ensure lines of enquiry remained true to participants' data, the pilot study outcomes were reviewed and discussed by two of the research team. In these first three interviews, the interviewer checked the phrasing of questions and "tested" the number of questions/length of interview. Consent was obtained from these first three interview participants, and their data were included in the main study. The "pilot" did not result in any changes to the interview guide.

Participants knew from the study's participant information sheet that the topic was compassion satisfaction and compassion fatigue. Participants were provided with an introduction to the study and were asked to describe their understanding of compassion satisfaction and compassion fatigue. The request for participants to provide their thoughts prior to the researcher explaining the concepts was to ensure that the participants were able to provide their answers in an informed manner and ensure that contextually relevant information was provided.

2.4. Data Collection. Interviews of 16 participants were conducted over the telephone in a private location of the participants' choice, with no presence of others. Interviews commenced with some demographic questions relating to employment type, locations and length of service in rural and remote rehabilitation, qualifications, living arrangements, and gender. Participants were then asked about their broad understanding of the terms "compassion satisfaction" and "compassion fatigue." If there were any misunderstandings about these concepts, the interviewer explained their meanings to ensure that in the main part of the interview, participants would be describing experiences related to the topic of the study. This clarification was simply around the terminology, and the interviewer did not discuss what might or might not support compassion satisfaction or lead to compassion fatigue. This was followed with a semistructured interview based around broad, open-ended questions from the interview guide (see Table 1). The guide was used flexibly so that participants could elaborate on topics of importance to them, and the interviewer could explore topics raised by participants in more depth.

Interviews ranged from 25 to 40 minutes and were recorded and transcribed verbatim. Other than the three pilot study participants, no prior relationships existed between the interviewer and participants, no participants withdrew from the study, and no repeat interviews were undertaken. After approximately nine interviews, no new concepts were being introduced by participants. By the 16th interview, codes were detailed and well-understood, and it was likely that saturation had occurred, and thus, no further recruitment was required [21].

2.5. Analysis. Braun and Clarke's six-phase framework for thematic analysis [22] with theoretical analysis and open coding was used to analyse interview data. These six steps are (1) data familiarisation and writing familiarisation notes; (2) systematic data coding; (3) generating initial themes from coded and collated data; (4) developing and reviewing themes; (5) refining, defining, and naming themes; and (6) writing the report. Rather than occurring in a linear fashion,

Table 1: Interview guide questions.

Did your professional training prepare you for working in a rural setting? (explore why/why not)
What type of things impact your ability to provide compassionate care when working with clients?
What workplace supports help you to provide compassionate care when working with clients?
Have there been times in your career where your ability to provide compassionate care has fluctuated?
Prompts: Why do you think it fluctuated at that time?
What would have helped you at that time?
Was help provided? What help?
Did you or anyone else make any changes to the way things were?
Did that help? How?
Are there any nonwork stressors or supports that impacts your [ability to provide compassionate care/compassion levels]?
What—can you describe?
You'll be familiar with the term "quality of life"—can you tell me about your work quality of life?
On a scale of 1–10 where 1 is very poor and 10 is very high, how would you rate your work quality of life?
Have you ever thought about leaving your current role or work in this profession?
If yes—can you explain why/provide examples? What has helped you stay in the role?
If no—can you explain why? What supports you in your role?
Do you have any suggestions or recommendations on ways the workplace can help to improve rehabilitation healthcare workers ability to provide compassionate care?

these steps were recursive with data collection and analysis being conducted simultaneously through an iterative process [22]. Importantly, within this study, we adopted a "codebook" version of Thematic Analysis [22]. An initial "codebook" was developed with potential codes drawn from a prior scoping review of relevant literature [9]. This was however a flexible starting point with expectation that codes would be refined and removed and new codes would be developed through inductive data engagement and the analytic process [22].

Authors one and two independently coded the first three transcripts. Inductive and deductive reasoning were simultaneously employed to recognise data segments that aligned with existing codebook codes and data that indicated the need for existing codes to change or new codes to be formed [23]. They then met to discuss and reach coding agreements. All following transcripts were then coded by author one. Throughout the process of analysis, authors one and two engaged in reflexive discussions around the developing codes and themes to ensure that codes faithfully represented the data. Author one took notes immediately after the interviews and during the coding process to aid reflective discussions. As the analysis progressed, conceptually similar codes were drawn together into broader themes. Codes that were similarly aligned were grouped into themes and then further grouped into subthemes, and this was defined in a thematic table (Table 2). All transcripts were deidentified and referred to as participants (P) and allocated a number based on their place in the 16 interviews.

3. Findings

The following section presents the findings of participant perceptions of possible reasons they may experience compassion satisfaction and compassion fatigue. Participant responses were categorised into three overarching themes: quality of work-life, organisational and workplace culture, and organisational management practices. The themes, subthemes, and codes are presented in Table 2.

3.1. Quality of Work Life. Theme one describes the aspects of quality of work life that participants perceived to impact upon their compassion satisfaction and compassion fatigue. It comprises three subthemes: psychosocial stressors, work-life balance, and rurality. Each of these subthemes is presented below. Participants talked about the positive and negative impacts of work, including workplace environment, professional development, company benefits, and workplace culture. They also suggested that the quality of work life was influenced by psychosocial stressors including home life and social environment.

3.1.1. Psychosocial Stressors. Participants reported psychosocial stressors, including personal relationships, family stress, and personal stress which have negatively impacted their quality of work life. Psychosocial stressors are life situations (personal or professional) or events which may lead to poor psychological and physical health outcomes.

(1) Personal Relationships. Personal "relationship problems" (P.14) within the family unit of participants were considered to negatively impact compassion levels "if you have hardship in your personal life, it can have a big impact on your ability to provide compassionate care." (P.8). This resulted in difficulty delivering compassionate care "if things at home were not that good, your capacity to deliver compassionate services is absolutely diminished" (P.10). One participant said, "I am 100% positive if me and my girlfriend had an argument, I was in a bad mood and didn't want to deal with anyone's crap, it would impact my ability to provide compassionate care" (P.13).

Participants reported having a "strong supportive partner to come home to" (P.1) made it easier to be "engaged and focussed with work" (P.10), with one participant advising "If I'm happy with my home life, I'm happy going into work" (P.1). Positive personal relationships appear to influence compassion satisfaction.

(2) Family and Personal Stress. Participants talked about family and personal stress including financial difficulties, parenting responsibilities (including pregnancy), relationship separation, and unemployment of a partner. They also suggested that flexible working arrangements were beneficial when managing burnout and minimising compassion fatigue, as one participant said, "being able to work from home, having flexibility is helpful, I had to find out the limit about how much work I can do before it becomes overwhelming" (P.2). Employer-provided allowances for self-

Table 2: Thematic table for aspects reported as influencing participants' compassion satisfaction and compassion fatigue.

Overarching themes	Subthemes	Codes	Perceived influence on CS and CF	
			CS	CF
Theme 1: quality of work life	(i) Psychosocial stressors	Personal relationships	✓	✓
		Family and personal stress	✓	✓
	(ii) Work-life balance	Personal boundaries	✓	✓
		Performance expectations	✗	✓
	(iii) Rurality	Professional isolation	✓	✓
		Travel	✓	✓
Theme 2: organisational and workplace culture	(i) Health, safety, and wellbeing	Environmental conditions	✗	✓
		Client behaviour	✗	✓
	(ii) Human resources	Workplace relationships	✗	✓
		Staff recruitment and retention	✓	✓
Theme 3: organisational management practices	(i) Stakeholder expectations	Stakeholder management	✗	✓
		Caseload	✓	✓
	(ii) Service delivery model	Provision of care	✓	✓
		Employee support	✓	✓

✓ Indicates a perceived influence on compassion satisfaction/compassion fatigue. ✗ Indicates no perceived influence on compassion satisfaction/compassion fatigue.

care were reported to assist in managing family and personal stressors because "you get to spend money on [your] health and self-care once a month which is good" (P.7).

When faced with heightened personal relationship concerns, family stress, and personal stress "you have days where you can't tolerate other people" (P.11), which "limits compassion" (P.12) and results in a decreased tolerance to case complexities. Participants reported frustration with their inability to compartmentalise stress arising from personal relationships, family stress, and personal stress. Reported impacts included being "really tired" (P.6), a "bad mood" (P.13), "feeling frustrated" (P.5), "exhaustion or being rundown" (P.9), and being "overwhelmed" (P.11). However, one participant reported attending work assists with managing personal stress: "my job keeps me sane because I go to work and that's pulling me out of the trauma so that's good" (P.7).

3.1.2. Work-Life Balance. Participants explained that in rural settings, it is difficult to separate work from personal life and set clear personal boundaries, particularly when managing performance expectations. Participants reported an immersion of home and work life, particularly when there is no regional office and staff work from a home office.

(1) Personal Boundaries. Participants reported difficulties in managing personal boundaries for home and work life regarding work hours. One participant said that they "found out the hard way what impact it might have on your home life if you're working all the time" (P.2). When working from home "it's difficult to make boundaries, you have your laptop in your home office, it's not easy to close that door and walk away" (P.11). When aiming to meet KPIs, "I'd work over the weekend, but that wasn't good for my mental health, and it has an impact on relationships" (P.1). One participant discussed the impact of work encroaching on personal time "My mood was impacted so, in my relationships, I wasn't me. They didn't enjoy spending time with me, I didn't enjoy [it] either." (P.16).

Participants reported that "flexibility to be in charge of work [structure]' (P.3), "working from home" (P. 11), and "flexibility of work hours" (P.6) enabled a better work life balance. This finding suggests that flexible employment options may contribute to compassion satisfaction.

(2) Performance Expectations. There was a perception amongst participants that it is difficult to set boundaries for work hours, particularly KPI expectations. All participants reported working within a schedule of billable hours, rather than standard working hours. The pressures of billable hours resulted in unsafe work practices such as working excessive hours, often extended periods without a break, resulting in fatigue: "I have a target I struggle to hit every month, no matter how much work I'm doing, which was really draining for me" (P.6) and "we work long hours in the day, so those boundaries are challenging" (P.11).

Most participants minimised their experiences with psychologically and physically unsafe work practices when discussing personal boundaries and performance expectations. It was noted as "part of the role" (P.8) and "the nature of work" (P.10) to be successful in meeting their KPI targets.

3.1.3. Rurality. Participants identified issues specific to rural and remote practice (professional isolation and travel) as impactful to their quality of work life. Rurality resulted in perceptions of unrealistic KPIs and limited opportunity for supportive interactions with their leadership cohort.

(1) Professional Isolation. Participants reported feeling isolated from management and colleagues when not based in

the same geographic location. The feelings of isolation appeared linked to perceptions of lack of support from management, due to the regional location. As one participant said, they "definitely feel isolated in terms of support" (P.13).

When management attended the rural and remote offices, participants felt there was disengagement and a lack of substance, with some participants wanting to have their isolation acknowledged and validated. One said, "Having head office or management visit, it's very short, sharp, and quick. If they spent time to get to know the team that would go a long way" (P.12), while another suggested, "Engagement with head office would be excellent. It feels like we're in a bubble, so having them say, we know you're here, we appreciate what you are doing, would help the overall environment and culture" (P.1).

Participants reported that professional isolation led to limited opportunities for face-to-face debriefing and collaboration with colleagues. They were often the only rehabilitation healthcare worker in their location, resulting in limited support following emotional or stressful situations: "you don't have the people around you to debrief" (P.10). This also applied to staff working from home due to no regionally based office space. One participant advised that they "get the sense of feeling isolated when I work from home because there's no one there to chat with or debrief" (P.9). Participants reported that they have access to Employee Assistance Providers (EAP); however, they reported a preference to debrief and deescalate with a colleague or manager. Opportunity to debrief with other rural and remotely based colleagues facing similar service delivery barriers had proven beneficial to some participants: "I have found the informal supports, talking with other consultants regionally, being able to connect with other regional branches, and debrief with them about the challenges is really helpful" (P.2).

Participants reported not only geographic isolation from management and colleagues but also professional isolation regarding workplace supports, such as access to referral services. They advised that "being regional is more challenging than Sydney [state capital of NSW], I struggle to find services" (P.6). Provision of equipment to undertake their roles adequately and safely was another challenge:

> If IT [information technology staff] could visit the remote sites and understand our issues that would be amazing. They tend to travel here for half a day and leave us with a pile of shit to pick up. It's one of the most frustrating things and the lack of resources. We have to wait for someone to come down to bring us something or wait for when one of us travels up to get some new stuff because freight costs money (P.12).

(2) Travel. Most participants reported fatigue, exhaustion, and stress due to the frequency and duration of travel: "there's a fair bit of travel, you start getting tired" (P.10). Participants noted frustrations with work-related travel impacting their personal life: "I struggled with travel quite a bit you might have an appointment late in the afternoon and then you've still got to travel back afterward" (P.1). One participant reported travel negatively impacted on ability to provide adequate support to all cases:

> When the caseloads are high and geographically, you're extended, the pressure is higher. You can bill for travelling, but when you have 30 other people on your caseload it's not equitable allocation of my time when they all need support (P.15).

Meeting KPIs while travelling was a challenge for participants, particularly timeliness of service provision. One participant commented that "travel impacts the service that people get from me. I drive 1500 kilometres a week and that's huge chunks of my time where I'm not available" (P.2). Participants reported a lack of connectivity with Internet and phone reception whilst travelling and time spent driving resulted in being behind on their workload: "on the road, you don't have the accessibility of being able to call or e-mail, you might have someone who needs support, but you can't contact them for a couple of days" (P.11).

It appeared for some participants that travel is likely to be a protective factor in the development and maintenance of compassion satisfaction, with participants reporting "I like the travel. I'm not happy behind a desk" (P.12), "I love being able to explore and the diversity of it" (P.1), and "this [travel] is why, I took the role" (P.12). One participant reported enjoying the autonomy of travel "I like travelling around and being my own boss, it's doing what I love" (P.7).

3.2. Organisational and Workplace Culture. Theme two describes the perceived impacts of organisational and workplace culture reported by participants. It comprises two subthemes: health, safety, and wellbeing; and human resources. Each of these subthemes is presented as follows.

Organisational culture is guided by the values, beliefs, and corporate objectives of the organisation and is modelled by leadership behaviour, which influences workplace culture encompassing employee satisfaction, attitudes, and behaviour. Environmental conditions, client behaviour, workplace relationships, and staff retention and recruitment are elements of organisational and workplace culture that participants in this study reported as influencing the development of compassion satisfaction and compassion fatigue. When questioned about culture, all participants reported that it can negatively or positively impact their quality of work life and it is regularly changing. This was attributed to the high turnover of management and staff and adequacy of work health and safety support and training, particularly when dealing with environmental considerations, personal safety, and unpredictability of clients.

3.2.1. Health, Safety, and Wellbeing. Participants reported workplace health and safety concerns including threats of violence, sexual harassment, aggressive and intimidating behaviour, and verbal abuse. Female participants were more likely to report concerns with health, safety, and wellbeing. Most participants noted some form of company policy or procedure relating to safety in clients' homes but were

unable to explain what the documents covered and whether they felt that the documents were situationally appropriate to rural and remote practice.

(1) Environmental Conditions. Participants reported concerns with undertaking home visits with clients. Risks included lack of phone or Internet reception when travelling and conducting appointments at client homes in isolated locations. For example, one participant said, "I've driven down a dead end and don't know where I am and there's no cell service, it's frightening going to farms by yourself meeting random people it is daunting going into places where safety may not be guaranteed" (P.12). Participants' only means of safety monitoring was reliant on telephone/Internet connectivity, which is unreliable in rural and remote areas. One participant reported that their company safety strategy is reliant on telecommunications: "once you're out of the appointment sending a message [to the receptionist] and say, heading home now. And keeping calendars updated with addresses, so if there are concerns, they know where we've been" (P1).

Participants described an absence of formal safety monitoring and risk assessment and a lack of strategy to manage or report poor client behaviour. Regarding their safety strategy, P7 who works in a remote office, two hours away from other staff reported, "we have a code word that we can text to somebody. But usually I stand up and scream."

(2) Client Behaviour. When questioned about personal safety and security experiences, no participants reported the availability of appropriate safety mechanisms to manage dangerous situations when dealing with clients, particularly in client homes or in a one-on-one setting. One participant noted a self-management strategy of sitting by the door and keeping a key and phone on their person:

> if you go into a house make sure you sit by the door, by an exit, so if you need to get out you can, making sure you're keeping your keys and your phone in your pocket, on your person so if you need to make a quick escape, making sure your car's parked so you can make a quick escape. Being in this regional area, you've got people who are out on properties and there is an element of, am I going to come out of this alive (P.1).

Participants reported frequent exposure to inappropriate client behaviour, including "very angry and very aggressive" (P.9) conduct, threats of physical violence such as "he came in with a knife" (P.12), "stalking" and "being held against our will" (P.14), "verbal threats" (P.13), and sexual harassment: "he had been sexually inappropriate and had potential to be quite aggressive" (P.2).

In most instances, this was reported to management and participants noted often nothing was done, or there was a change of rehabilitation healthcare worker, passing the problem between consultants, for example, one participant said, "people have acted very inappropriately, and we've decided to change consultants to a male. Sometimes, we get cases flagged with us that this [client] is going to be a concern. We're an all-female office" (P.12). Another participant who reported experiencing sexual harassment and violence noted that management was informed but did not reallocate the case as there were no other locally based consultants available:

> It can get very violent. I was imagining my death at one of them, it was real bad. I reported it, he was sexually harassing me, but they were like we'll try and get it closed as quick as possible, make sure you're just meeting in a public place, keep meeting in a public place for a few more times and then we'll close it (P.7).

3.2.2. Human Resources. Participants reported workplace relationships and staff retention and recruitment as ongoing concerns which impacted their quality of work life. Workplace relationships encompassed relationships between staff, colleagues, and management and were identified by participants as being influenced by workplace and organisational culture. They further suggested that staff recruitment and retention directly impacted workload and workplace culture due to the constant turnover of staff.

(1) Workplace Relationships. Participants reported that the organisational culture, and engagement and leadership from management, influenced their ability to successfully develop and maintain workplace relationships. One participant expressed frustration with the lack of engagement from urban based management, as they demonstrated little understanding of the complexities associated with rural and remote practice: "From the head office, it feels like we are forgotten about because we're out here, rural and no one thinks about or understands what it is that goes on" (P.1).

Respondents commented that relationships between colleagues are impactful on "the culture of the office" (P.12). One participant reported "relationships at work impact compassion; the environment and employee support have a real impact on your work, and you lose motivation and ability to develop relationships" (P.8). The small communities within rural locations made it difficult for participants to separate their work and social lives, with participants often knowing clients or colleagues outside of work: "negative attitude has [sic] been hard to cope with; whenever there's work drinks, everyone's getting in each other's hair" (P.1).

(2) Staff Recruitment and Retention. Participants discussed ongoing issues with high rates of staff attrition: "we've had a lot of turnover in regional branches" (P.2). Frequent staff turnover impacts caseload management, resulting in cases consistently being reallocated to colleagues, often resulting in lower recovery rates and increased burden of caseload on remaining staff:

> Being the only OT [occupational therapist] I get swamped with work, I had too many files and was not coping. I was crying every day because I was overwhelmed. Another OT would be nice, but it's hard to get people in this area (P.6).

Despite reporting "such a high turnover" (P.6), participants described poor labour market conditions for career options with alternative employers in their region: "I have looked for other jobs down here, but the labour market's pretty poor" (P.12). Although there is a high demand for rehabilitation healthcare workers in rural and remote areas, the lack of employer options has resulted in participants staying in employment they are not happy with. One participant disclosed that "we had some issues in the office with culture, I was considering moving to a different job" (P.8). When participants have considered changing employers, they have been faced with poorer job prospects due to limited alternative employers "the job prospects are not as good compared to the city. There might not be any other options" (P.5).

Participants reported "job security and [positive] workplace culture" (P.5), "management support" (P.2), and opportunity for "career progression" (P.8) have retained them in rural/remote practice with one participant reporting that they have "thrived and enjoyed the challenges" (P.8). These factors are likely indicators for compassion satisfaction.

3.3. Organisational Management Practices. Theme three describes the perceived impacts of organisational management practices reported by participants and reflects the two subthemes of stakeholder expectations and the service delivery model. Organisational management practices, namely, stakeholder expectations, and service delivery models were reported by participants as influencing their professional quality of life. Stakeholder management, caseload, provision of care, and employee support are governed by organisational management practices through internal policy and procedure and contractual obligations with external clients such as insurers.

3.3.1. Stakeholder Expectations. Stakeholder expectations include managing internal and external stakeholder relationships between colleagues and management, the client (care recipient), the paying customer (workplace or insurer), and treating healthcare practitioners.

Case management is the fundamental element of rehabilitation healthcare work and cases need to be managed within the organisational KPI framework to ensure that stakeholder expectations are met. However, caseload and case complexity were reported as a central feature contributing to participant stress and fatigue:

> It's not necessarily the number of clients that is an issue. If I go over 45, 50 [cases] then it really starts to get quite difficult and there just aren't enough minutes in a day. I have had instances where I have had a lower caseload but because they've been so complex, there's so much additional work and time that needs to go into it (P.9)

Caseload and case complexity "impact your ability to cope and manage stress" (P.3) which was reported as influencing case outcomes and stakeholder expectations. One participant reported "having caseloads that are manageable, so you are able to service clients in the best way possible and maintain a client focus" (P.3) assisted in delivering positive case outcomes and decreased stress associated with managing stakeholder expectations. A participant reported difficulty in managing stakeholder expectations when there is little tolerance from the stakeholders with managing case complexities:

> There's [sic] challenges of trying to do business with somebody trying to find something wrong in everything you do, that's a stressor. They can be the biggest barrier in everything, the attitude that the insurers have. Particularly the more complex it gets and more things that should have happened [with cases] don't happen or, it doesn't go as well as it could [because of administrative errors] (P.10).

(1) Stakeholder Management. Respondents reported that stakeholder expectations were the same regardless of geographical location. Having the same expectations as better resourced urban areas resulted in additional stress. This was due to the lack of available referral and "recommending services" (P.6) and poor "labour market" (P.12) options with "very little jobs available" (P.6) to match transferrable skills and experience of clients. Participants reported that expectations from workers' compensation and life insurers were a significant stressor: "insurers are a barrier, there might be services that you think are appropriate that they don't approve of" (P.13). Participants felt conflicted between providing treatment goals of what is best for the care recipient and that of the insurer because "the insurance company want a certain outcome that might not be best for the client" (P.1). What resulted were feelings of conflict between personal and professional standards of ethical practice and meeting KPIs. Participants' internal service delivery models were largely "client [care recipient] focussed" (P.12) which conflicted with the insurer claims management method reported as

> People [insurers] making decisions with regards to a person [care recipient] who have never seen them, never met them and their [sic] directing you to make some sort of action on the file that you don't necessarily agree with or may not work (P.3).

Participants reported feeling uncomfortable when their case management work was being used by the insurer or workplace to determine and manage ongoing liability of the care recipient: "I feel uncomfortable writing reports when I know the insurance [companies] are going to use it to make a compensation decision" (P.4). One participant explained the conflict between working in a helping profession with a client-focused model of care but being engaged to provide services to an insurer: "you're working with people [insurers] to get a particular outcome. There are structures that can be frustrating and that impact your overall positivity towards a helping profession. It's coming to accept that you're a player within that system" (P.3).

(2) Caseload. Large caseload numbers were reported, with cases continuously allocated regardless of the current capacity: "I need to drop my caseload down, I'm having to take on cases that nobody else is trained to do" (P.1). Large and

increasing caseloads led to increased stress and frustration reported by participants. Case complexity was not considered during case allocation, so "they send through referrals, they only look at the number of files that you have, they don't actually go into how complex those files are" (P.11). Case complexities included trauma, such as "when you get a whole stack of deep traumas [cases] all at once, it can be overwhelming" (P.7); difficult care recipients that were emotionally taxing: "I was crying almost every day because I was overwhelmed I had very difficult clients and I did get compassionate fatigue" (P.6); and recovery motivation, which is where participants reported that "it can be difficult to have compassion when some clients might not be entirely legitimate" (P.4).

Participants reported manageable caseloads and minimised feelings of being "overwhelmed" (P.5) and enabled them to "service clients in the best way possible" (P.3). Proactive management practices with assisting participants to effectively manage their caseloads resulted in one participant reporting "I feel so much better like I'm doing a good job at helping my clients and I'm able to shut off at night and the weekends from thinking about work" (P.6).

3.3.2. Service Delivery Model. A service delivery model is the organisational model of care which is based on values, principles, internal policy, and legislative requirements. Service delivery models are a key organisational function aimed to lead to increased and enhanced service and are measured by KPIs, such as case goal attainment, appropriate and timely services, proactive case management, and provision of care. They outline service and quality standards, procurement, supply, and financials to ensure that a baseline standard is maintained if not exceeded when delivering rehabilitation services. Provision of care and employee support are issues influenced by the service delivery model enforced by the employer.

(1) Provision of Care. Provision of care is the service provided to an injured or ill client by the participant, and employee support is the formal and informal support offered to participants to assist with managing work stressors and personal and work-life balance.

Participants reported that their service delivery model had an ongoing ability to fluctuate the quality of their work life, which was mainly because of the "high turnover of staff" (P.6), the inadequacy of "safety and risk management practices" (P.8), and the lack of appropriateness of "training and services" (P.1).

All respondents advised that their service delivery model was the same as that used in urban locations. Respondents reported difficulties with developing rapport and providing compassionate care when servicing their clients via telehealth. This is because "on the phone, you lose ability to have face-to-face body language and things that can relay compassion" (P.5) and this is central because "from a regional perspective, face-to-face contact is the key to providing compassionate service" (P.13). This difficulty was likely attributed to differences between care provision needs in rural/remote areas as compared to urban locations: "the more regional the office, the more issues there is, particularly with a change in cohort of clients [needs]" (P.9). With one participant reporting a "blanket approach" (P.15) to KPIs "There is not any model around the KPIs that consider cultural and significant events within indigenous communities, if there's an event in this region there'd be no KPIs met that month, it just looks like I have not done my job" (P. 15).

Some participants described elements of compassion satisfaction when discussing provision of care, with P1 reporting that they "Love this work," particularly the satisfaction of the collaborative "multidisciplinary approach." One participant reported that their company recently changed their service delivery model to be "more aligned with the Occupational Therapy values," which has increased their "ability to be compassionate" (P.6). Another participant reported when their work is aligned with their "professional values," and this "increases compassion satisfaction" (P.8).

(2) Employee Support. Participants reported that they were unprepared in their training as a rehabilitation healthcare professional: "There's no focus on compassionate care when you commence training as a rehab consultant" (P.3). All participants confirmed that they had not received any formal or professional development training on managing compassion fatigue and how to deliver a patient-centered model of care while maintaining professional boundaries.

Frustrations arising from a lack of accessibility to management and inadequate employee support services for them to access were noted. Participants perceived that they were not provided with the same level of support and manager compassion as their urban counterparts: "having some manager who's capable of being compassionate would help and a regular official meeting, just to get it all off your chest" (P.7).

Most participants reported access to an EAP. Accessibility concerns were noted with formal and informal debriefing when being remotely managed: "it's not as accessible because it's over phone calls" (P.6) and participants were "not sure where to get support and guidance" (P.2). When managed remotely, participants reported that managers were unwilling or unable to assist due to different geographic locations and referred staff to EAP. One participant said, "we've got an employee assistance programme accessible by staff not getting direct support within their immediate work environment" (P.3) and noted that participants with locally based management reported their supervisors "don't do a formal debrief" (P.3), advising "that it's not her role then she points me to EAP" (P.12). Informal support offered includes "flexibility of work hours" (P.6), general "chat in the office" (P.7), and encouragement to "go for a walk or have a coffee" (P.11). Most participants reported, "monthly file reviews" (P.4) are the primary source of debriefing, with management encouraging debriefing to wait until the reviews: "we have monthly case reviews which is an opportunity to debrief" (P.1).

Due to requirements of the consultants to meet their KPIs, "the end of month stuff you've got your 80 [KPI

billable] hours" (P.11), one participant reported that they are "piloting a dictation service where if I'm on the road I can dictate my notes" (P.8) to alleviate the pressure of having to meet nonnegotiable deadlines for administrative tasks and lost time due to excessive travel. One participant reported that having dedicated administration staff to assist with nonspecialised work enabled them to undertake "more focused work which takes the pressure off" (P.8). Another participant reported that their employer provided supports as inadequate and stressed the importance of having their "own self-care program including faith" as important to "peace and serenity within myself" to maintain their compassion satisfaction and manage burnout (P.14).

4. Discussion

To our knowledge, this qualitative study was the first to explore the compassion satisfaction and compassion fatigue-related experiences of rural and remote Australian rehabilitation healthcare workers. The thematic analysis revealed three overarching themes: quality of work life, organisational and workplace culture, and organisational management practices. These themes have similar elements to those identified in previous studies in other sectors of the rural health workforce. These similarities suggest that there are many common compassion satisfaction and compassion fatigue related experiences for rural and remote healthcare workers irrespective of their professional training or role.

The quality of work life outcomes in Australian rural and remote medical specialists was influenced by psychosocial stressors attributed to the rural or remote location. For those who chose to leave the rural or remote location, their decision was based on stressors including poor work-life balance and excessive work demands which resulted in exhaustion and burnout [24].

Organisational and workplace culture was identified as a common theme for Australian rural and remotely practicing registered nurses and mental health nurses. For Australian rural and remote mental health nurses, workplace culture (including workplace relationships) was both a risk and protective factor for their workplace psychological wellbeing, subsequently influencing recruitment and retention rates [25]. In a study of Australian rural and remotely practicing registered nurses undertaken by Whiteing et al., stress and burnout reported by participants were largely attributed to poor workplace health and safety practices and concerns related to human resources. All participants reported lack of personal safety as a significant stressor which was impactful to their health and wellbeing as they were frequently working in high-risk situations with minimal support, some without critical incident debriefing, and a lack of organisational interest in listening to staff concerns [26].

Organisational management practices influenced by the service delivery model and leading to burnout in Australian rural and remotely practicing registered nurses included excessive workload and working outside of professional areas of expertise, working extended hours, professional isolation, lack of employee support, and organisational processes which are not aligned with the specific needs of rural and remote practice [26]. These findings are similar to a recent scoping review of rural and remote healthcare workers which identified work environment, work-life balance, professional isolation, workload, and job dissatisfaction (see, for example, McGrath et al., 2022) as potential predictors of compassion satisfaction and compassion fatigue.

While our findings identified common experiences that were reflected in the broader literature, it also identified potentially unique or different compassion satisfaction and compassion fatigue experiences faced by rehabilitation healthcare workers within the rural and remote context. The unique experiences all appeared to be linked to the theme of organisational management practices, in particular the service delivery model, and the use of KPIs which is unsuitable for the rural and remote context. KPIs are measurable outcomes specifically related to rehabilitation healthcare and generally include return to work/recovery outcomes, timeliness of service, cost of service, customer service delivery experience, durability of service, and status at case closure [27]. KPIs within the rehabilitation sector are informed by the employer and/or insurer and are based on cost-effective, timely outcomes which are not always in the best interest of the care recipient [28]. Australian rehabilitation healthcare holds a long-term reputation for work dissatisfaction, largely attributed conflicting factors including privatisation of the industry, rehabilitation philosophy, and the profit-driven motivators of employers [18].

The quality of work life is negatively influenced by rurality as all participants reported that the KPIs are uniform across their employers nationally. Many participants reported that KPIs are a significant source of stress as they are largely unattainable due to the complexities of rural and remote practice and were more suited to urban locations. In aiming to meet the rigid and difficult to attain KPIs, staff reported difficulties with maintaining a healthy work-life balance, which negatively impacted personal relationships and caused family and personal stress. Participants perceived that their employers did not consider work-life balance as a priority as they were more focused on profit. This is aligned with previous research on rehabilitation healthcare workers which identified that financially driven KPI outcomes were more of a focus than employee wellbeing [29]. In attempting to reach the KPIs, participants reported having to work in their own time and this was often due to reasons attributed to rurality such as excessive travel to attend to remote clients, and this led to increased psychosocial stress. This is consistent with research that states KPIs for rehabilitation healthcare providers are used as markers of success in the role which results in a constant demand on their time and energy, dehumanising the role and increasing stress [29].

The geography of participants' rurality resulted in excessive travel, with one participant reporting travelling via road approximately 1500 kilometres weekly, and still being required to meet their KPIs regardless of the time taken to undertake the travel and needing to make up their billable hours in their personal time. Concerningly, rather than amending the KPIs to suit rural and remote practice, one employer implemented a dictation service enabling the

participant to dictate their notes whilst driving to assist with meeting their nonnegotiable KPIs. Regardless of the frequency and duration of travel, participants were still expected to meet the same KPIs as their urban colleagues and this resulted in unsafe work practices and negative impacts on the quality of work life and work-life balance. Our participant experiences with travel echoed other Australian rural and remote healthcare workers experiences in that they are faced with unique risks when it comes to rural and remote work-related travel as they are frequently required to drive long distances and alone under tight timeframes, often on remote and unsealed roads in adverse weather conditions at all hours, and with poor communication reception, limiting support in the event of emergency [30].

Participants also experienced professional isolation, which in this context is very different to an urban setting as the managers are often hundreds of kilometres away with little regular engagement, resulting in an inability to provide adequate mentoring, professional development, and pastoral care [31]. It is noted that professional isolation faced by rural and remote healthcare workers increases emotional exhaustion, stress, and anxiety [30]. Participants described management disengagement with rural and remote staff and expressed frustrations that management does not regularly attend the rural and remote locations to adequately understand the complexities and barriers facing participants in attaining their KPIs.

Organisational and workplace culture, in particular health, safety, and wellbeing appeared to be a significant risk for participants. In aiming to meet the rigid and difficult to attain KPIs enforced by their employers, participants perceived that their employers were prioritising profit over staff safety, particularly when it came to management of poor client behaviour. When poor client behaviour was raised to their employer, participants reported that their experiences were minimised, resulting in participants normalising the behaviour as an expected part of the role and no longer reporting incidents. This is consistent with research on Australian rural and remote nurses, were normalisation of workplace violence has occurred and it is seen by the nurses and their employers as a part of the role, resulting in a poor reporting culture [30]. Some participants reported that they were instructed by their employer to continue engagement with inappropriate clients despite their concerns, due to the lack of available staff in their rural and remote location and the need to meet their KPIs. In our study, a participant experiences with how their employers have inadequately managed situations of reported inappropriate client conduct have resulted in a poor Workplace Health and Safety (WHS) reporting culture with underreporting of incidents. Our participant responses appear to be consistent with research on workplace violence and reporting culture in healthcare workers, with 88% of healthcare workers in a clinical setting who disclosed that they were exposed to physical or nonphysical workplace violence not formally reporting the incident [32].

Most female participants reported experiencing inappropriate client conduct (including verbal abuse, physical assault, and sexual harassment). This is consistent with research that female healthcare workers are more likely to be exposed to physical and nonphysical violence from patients, including sexual harassment [33], and that those working remotely, who have reduced ability to access assistance during and following incidents of workplace violence, are reluctant to continue the work given previous inaction by their employer and normalisation of workplace violence [34]. Concerningly, participants were generally unclear what, if any, protective strategies and resources their employers had in place to manage their safety when working alone in rural and remote locations. Exposure to workplace violence and difficult work conditions are high-risk factors for the development of compassion fatigue, especially for those practicing in rural areas [35].

Organisational management practices, specifically the service delivery model engaged by participant employers, was noted by all participants as being uniform across their company nationwide regardless of consideration of rural and remote challenges and based on urban needs. The service delivery model informed the KPIs which participants were required to meet, and this often conflicted with their ability to deliver provision of care in a way which was aligned with their professional values, which significantly increased their stress levels. The professional values developed from training and education often conflicted with the legalistic and economically driven business models of their employers [18]. The findings from this study may help explain the common motivator amongst participants wanting to leave the rehabilitation healthcare sector, a lack of job role alignment with their professional values [36].

Most participants reported heightened stress attributed to working excessive hours and have increased workloads not only due to KPIs but due to the constant turnover of staff and difficulty with recruitment in their locations. Short staffing has been previously noted as a risk factor for the development of compassion fatigue in healthcare workers, as it leads to increased workloads and hours, which overflows into personal lives [37].

Some participants reported feeling as though rehabilitation healthcare is focused on profit and business, rather than being an integral part of the healthcare system. Some participants felt that employer profit gain and expenditure minimisation were prioritised over appropriateness of treatment for their care recipients and were often required to manage cases where they felt the agenda was driven by economic motivators of their employer, rather than delivering best practice healthcare for the care recipient. This may be attributed to the uniqueness of the rehabilitation sector of the Australian healthcare workforce, in that it is a largely profit-driven and privatised industry, as compared to the general Australian healthcare workforce which is often publicly funded, informed by social need, and engaged in a person-centered approach [38].

Research suggests that urban models of healthcare are unsuitable for rural and remote locations as they fail to effectively manage diseconomies of scale with large geographic areas with dispersed populations [39]. Rehabilitation healthcare workers employed in rural and remote locations face unique job role demands and

environmental challenges which are generally not experienced by their urban counterparts. These include limited labour market and higher unemployment rates, lower education and less transferrable skills of care recipients, excessive travel over a large geographic area, dual relationships, and fewer healthcare referral services, all of which impact the service delivery of rehabilitation healthcare [40].

The general tenor of the interviews was participants expressing their frustrations with the role and discussing what would be considered compassion fatigue or their experiences with compassion fatigue influences. Participants commonly reported symptoms including burnout, stress, depression, and anxiety, all of which indicate compassion fatigue. Most participants had little to discuss when it came to positive elements of their roles and what may constitute compassion satisfaction experiences or potential for compassion satisfaction. When they did, the satisfaction they got came from working with their care recipients and generally not from organisational benefits such as reward and recognition or positive workplace conditions.

Findings from this study indicate that, unlike other healthcare sectors, rehabilitation healthcare is commonly influenced by third parties such as insurers which are largely motivated by economically driven business models, which inform employer KPIs. The KPIs are an issue for rural and remotely practicing rehabilitation healthcare workers as they are largely unattainable due to the complexities and barriers associated with rural and remote practice. In an attempt to reach their KPIs, participants were exposed to unsafe work practices and employers were faced with higher rates of staff attrition. The unsafe work practices and problems with staff attrition indicate that rural and remotely practicing rehabilitation healthcare workers are at a risk of developing compassion fatigue and there is little in the way of workplace protections which would facilitate or maintain compassion satisfaction.

4.1. Limitations and Future Research. As is the case with any qualitative inquiry, the relevance or applicability of the findings should be assessed with participant characteristics in mind [41]. Participants all worked within the Australian rural and remote context. Given the vast geographical expanses and extremely low population density within the Australian context for example, further work is needed to explore whether findings from this study hold true for rehabilitation healthcare workers practicing in other countries and under different healthcare systems and organisational structures. This would be of particular value given that many compassion fatigue-related experiences that participants reported stemmed from organisational practices and supports or lack thereof.

Further, despite reaching a sense of data saturation, due to the smaller sample sizes in exploratory studies and the small percentage of eligible participants for this study (relatively small workforce in rural and remote Australia), participants may have been concerned about being identified and therefore may not have provided an accurate recollection of their experiences or may have provided an exaggerated response due to industrial grievances and feelings of compassion fatigue.

The first author who conducted the interviews and led the analyses is themselves a rural and remote working rehabilitation healthcare worker. While this "insider" perspective is not a limitation and in fact recognised as "treasurable" [42] because of insights they add to the line of inquiry and the interpretation of findings, transparency is important. Additionally, frequent reflexive team discussions throughout the analysis process, as well as team review of early "pilot" interviews ensured that lines of inquiry remained open, and codes stayed true to the participants' data.

Future research is needed. A qualitative study with greater numbers would enable a comparison of themes against particular demographic features of participants. For example, it is possible that the experiences of compassion satisfaction and compassion fatigue differ depending upon the population served and the type of professional training received. It was not possible to delve into this with the current sample size. Future work that examines the rates or extent of compassion satisfaction and compassion fatigue experienced within the Australian rural and remote rehabilitation healthcare workforce is also needed.

Despite the limitations and need for future research, findings from this study provide preliminary insights that can assist in the development of targeted strategies to enhance the protective factors of compassion satisfaction and minimise the risk factors of compassion fatigue in rehabilitation healthcare workers who provide services in rural and remote Australia.

5. Conclusion

Findings indicate that there are similarities in experiences of compassion satisfaction and compassion fatigue across various healthcare specialisations working in rural and remote settings, but they also indicate differences. The unique difference for rural and remotely practicing rehabilitation healthcare workers is that they are required to work under a service delivery model which has stringent performance expectations in the form of KPIs, which appear unsuitable for the rural and remote context. The employer-enforced KPIs are uniform across their organisations regardless of geographic location and without consideration to the complexities associated with rural and remote practice for participants. This resulted in increased work-related pressures which may indicate a heightened risk of developing compassion fatigue and reducing opportunities for compassion satisfaction. Further research that provides a better understanding of the rates and risks of compassion fatigue in this group of healthcare workers will provide employers and other key stakeholders with information to make informed decisions about the appropriateness of their models of care in rural and remote locations. This information will assist employers with ensuring that they are meeting their WHS obligations by providing a safe work environment for their employees, whereby the risk of compassion fatigue is minimised.

Data Availability

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research, supporting data are not available.

Disclosure

Kelly McGrath conducted this study as a component of the degree of Doctor of Philosophy (PhD) at the University of Sydney, under the supervision of Honorary Associate Professor Lynda Matthews, Associate Professor Nicola Hancock, and Dr Robert Heard.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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References

[1] S. Ryali, A. Kumar, and P. Bhat, "Study of quality of life among health workers and psychosocial factors influencing it," *Industrial Psychiatry Journal*, vol. 27, no. 1, pp. 96–102, 2018.

[2] I. Portoghese, M. Galletta, R. C. Coppola, G. Finco, and M. Campagna, "Burnout and workload among health care workers: the moderating role of job control," *Safety and Health at Work*, vol. 5, no. 3, pp. 152–157, 2014.

[3] E. Shdaifat, N. Al-Shdayfat, and N. Al-Ansari, "Professional quality of life, work-related stress, and job satisfaction among nurses in Saudi arabia: a structural equation modelling approach," *Journal of Environmental and Public Health*, vol. 2023, Article ID 2063212, 9 pages, 2023.

[4] D. A. El-Shafei, A. E. Abdelsalam, R. A. M. Hammam, and H. Elgohary, "Professional quality of life, wellness education, and coping strategies among emergency physicians," *Environmental Science and Pollution Research*, vol. 25, no. 9, pp. 9040–9050, 2018.

[5] ProQol, "Professional quality of life measure," 2009, https://proqol.org/ProQol_Test.html.

[6] D. Nanjundeswaraswamy and D. R. Swamy, "Review of literature on quality of worklife," *International Journal for Quality Research*, vol. 7, no. 2, pp. 201–214, 2013.

[7] Australian Government Australian Institute of Health and Welfare, "Rural and remote health," 2020, https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health.

[8] A. Tabaj, S. Pastirk, Č. Bitenc, and R. Masten, "Work-related stress, burnout, compassion, and work satisfaction of professional workers in vocational rehabilitation," *Rehabilitation Counseling Bulletin*, vol. 58, no. 2, pp. 113–123, 2015.

[9] K. McGrath, L. R. Matthews, and R. Heard, "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*, vol. 30, no. 2, pp. 264–280, 2022.

[10] T. Opie, M. Dollard, S. Lenthall et al., "Levels of occupational stress in the remote area nursing workforce," *Australian Journal of Rural Health*, vol. 18, no. 6, pp. 235–241, 2010.

[11] B. A. Clough, M. J. Ireland, S. Leane, and S. March, "Stressors and protective factors among regional and metropolitan Australian medical doctors: a mixed methods investigation," *Journal of Clinical Psychology*, vol. 76, no. 7, pp. 1362–1389, 2020.

[12] F. Cocker and N. Joss, "Compassion fatigue among healthcare, emergency and community service workers: a systematic review," *International Journal of Environmental Research and Public Health*, vol. 13, no. 6, p. 618, 2016.

[13] Allied Health Professions Australia, "Rehabilitative care," 2020, https://ahpa.com.au/key-areas/rehabilitation/.

[14] National Institutes of Health Medical Rehabilitation Coordinating Committee, "National institutes of health research plan on rehabilitation," *American Journal of Occupational Therapy*, vol. 71, no. 3, 2017.

[15] World Health Organisation, "Rehabilitation," 2023, https://www.who.int/news-room/fact-sheets/detail/rehabilitation.

[16] S. K. Graham and I. D. Cameron, "A survey of rehabilitation services in Australia," *Australian Health Review*, vol. 32, no. 3, pp. 392–399, 2008.

[17] T. S. Jesus, M. D. Landry, G. Dussault, and I. Fronteira, "Human resources for health (and rehabilitation): six Rehab-Workforce Challenges for the century," *Human Resources for Health*, vol. 15, no. 1, p. 8, 2017.

[18] E. Kendall and J. Clapton, "Time for a shift in Australian rehabilitation?" *Disability and Rehabilitation*, vol. 28, no. 17, pp. 1097–1101, 2006.

[19] J. Sutton and Z. Austin, "Qualitative research: data collection, analysis, and management," *Canadian Journal of Hospital Pharmacy*, vol. 68, no. 3, pp. 226–231, 2015.

[20] A. Tong, P. Sainsbury, and J. Craig, "Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups," *International Journal for Quality in Health Care*, vol. 19, no. 6, pp. 349–357, 2007.

[21] B. Saunders, J. Sim, T. Kingstone et al., "Saturation in qualitative research: exploring its conceptualization and operationalization," *Quality and Quantity*, vol. 52, no. 4, pp. 1893–1907, 2018.

[22] V. Braun and V. Clarke, "One size fits all? What counts as quality practice in (reflexive) thematic analysis?" *Qualitative Research in Psychology*, vol. 18, no. 3, pp. 328–352, 2021.

[23] M. R. Armat, A. Assarroudi, M. Rad, H. Sharifi, and A. Heydari, "Inductive and deductive: ambiguous labels in qualitative content analysis," *Qualitative Report*, vol. 23, pp. 219–221, 2018.

[24] P. Allen, J. May, R. Pegram, and L. Shires, "'It's mostly about the job' – putting the lens on specialist rural retention," *Rural and Remote Health*, vol. 20, no. 1, p. 5299, 2020.

[25] A. John Crowther and A. Theresa Ragusa, "Realities of mental health nursing practice in rural Australia," *Issues in Mental Health Nursing*, vol. 32, no. 8, pp. 512–518, 2011.

[26] N. Whiteing, J. Barr, and D. M. Rossi, "The practice of rural and remote nurses in Australia: a case study," *Journal of Clinical Nursing*, vol. 31, no. 11-12, pp. 1502–1518, 2022.

[27] Comcare, "Operating as a rehabilitation provider," 2023, https://www.comcare.gov.au/service-providers/workplace-rehabilitation-providers/operating.

[28] D. C. Roberts-Yates, "Examining the role of rehabilitation in the South Australian workers' compensation system," *The Australian Journal of Rehabilitation Counselling*, vol. 9, no. 2, pp. 82–101, 2003.

[29] L. McAulay, J. Fadyl, and G. Terry, "Effective teams in vocational rehabilitation: an exploration of complexities and practice in aotearoa-New Zealand," *Journal of Occupational Rehabilitation*, vol. 33, no. 3, pp. 518–527, 2023.
[30] L. K. Wright, S. Jatrana, and D. Lindsay, "Workforce safety in the remote health sector of Australia: a scoping review," *British Medical Journal Open*, vol. 11, no. 8, pp. 1–16, 2021.
[31] M. A. Williams, "Rural professional isolation: an integrative review," *Online Journal of Rural Nursing and Health Care*, vol. 12, no. 2, pp. 3–10, 2012.
[32] J. E. Arnetz, L. Hamblin, J. Ager et al., "Underreporting of workplace violence: comparison of self-report and actual documentation of hospital incidents," *Workplace Health and Safety*, vol. 63, no. 5, pp. 200–210, 2015.
[33] B. Miedema, S. Tatemichi, R. Hamilton et al., "Effect of colleague and coworker abuse on family physicians in Canada," *Canadian Family Physician*, vol. 57, no. 12, pp. 1424–1431, 2011.
[34] J. A. Wressell, B. Rasmussen, and A. Driscoll, "Exploring the workplace violence risk profile for remote area nurses and the impact of organisational culture and risk management strategy," *Collegian*, vol. 25, no. 6, pp. 601–606, 2018.
[35] D. K. Thapa, T. Levett-Jones, S. West, and M. Cleary, "Burnout, compassion fatigue, and resilience among healthcare professionals," *Nursing and Health Sciences*, vol. 23, no. 3, pp. 565–569, 2021.
[36] S. M. Bragg and A. Bonner, "Degree of value alignment-a grounded theory of rural nurse resignations," *Rural and Remote Health*, vol. 14, no. 2, pp. 110–120, 2014.
[37] A. G. Nolte, C. Downing, A. Temane, and M. Hastings-Tolsma, "Compassion fatigue in nurses: a metasynthesis," *Journal of Clinical Nursing*, vol. 26, no. 23-24, pp. 4364–4378, 2017.
[38] Australian Government Australian Institute of Health and Welfare, "Health system overview," 2022, https://www.aihw.gov.au/reports/australias-health/health-system-overview.
[39] J. Wakerman, J. S. Humphreys, R. Wells, P. Kuipers, P. Entwistle, and J. Jones, "Primary health care delivery models in rural and remote Australia–a systematic review," *BMC Health Services Research*, vol. 8, no. 1, p. 276, 2008.
[40] T. Landon, A. Connor, M. McKnight-Lizotte, and J. Pena, "Rehabilitation counseling in rural settings: a phenomenological study on barriers and supports," *Journal of Rehabilitation*, vol. 85, pp. 47–57, 2019.
[41] S. Polgar and S. A. Thomas, *Introduction to Research in the Health Sciences: Introduction to Research in the Health Sciences E-Book*, Elsevier Health Sciences, Philadelphia, PA, USA, 6th edition, 2013.
[42] L. Leung, "Validity, reliability, and generalizability in qualitative research," *Journal of Family Medicine and Primary Care*, vol. 4, no. 3, p. 324, 2015.