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Impact of Resiliency Training on Combating Burnout

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Impact of Resiliency Training on Nursing Burnout Benchmark Study

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Executive Summary

Occupational burnout has long since been a problem but has only recently been acknowledged as the spark behind the fire that has led to our critical nursing shortage. Considering the emotional aftermath of the pandemic and the hardships that a strained economy will bring, we must learn how to extinguish these flames rather than adding fuel to this complex problem. Burnout is causing a vicious cycle within the healthcare workforce that will lead to detrimental effects on quality patient care. We must learn how to break the cycle.

The cycle starts with experienced nurses leaving unprecedented numbers and units primarily populated by new or travel/agency nurses. In several cases leads to chaos where the blind are leading the blind. Chaotic departments and worn-down staff increase the likelihood of errors that could be harmful to the patient and the nurses.

Units are being run short-staffed, and nurses are working even longer hours than ever before. Hospitals where nurses continually work over 13 hours are correlated with hospitals that receive the lowest HCAHPS ratings (Symplr, 2021). Patients know when they are getting lower quality care because it clearly shows. A 2010 Annals of Surgery study that measured the three critical areas of burnout found that for every one-point increase in depersonalization, there was an 11% increase in error reporting (Symplr, 2021). The cost of burnout is evident, which is demonstrated by the increased turnover rates alone. According to an article by Katulka (2022), the average cost of refilling one bedside RN position is 46,100, and the financial toll turnover can cause on a hospital can range from $5.2 to $9.0 million.

It is true that burnout has many causes and will take a multifaceted approach to find a lasting solution. However, the best foundational starting place is in promoting the physical and emotional wellness of the nursing population. If nurses are better cared for by the organizations they work for and themselves, they will become a part of the solution. Nurses at their core want to help, but how can we when we have nothing else to give at the end of the day? It is for this reason that resiliency training should be utilized in all hospitals because a more vital workforce, both physically and emotionally, is a workforce that will be the fundamental catalyst for lasting change at an organizational level.

Impact of Resiliency Training on Nursing Burnout Benchmark Study

Resiliency training incorporates self-care, stress management techniques, and how to respond to stressful situations to foster emotional wellness. This multipronged program makes it an excellent approach to healing the individual. The individual is not the root cause of burnout, but burnout has at least to some extent broken the individual, and we need to fix what is broken. For instance, in medicine, when a person comes in with severe anemia, we cannot just give them blood and send them on their way. We must find the source of the bleeding. Resiliency training is akin to giving blood to revive our workforce, and then together, we can address the many different causes that fuel burnout.

The Rationale for the Project

Occupational burnout is a prevalent problem in United States culture, but the consequences are never felt as deeply and by so many as burnout that affects our healthcare workforce. It is imperative to help find solutions that can treat burnout in the here and now and in the future. How do you find solutions to such a multifaceted problem? The answer is from the nurses and physicians experiencing the problem and not from hospital administrators or other stakeholders who have no real emotional or personal backlash from the issue at hand. It is easy to understand why feedback from healthcare providers is crucial, but obtaining it is entirely different.

Countless nurses feel beaten down by the current healthcare system. They are asked to put aside their exhaustion and find enough energy to lobby and stand up to lawmakers and administrators for real change. How can we do that when we are already so tired? The answer is that we cannot. As in an airplane, you must apply your face mask before assisting others. The same is true for nurses, and that is what resiliency training is trying to teach, how nurses can put

on their life preservers. Improving our nurses' physical and emotional wellness will translate into a more productive workforce and enhanced patient safety with positive care outcomes.

The primary goal of this Project is to reduce the burnout currently experienced within nursing, implement lasting change over time on nursing turnover, and promote job satisfaction. Healthcare has various everyday stressors, such as long work hours, heavy patient load, and a highly stressful work environment. Innumerable factors in the nursing environment increase stress, which can or cannot be modified. This change project aims to prepare nurses to efficiently manage the stressors they cannot change or control, leaving them in a better mental position to advocate for things that need to improve in the workplace. The previously mentioned goal will be achieved through an innovative approach to stress management with resiliency, mindfulness training, and self-management techniques. This training has been shown to make positive changes in nursing well-being and outlook on life and is routinely used by Mayo Clinic (Mayo Clinic Staff, 2022). Resiliency training comes in different forms, but it is important to note that the resiliency training program chosen in this Project will include mindfulness education as part of the course.

Literature Synthesis

Initially reviewing the existing research on interventions against burnout, one will quickly discover that not everyone defines burnout similarly. Therefore, various associated symptoms are investigated as indicators of the condition. There have been different interventions investigated, but there were two species that had a great deal of overlap and were frequently discussed interchangeably: mindfulness training and resiliency training. In looking at the methodology of each training, one will find they are the same as resiliency training, including

mindfulness within its teachings. For this purpose, this literature synthesis will discuss study findings that investigated both types of training.

As mentioned previously, every article measured the effect of resiliency or mindfulness training on a substantial number of factors that can either be seen as protective factors against burnout or factors that contribute to the development of burnout. Of the three articles that analyzed actual burnout scores, two studies (Sulosaari et al., 2022; Zhai et al., 2021) found that scores were significantly reduced post-training, and one study (Grabbe et al., 2019) showed no change in scores. Interestingly, the study that showed no change in burnout scores (Grabbe et al., 2019) showed a significant improvement in self-rated well-being and quality of life as the only other study that measured this outcome (Sulosaari et al., 2022). An improvement in job satisfaction was noted in the two studies that examined this outcome (Ghawadra et al., 2020; Sulosaari et al., 2022), but in only one of these studies, the change was significant (Ghawadra et al., 2020).

In reflecting on the positive outcomes of this training, one would also want to understand if the training did what it intended or if these outcomes were simply happy coincidences. To understand if these resiliency and mindfulness training did improve resiliency and mindfulness, all studies examined self-rated survey scores exploring these characteristics pre- and post-intervention. Significant improvements were noted in the three studies that examined resiliency scores (Grabbe et al., 2019; Sulosaari et al., 2022; Zhai et al., 2021). Additionally, of the two studies that examined mindfulness scores, significant improvement was noted in the studies post-intervention (Ghawadra et al., 2020; Lin et al.,2019; Sulosaari et al., 2022). This information displays factual data that this type of training does achieve what it sets out to do. Two studies noted that resilience training implemented over an extended period was more

effective (Cleary et al., 2018; Melnyk et al., 2020). it will be beneficial to continue implementing the benchmark project beyond the three-month mark to evaluate its effectiveness.

When looking at burnout and the factors that cause burnout, several states of being are often highlighted comorbidly. They can contribute to the development of burnout, including anxiety, depression, and feelings of stress. For this reason, five studies examined these indicators and found a significant reduction across the board for all these contributing factors (Deldar et al.,2018; Ghawadra et al., 2020; Melnyk et al., 2020; Sulosaari et al., 2022; Zhai et al., 2021). This data indicates that the positive effects of resiliency training are far-reaching and go beyond just enhancing the emotional strength of a workforce.

Project Stakeholders

The key stakeholders to this change project and the most challenging buy-in to obtain are amongst the nursing staff affected by the resiliency training. The data behind the need for change and the positive results experienced by prior nurses will need to be addressed, and incentives offered for initial and continued participation. Ideally, this change should be implemented at an organizational level for all staff, not just the nursing workforce, as all experience occupational burnout. It would be essential to bring in lead staff members within each nursing unit and in other disciplines such as physicians, patient-care technicians, and areas like social work. If we can obtain buy-in from these individuals early in the project, they can be prepared to lead these changes in their disciplines.

Organizational buy-in through hospital administrators, directors, and nurse managers will be needed. However, this hurdle should be easily tackled. Issues such as staffing turnover, patient safety events, and poor results from patient surveys are all items that are of great concern to hospital administrators, and the financial burden experienced due to these issues are potent

motivating factors for making positive changes in their workforce. Resiliency training is one of the most cost-effective measures that can make a lasting change to their most costly problems.

Patients and their family members will also be vital in evaluating the effectiveness of this change as a happier and healthier workforce should provide higher quality care. Their input will be invaluable as this is where nurses can see the positive effects of the changes they make. This will be an important way to celebrate successes throughout this change project.

Implementation Plan

EBP Vision

The initial steps of this implementation plan would be to discover the mission statement and values of that healthcare facility and how improved resiliency will work towards that goal. This is key to organizational decision-making and will aid in obtaining administrative buy-in. Any morally sound organization has values tied to the positive effects of resilience training and stress management techniques through improvement in compassion fatigue, promoting colleague well-being, and promoting the quality and safety of their clients. The vision of what this change could achieve for the nurses individually and the organization would be expanded upon during an initial presentation with hospital administrators.

Once the above-shared vision is obtained, administrative buy-in would be achieved by displaying the cost of nurse turnover and the detriment to patient safety when burnout levels are high on a unit. If the administration fails to give initial buy-in, then permission will be obtained to conduct at least the initial MBI survey to show the level of burnout experienced in their units now. Displaying this real threat to future organizational stability will serve as a motivator for the need for change. Obtaining this shared vision and achieving administrative buy-in will take

place over a 1–2-week period, with the initial Maslach Burnout Inventory [MBI] survey being completed concurrently for two weeks. All nursing staff will be asked to complete baseline surveys, and the evaluation tool of choice will be elaborated on in a later step.

After administrative buy-in and survey completion, a unit will be chosen randomly as the pilot unit for change. The following week will obtain a shared vision and buy-in amongst unit leaders, managers, and nursing staff. During this time of obtaining unit buy-in, the beginning of the leadership team will also be formulated of organizational EBP leaders and unit members that could help with individual nurse participation in the project. If the unit had a unit-based council or EBP committee, then involvement of these individuals on the leadership team would be sought.

Engagement

Initial steps at fostering engagement would be to analyze the possible barriers to nurse participation and attempt to eliminate these barriers. There are three primary barriers which include the following: Class timing, too many attending at one time, and short staffing of the unit, lack of physical exercise, nurses not seeing the value in training.

The first and second barriers can be eliminated by involving the staff in the formulation of the scheduling of classes and making a signup sheet for different days and times to assure there are not too many attending in one day. Encouraging group members can eliminate the third barrier of lack of physical exercise to work out together. The fourth barrier would be harder to address because the name of resiliency could be interpreted as the blame solely on the nurse for feeling burned out. The fourth barrier will open a door for disseminating evidence to come into play for the staff and what resiliency training entails, which is a focus on maintaining the

individual's emotional well-being. If nurses see the data on the improvement in personal well-being, they will feel more supported rather than punished for not reacting a sure way to workplace stressors.

The initial excitement building, buy-in of stakeholders, formulation of the team, elimination of barriers, and formulating of the platform to be used for follow-up education will take approximately four weeks. In-person classes will then be held over multiple days and times to allow options for attendance over two weeks. Afterward, weekly check-ins, encouragement, and education will be offered on the preferred social media platform, app, or website. These weekly check-ins will continue over the following two and a half months, with the initial re-evaluation occurring over the last two weeks. There will be a total of 3 months spent during the initial implementation period.

After initial implementation, the MBI scores will be reviewed, and staff feedback on how the training was throughout the three months and what could be done to improve the process. Once these improvements are made and if the MBI scores show improvement, then the rollout to all other nursing units over the same time. This rollout will start with disseminating evidence from what was learned and gained from the pilot unit. Each unit will have teams formulated to assist and lead the rollout in their respective areas and help coordinate their education and training sessions. Weekly education and check-ins on the chosen platform will continue to be offered over the next nine months. Initial training should also be offered to all new nursing hires, and then the exact timeline for re-evaluation will be completed based on that cohort's initial education date.

Evaluation

In planning the appropriate evaluation of this change, the primary consideration was accurately measuring the outcome of interest. The outcome of interest in this change project is burnout, and there is no single definition that conclusively describes this phenomenon. The most generally accepted description of burnout is reported by the World Health Organization (2019) as feelings of energy depletion or exhaustion, increased mental distance from one's job, feeling of negativism or cynicism related to one's job, and reduced professional efficacy.

The tool that is the most widely used internationally and measures these dimensions accurately is the Maslach Burnout Inventory [MBI](Dall'Ora et al., 2020). The scoring is based on the three dimensions of Burnout/emotional exhaustion (or depression anxiety syndrome), Depersonalization, and Personal Achievement. It is interpreted as low-level, moderate-level, or high-level burnout. A high score in burnout (score of >30) and depersonalization (score of >12), as well as a low score in personal achievement (score of <33), is indicative of a high degree of burnout (Maslach et al., 1996). After establishing this screening tool as the most likely to measure our outcome of interest accurately, we will administer this screening tool to all nursing staff with whatever the hospital is already utilizing online learning platform. The survey will be mandatory for all staff over two weeks and will offer incentives to the units which get the survey did first, such as prizes or a unit pizza party. During survey administration, we will collect data on turnover rates, hospital expenditures on travel/contract staffing, and the cost of hiring fresh staff. A review of hospital incident reports that involve preventable errors or patient safety events such as falls will also be completed as improvement in the rate of these events could be a positive secondary outcome. After collecting all baseline data, we will choose a random unit to trial this change project as later inferential statistical analysis will be valuable in measuring

primary and secondary outcomes. Random selection is essential in ensuring the population being evaluated is a representative subset of the whole (Taylor, 2020).

As mentioned, surveys will be used to measure burnout scores at baseline and in the last two weeks of the initial 3-month implementation and a 6-month and one-year follow-up survey. The 3-month survey will be necessary to evaluate the effect on the primary outcome of burnout. However, the 6-month and 1-year evaluations will assess whether reducing burnout was sustained and whether this intervention affected turnover rates and patient safety incidents. The survey will always take place over two weeks online with the same or comparable incentives. Incentives, such as pizza parties or paid unit outings, should be offered to staff to complete surveys and to maintain participation throughout the year. Success should be celebrated along the way when any positive change is noted in scores.

Baseline data will be compared to each survey result using descriptive summary statistics of measures of central tendency with a focus on the mean score of each of the three dimensions separately (emotional exhaustion/burnout, depersonalization, and personal achievement) along with the standard deviation of the data. The data from each dimension score will be displayed using three separate histograms, with each one representing a single dimensions survey result.

The ranges of scores will be represented on the x-axis, and the y-axis will represent the frequency/# of individuals with a particular score. To make the relevance of results easier for the stakeholders, the bars representing scores that reflect low degree burnout will be in green, moderate degree burnout will be in yellow, and high degree burnout will be in red. A final bar chart will be used to display the categorical data for comparison of each survey time. The y axis of the bar chart will display the frequency or number of times that scores fell within a low degree, moderate degree, or high degree of burnout. The x-axis of the bar chart will show the

categories of low, moderate, and high degree results with color coding to represent the time survey being displayed with a key to tell the viewer what color represents baseline, 3-month, 6-month, or one-year data.

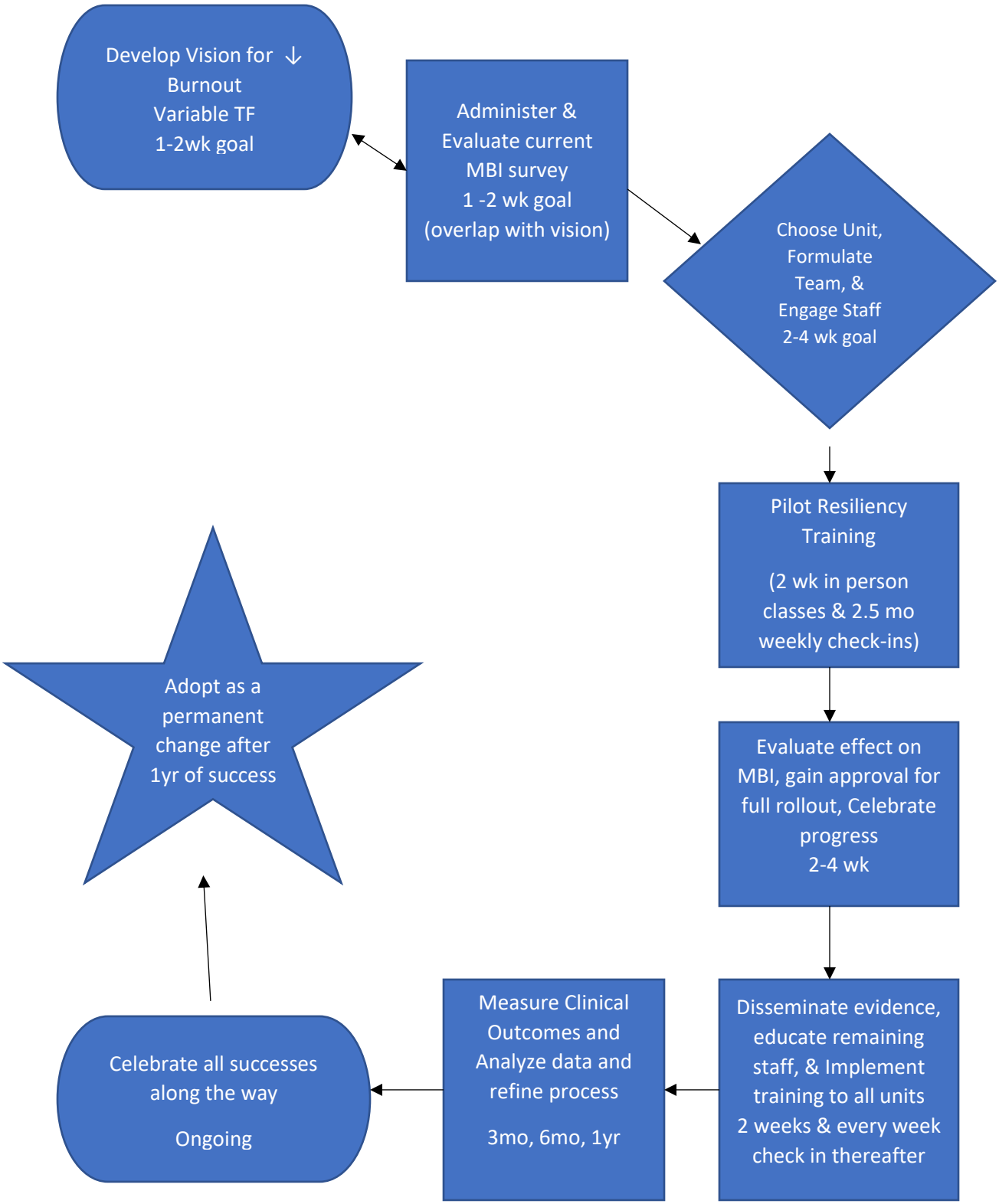
Inferential statistics will help visualize possible positive effects on secondary outcomes and will be displayed using scatterplots for baseline data. Variables to be displayed include how the mean MBI scores correlate to patient safety events, errors, and turnover rate. Completing this based on baseline data will show critical stakeholders the expected long-term benefits that should be gained if a reduction in burnout is achieved. Secondary outcomes, such as turnover rates, take time to manifest and would not be worth analyzing at every evaluation period. Variables such as this will be measured at baseline and then again at one year. Unit dashboards should be utilized and distributed to all units after each evaluation period that shows the unit's mean MBI scores and unit initiatives to show how nursing wellness translates to an improvement in the quality and safety of patient care (Alexandrov et al., 2019). These dashboards should also show unit compliance with continued training and wellness initiatives to show if participation in the program is helping to reduce burnout. Compliance data will be obtained by how much time each nurse spends on the online database/application on a particular unit. The dashboard will offer real-time encouragement so nurses can see the difference their efforts are making and will aid in continued buy-in throughout the project, which will foster a permanent practice change. Using various methods to display project successes and shortcomings ensures continual process improvement and stakeholder support.

Timetable/Flowchart

As discussed, the initial development of a shared vision, obtaining baseline data, obtaining stakeholder buy-in, and establishing staff engagement will occur over four weeks, with

items happening concurrently. The initial pilot implementation will take place over three months, with the last two weeks being the survey period. During these last two weeks of the survey period, perspective teams should be formulated on each unit if continued rollout should occur. Suppose the implementation goes smoothly and further rollout indicates a positive change in MBI scores. In that case, expansion of implementation to all other nursing units will be completed over the same time. After the initial two-week in-person training, there will be weekly education and check-ins for the year. The re-evaluation interval will be completed at three months, six months, and one year after training is initiated. Suppose positive change is noted at an organizational level or an overall level of nursing wellbeing after one year. In that case, this change will be adopted for long-term adherence within this hospital system.

*See the flowchart below


Develop Vision for ↓ Burnout
Variable TF
1-2wk goal
Administer & Evaluate current MBI survey
1 -2 wk goal
(overlap with vision)
Choose Unit, Formulate Team, & Engage Staff
2-4 wk goal
Pilot Resiliency Training
(2 wk in person classes & 2.5 mo weekly check-ins)
Evaluate effect on MBI, gain approval for full rollout, Celebrate progress
2-4 wk
Disseminate evidence, educate remaining staff, & Implement training to all units
2 weeks & every week check in thereafter
Measure Clinical Outcomes and Analyze data and refine process
3mo, 6mo, 1yr
Celebrate all successes along the way
Ongoing
Adopt as a permanent change after 1yr of success

Data Collection Methods

The projected method of data collection will be a survey. The allocated surveys will be completed through an online platform. The randomly selected nurses will complete a pre-survey before beginning the benchmark project. During the last two weeks of the benchmark project, an online post-survey will be conducted. At the end of the three months, six months, and one-year mark, a post-online survey will be done and compared to the baseline survey. Comparing the pre- and post-surveys will indicate if there were a reduction in burnout among nurses participating in the project over time.

Cost/Benefit Discussion

Burnout over time causes massive nurse turnover and increases medical errors. As previously mentioned, burnout can become quickly costly for healthcare institutions, and the cost can easily climb from 5.2 to 9.0 million (Katulka, 2022). According to *the National Health Care Retention & RN Staffing Report*, every added percent in Nurse turnover will cost or save an average of $ 262,300 annually to healthcare facilities (2022). Medical mistakes arising from burnout are also expensive; approximately $ 20 billion is spent yearly on errors in hospitals and clinic settings (*The cost of burnout in healthcare,* 2021). It is therefore imperative to implement strategies to reduce burnout and correlatively reduce expenses.

Discussion of Results

The benchmark project is yet to be implemented. Based on the reviewed studies, the project, if implemented, could potentially result in positive outcomes for the nurses, the patients, and the hospital facilities.

Conclusions/Recommendations

Burnout is like an uncontrollable wildfire continuously growing rampant in the healthcare profession. It is imperative to find solutions to reduce this phenomenon. Incorporating resilience and mindful training is a huge step toward addressing the healthcare industry's problem. Reducing burnout among nurses will go a long way toward reducing staff turnover, patient error, patient dissatisfaction, and expensive medical costs to healthcare facilities. Successfully implementing this benchmark project will serve as a steppingstone for other healthcare organizations to follow suit.

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