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Developing a Resiliency Bundle for Home Care Nurses

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Conflicts of Interest and Source of Funding:

The author is also an employee in the home care department where the study took place.

Abstract

Home care (HC) nurses are experiencing increased stress related to workload, isolation on the job, and COVID-19 restrictions. A literature review found numerous interventions effective in reducing nurse burnout through building resiliency and decreasing moral distress. The purpose of this evidence-based project was to improve resiliency and decrease the risk of burnout in HC nurses through the introduction of a resiliency bundle. Based on the evidence, the following priority interventions for a resiliency bundle were chosen: a) gratitude strategies, b) connecting with co-workers, c) storytelling, and d) resiliency training. Duffy's Quality-Caring Model and Neal's Theory of Home Health Nursing Practice were used to frame the study. The Iowa Model framework was used to implement and integrate the practice change in a home healthcare department at a large Midwestern pediatric hospital. Outcomes were measured using a pre-and post-implementation resiliency and burnout survey, which used a Likert scale to allow for quantitative statistical analysis. Fourteen nurses completed the pre-survey, 11 completed the post-survey, and 10 completed both pre- and post-surveys. Results showed no statistically significant change in resiliency or burnout after implementation; however, nurses expressed desire to continue using the bundle pieces, especially the gratitude strategies, connecting with co-workers, and sharing stories. Leadership should take burnout risk in HC nurses seriously and look for innovative ways to promote resiliency within nurses. There is little found in the literature about interventions to improve burnout in HC nurses; therefore, further research is needed to examine how to better support this unique nursing role.

Nurse burnout is a critical topic in healthcare today, across all nursing specialties. Burnout has been defined as a syndrome consisting of three dimensions: emotional exhaustion (EE), depersonalization (DP), and low personal accomplishment (PA; Adwan, 2014). The EE component is related to becoming depleted, debilitated, and fatigued (Maslach, 2017). The DP component is described as cynicism or “having negative or inappropriate attitudes toward clients” (Maslach, 2017, p. 143). Finally, the low PA component - also called inefficacy – is described as having low morale, decreased viewpoint of self-competence (Cao & Naruse, 2019).

Providing quality home healthcare services is vital, as the demand for nurses in home health settings is increasing, due to increased life expectancy, technological advances that allow more complex care to be provided in a patient’s home, and support to decrease costly hospitalizations (Jarrin et al., 2019). The HC work setting has unique characteristics that are important when considering burnout. A typical day consists of working alone, long drive times, potentially poor environmental conditions in patients’ homes, high emotional involvement due to a strong relationship with patient and family, and coordination of care needs from the nurse’s car.

The work environment for nurses influences the quality of care and thus impacts patient outcomes (Irani et al., 2018). Looking specifically at HC nurses, supportive work environments in HC agencies are very important in retaining HC nurses (Jarrin et al., 2017). Nurse managers must develop strong support systems for their team in order to reduce burnout risk (Irani et al., 2018).

Health care workers are statistically more likely to experience burnout compared to most other professions (Children’s Hospital Association, 2019). Burnout in nursing has been linked to patient care and job turnover (Brown et al., 2018). In a large cross-national study, Poghosyan et

al. (2010) found an association between burnout and nurse-rated quality of care. According to a Nursing Solutions Incorporated (2016) survey, close to 30% of nurses leave the profession with less than one year of experience. Bong (2019) argues this high turnover among new nurses is due to harmful consequences of moral distress. Vander Elst et al. (2016) found emotional demands contributed to burnout in HC nurses.

Along with the unique challenges that come with the HC environment, the pediatric specialty adds another layer of burnout risk for nurses. Out of a diverse sample of 1600 pediatric nurses, the systematic review and meta-analysis of Pradas-Hernandez et al. (2018) found a significant number of the sample to have moderate levels or higher of EE and DP. The authors also found exposure to stress and a lack of emotional intelligence were associated with higher levels of burnout (Pradas-Hernandez et al., 2018).

HC nurses value the autonomy and flexibility their job offers, as they can schedule their patients and create variety in each day. However, HC nurses struggle to maintain their autonomy and flexibility with growing concerns related to productivity requirements, case management overload, and increased documentation requirements (Irani et al., 2018). “Excessive workload is one of the most frequently cited stressors for nurses in all practice settings” (Samia et al., 2012, p. 245). Ellenbecker et al. (2006) reported high workload demands was the primary reason given by HC nurses for leaving their job, and increased burnout has also been associated with a nurse’s intention to leave (Naruse et al., 2012). This makes the prevention of burnout all the more critical.

An important factor contributing to burnout is moral distress, which is defined by the American Nurses Association Code of Ethics as the condition of knowing the morally right thing to do, but being able to do the right thing is nearly impossible due to social or institutional

constraints (Rushton et al., 2017). Other terms often used alongside moral distress include compassion fatigue and secondary traumatic stress (Sullivan et al., 2019). In contrast, moral resilience is the ability to restore integrity when responding to moral adversity (Gujral et al., 2020). Building resiliency has been shown to improve a person's response to stress and help mitigate burnout (Rushton et al., 2015). The added stress of the coronavirus pandemic (COVID-19) almost certainly has increased moral distress and burnout in nurses, making the need to support our nurses' well-being a current necessity (Gujral et al., 2020).

Purpose

The unique position of pediatric HC nurses requires innovative ways to support their well-being. The purpose of this evidence-based practice (EBP) project was to reduce burnout in the HC nurse population by improving resiliency. A bundle approach was used to combine multiple resiliency-building interventions. Supporting nurses to develop their resiliency can be instrumental in improving moral distress and reducing other risk factors of burnout (Irani et al., 2018; Rushton et al., 2015).

Resiliency Bundle

There is a plethora of literature discussing the risk of burnout in nurses and health care professionals, and the importance of building resiliency to combat burnout (Gujral et al., 2020; Rushton et al., 2015). The literature is also robust with interventions that effectively improve resiliency and decrease moral distress in nurses (Brown et al., 2018; Lee et al., 2015; Low et al., 2019; Sullivan et al., 2019; Zhang et al., 2020). After a thorough literature review, common intervention themes were identified, with multiple studies encouraging a bundle approach (Sullivan et al., 2019; Vaclavik et al., 2018; Zhang et al., 2020).

Almost every study included some sort of intervention related to resiliency education (Brown et al., 2018; Grabbe et al., 2020; Low et al., 2019; Magtibay et al., 2017; Sullivan et al., 2019; Zhang et al., 2020). Grabbe et al. (2020), Magtibay et al. (2017), and Sullivan et al. (2019) demonstrated improved resiliency and burnout outcomes related to a variety of resiliency education. Gratitude strategies showed positive outcomes across all studies that used the intervention, and the strategies allow flexibility in implementation which made it a strong choice for this project (Adair et al., 2020; Guo et al., 2020; Luo et al., 2019). Connecting with co-workers was described as having a positive effect through multiple methods among a number of the studies and included debriefing, support groups, and outside work events (Brown et al., 2018; Lee et al., 2015; Low et al., 2019; Zhang et al., 2020). The literature review included a small amount of evidence regarding storytelling; however, the uniqueness of storytelling is that the connection created between nurses through story spans generations, specialties, experience, or training (Reich, 2011).

Theoretical Basis

The theories that provided the framework for the project were Duffy's Quality-Caring Model and Neal's Theory of Home Health Nursing Practice. The Quality-Caring Model is a middle-range theory that "supports the connections between nurse caring and quality health outcomes" (Butts & Rich, 2018, p. 554). The Quality-Caring Model framed the importance of identifying relationships as central when wanting to improve how HC nurses adapt to new processes of change. Along with stressing the importance of the nurse-patient and nurse-family relationship, the Quality-Caring Model also emphasizes collaborative relationships, which was vital for a successful project.

Adaptation is a strong facet of home health nursing, so Neal's Theory of Home Health Nursing Practice guided the introduction of new practices (Neal, 2000). Neal's theory is based on concepts from the Roy Adaptation Model and identifies three stages of autonomy the HC nurse moves through: dependence, moderate dependence, and autonomy (Neal, 2000). HC nurses will move back and forth through these stages when changes occur in roles and processes. This theory guided the implementation of resiliency-building measures, by identifying what stage each nurse was in, and then implementing individualized steps to encourage the nurse's progression towards autonomy (Neal, 2000).

Methods

Project Design

This project was designed as a semi-experimental, one-group pre-test and post-test intervention conducted at a large U.S. Midwestern hospital-based HC agency. The Iowa Model EBP framework guided the implementation for the project by providing four phases of implementation to progress from creating awareness to integration and sustained use. Each phase included strategies addressing the goal of that phase and gave ideas specifically targeting clinicians, key stakeholders, and the organizational system (Cullen et al., 2018). Approval was received from the participating hospital and university Institutional Review Boards prior to implementation.

Participants

Eligible participants included pediatric HC registered nurses (RNs) from the identified agency. Exclusion criteria included non-nursing support staff, inpatient nurses, and leadership positions. The HC agency serves patients and families living within a 30-mile radius of the office, covering seven counties in and around a large metropolitan area. Skilled nursing visit

types include lab draws, central line cares, weight checks, immunoglobulin infusions, diabetes management, and palliative/hospice care.

A total of 16 RNs (13 full-time equivalents {FTE}) RNs, including four palliative/hospice RNs, and three casual RNs) were eligible to participate at the start of the project. The FTE ranged from 0.6 to 1.0, with the majority of RNs working at least 0.8 FTE. The casual RNs work at least one weekend per month and pick up shifts during the week as desired. Before the end of the project, 2 FTE RNs had left the agency, but it was unclear if they participated in the pre-intervention survey due to the anonymous nature of the survey.

Procedure

The project was conducted from January 2021 to April 2021. Upon starting the project, participating RNs were provided with informed consent. Participation was voluntary for each bundle piece but strongly encouraged by department leadership. Incentives included paid education hours and qualifications for \$200 through the employee wellness program for completing parts of the bundle. The risk of harm to RNs or patient care was low as interventions did not create a heavier workload for the nurses.

Intervention

See Table 1 for a summary of the four interventions chosen for this project's resiliency bundle, based on the literature review themes. Implementation of the bundle involved providing basic resiliency training for all HC nurses, incorporating gratitude into the morning huddle phone call with nurses, integrating stories into the monthly staff meetings, and starting a department wellness committee.

The resiliency modules were promoted at regular intervals during implementation. Each module was broken into three parts, requiring 15-20 minutes to complete each section. It was

recommended that participants give themselves multiple days to go through each section, to practice exercises suggested within the previous section.

During the Monday through Friday, 3–5-minute, morning phone huddle, participants were encouraged to call out one thing they were grateful for that day. Participation was voluntary and the process was evaluated halfway through implementation to check participant feedback and make changes if needed. Starting a wellness committee was promoted at all staff meetings, and two employees volunteered to lead the committee, with the focus on connecting with co-workers outside of work. At each staff meeting, one nurse shared a 2–5-minute story about a clinical experience he or she had.

Outcome Measures

Outcomes were measured using an online survey at baseline and 3 months. The survey included four questions related to resiliency-decompression and nine questions on burnout. The post-implementation survey also included four questions requesting feedback on the interventions, so to see if parts of the bundle were more meaningful than others. The resiliency-decompression questions were on a five-point Likert scale, where 1 equaled “strongly disagree” and 5 equaled “strongly agree”. These specific questions have been validated as part of a larger resilience survey to be a consistent technique for determining resilience in health care workers (Morgan et al., 2019). The burnout questions were from the abbreviated Maslach Burnout Inventory (MBI), a validated tool for identifying the three main domains of burnout, and included 3 questions for each domain (EE, DP, PA; Riley et al., 2018). The MBI questions were scored on a seven-point Likert scale, ranging from “never” (0) to “every day” (6). The MBI is copyrighted through Mind Garden, Menlo Park, California, USA, and a license was purchased to use the survey (Maslach & Jackson, 2016). See Figure 1 for an example of survey questions.

Surveys were completed anonymously through a Survey Monkey platform. Participants received the surveys via an email link and reminders were given at staff meetings and through follow-up emails. Participants were asked to create a code to use with both surveys, to match pre-and post-implementation data. The post-intervention survey was completed 3 months after implementation began.

Data Analysis

Quantitative data analysis was done with a university statistician, using JMP software (2019). A paired t-test and a Wilcoxon Signed-Rank Test (non-parametric) were used to determine any statistically significant differences between the pre-and post-intervention data. Statistical significance was set at $p \leq .05$. Total individual resiliency scores could range from 4-20, with higher values indicating greater resiliency. The MBI scored 0 to 18 for each 3-question subscale domain. The total burnout score was calculated by adding the sums of the EE and DP scores with the reverse of the PA scores, as a lower PA signifies greater burnout.

Results

Of the 16 RNs invited to complete the survey, 14 RNs completed the pre-survey, and 11 completed the post-survey. Ten RNs completed both surveys, so $n = 10$ was used for any change score analysis. No demographic information was gathered from the participants to protect anonymity in the small department. Table 2 displays descriptive statistics of the survey results, including pre-and post-intervention and the change between the two scores.

Pre-implementation resiliency scores showed a mean of 11.79 with a standard deviation of 3.7 ($n = 14$). The mean resiliency score post-implementation was slightly higher at 12 with a standard deviation of 4.1 ($n = 11$). When looking at the change between the post and pre-implementation, results showed more positive change scores ($n = 7$) versus negative ($n = 3$). The

mean resiliency change score (post minus pre) was 0.9, with a standard deviation of 2.5 ($n = 10$). The Wilcoxon two-tailed p -value was .4375, thus no statistically significant change in resiliency occurred.

Looking at the EE burnout domain (3 questions), the pre-implementation participants displayed a mean score of 8.4 and standard deviation of 3.3 ($n = 14$). The post-implementation sample showed a mean score of 7.6 and standard deviation of 3.0 ($n = 11$). The mean change score for EE was -1.5, with a Wilcoxon p -value of .2813 ($n = 10$). Participants displayed low DP burnout at baseline ($M = 1.5$, $SD = 1.65$, $n = 14$) and this did not change significantly after implementation ($M = 1.6$, $SD = 2.3$, $n = 11$; $p = .98$). Finally, the PA burnout score improved but not significantly from pre-implementation ($M = 14.64$, $SD = 3.97$, $n = 14$) to post-implementation ($M = 16.18$, $SD = 1.9$, $n = 11$), with a mean change score of 0.6 ($n = 10$) and Wilcoxon p -value of .1484. For overall burnout, the higher the score the greater the burnout. Results showed a decrease in total burnout from pre-implementation ($M = 16.29$, $SD = 3.6$, $n = 14$) to post-implementation ($M = 14.09$, $SD = 4.6$, $n = 11$); however, like with the individual domains, there was no significant change found ($M = -2.1$, $SD = 4.8$, $n = 10$, $p = .2891$).

One hundred percent of the sample ($n = 11$) participated in the gratitude bundle piece; 7 nurses found the strategy meaningful to their work, and 8 thought the strategy should be continued in the department. Four nurses (36%) completed one or more online resiliency modules; 2 nurses thought the modules were meaningful to their work, and 7 nurses thought the bundle piece should be continued in the department. Nine nurses (81%) participated in the storytelling bundle piece, and 11 (100%) thought storytelling should be continued in the department. Over 80% of the nurses participated in two parts of the bundle. Results showed 1 nurse (9%) participated in the wellness committee, but 7 (63%) wanted the committee to

continue. The most common combination of interventions was the gratitude moment and story sharing (n = 7, 63.3%). Two out of the 11 post-survey respondents identified participating in 3 parts of the bundle, and only 1 participant said they took part in all 4 bundle interventions.

Discussion

The purpose of this study was to improve resiliency and decrease burnout in HC nurses through the implementation of a resiliency bundle. The results did show some improvement in resiliency and burnout; however, the data did not reveal a statistically significant change in resiliency or burnout scores after implementation. Of note, the DP burnout score was low for participants before implementation, so seeing no significant change in these scores after starting the resiliency bundle was expected.

The gratitude moment strategy was incorporated into a work process already utilized by all participants (morning phone huddle), and feedback was overall positive, as 8 out of the 11 nurses who completed the post-survey wanted to continue using the bundle piece. This moment to express gratitude created an unexpected connection with co-workers for which many nurses voiced appreciation. Sharing stories was also well-received, with 100% of participants wanting to see stories continue to be incorporated during staff meetings. Nurses naturally share clinical stories with co-workers, but COVID-19 made this more difficult for the HC department due to all meetings being held remotely. Even though there was no statistically significant change seen using story in the resiliency bundle, nurses found it meaningful and wanted to see it continued to be used.

There were limitations to the study, including a small sample size. The COVID-19 pandemic limited the bundle choices to those that allowed for social distancing and working remotely. The short implementation period may have limited the ability to see meaningful

change in resiliency and burnout as these outcomes, by nature, do not change overnight. Due to work constraints in the department, the wellness committee did not get started until 2 weeks prior to when the post-survey was completed, so participants had limited opportunity to utilize this resource during the implementation phase. At the same time, 63% of participants stated they would like to see the wellness committee continued.

Conclusion

The COVID-19 pandemic and all its added stress has undoubtedly tested nurses' resiliency and put them at an increased risk of burnout. HC nurses have distinctive challenges working in such an independent work setting. One of the benefits of a resiliency bundle is the versatility it offers to a diverse work environment. Offering a variety of resiliency-building aids for nurses provides a potentially stronger support system for entire departments. Even though the sample size was small and no significant change in resiliency or burnout was found in this study, findings can be used to further study resiliency building in HC nurses. It would be valuable to study resiliency-building interventions in the same population for a greater length of time. Leadership should take burnout risk in HC nurses seriously and look for innovative ways to promote resiliency within nurses. There is little found in the literature about interventions to improve burnout in HC nurses; therefore, further research is needed to examine how to better support this unique nursing role.

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Table 1**Summary of Bundle Interventions Based on Literature**

| Intervention Theme | Application to Project | References |
|---------------------------|---|--|
| Resiliency education | <ul style="list-style-type: none"> • Basic resiliency presentation at staff meeting provided by hospital wellness coordinator • Encouraged two free online resiliency courses: “Find purpose and meaning”; “Bring your best self to work” (Health Partners, 2020) | Grabbe et al. (2020), Health Partners (2020), Low et al. (2019), Magtibay et al. (2017) Sullivan et al. (2019) Vaclavik et al. (2018) |
| Gratitude exercises | <ul style="list-style-type: none"> • Moment of gratitude shared during Monday- | Adair et al. (2020) Guo et al. (2020) Luo et al. (2019) |

| | | |
|----------------------------|---|--|
| | Friday morning huddle | |
| Connecting with co-workers | <ul style="list-style-type: none"> Initiated a wellness committee in the department: responsible for organizing staff gatherings outside work, along with other ways to support each other | Brown et al. (2018), Lee et al. (2015), Vaclavik et al. (2018) |
| Storytelling | <ul style="list-style-type: none"> Highlighted a nurse's clinical story during monthly staff meetings | Reich (2011) |

Table 2

Change in Scores of Participants' Report of Resiliency and Burnout Domains

| Domain | Pre-Intervention (n = 14) | | Post-Intervention (n = 11) | | Change (n = 10) | | |
|---|------------------------------|----------|-------------------------------|----------|--------------------|----------|----------|
| | Mean (SD) | Range | Mean (SD) | Range | Mean (SD) | Range | <i>p</i> |
| Resiliency* (4 questions) | 11.79 (3.704) | 7 to 20 | 12 (4.147) | 5 to 19 | 0.9 (2.514) | -1 to 7 | 0.4375 |
| Burnout** – EE (3 questions) | 8.429 (3.322) | 2 to 14 | 7.636 (3.009) | 4 to 12 | -1.5 (3.659) | -10 to 3 | 0.2813 |
| Burnout** – DP (3 questions) | 1.5 (1.653) | 0 to 4 | 1.636 (2.335) | 0 to 7 | 0 (2.585) | -4 to 5 | 0.9844 |
| Burnout*** – PA (3 questions) | 14.64 (3.973) | 2 to 18 | 16.18 (1.888) | 12 to 18 | 0.6 (1.35) | -1 to 2 | 0.1484 |
| Total Burnout** (9 questions) | 16.29 (3.604) | 11 to 22 | 14.09 (4.614) | 7 to 23 | -2.1 (4.818) | -14 to 3 | 0.2891 |
| <p>*higher values = greater resiliency</p> <p>**higher values = greater burnout</p> <p>***higher values = less burnout</p> <p>EE = emotional exhaustion; DP = depersonalization; PA = personal accomplishment; <i>p</i>-value = Wilcoxon Signed-Rank Test</p> | | | | | | | |

