

Date 10/31/2012

Title Building Resiliency in Nurses

Clinical Question

- P (Population/Problem) *Among critical care nurses*
- I (Intervention) *does receiving resiliency training* plus standard orientation*
- C (Comparison) *compared to standard orientation* alone*
- O (Outcome) *improve nurse satisfaction and decrease nurse turnover?*

[Definitions for terms marked with * may be found in the Supporting Information section.](#)

Target Population for the Recommendation

Nurses working in a critical care environment

Recommendation

It is recommended that resiliency education be provided to nurses in a critical care environment to increase job satisfaction (Loprinzi et al. 2011 [2a], Sood et al. 2011 [2a], Steinhart et al. 2008 [2b], Burton et al. 2010 [4a], Pipe et al. 2012 [4a], Waite et al. 2003 [2b]) and decrease nurse turnover (Pipe et al. 2012 [4a]).

Discussion/Synthesis of Evidence Related to the Recommendation

One article answered the PICO question directly. Pipe et al. (2012 [4a]) studied the effects of implementing a resiliency education program with oncology nurses and their management and saw a decrease in job turnover. Waite et al, (2003 [2b]) saw an increase in job satisfaction, although the difference was not statistically significant.

Evidence exists in other populations similar to that of nurses. Steinhart et al (2008[2b]) studied resiliency training in college students while Sood et al (2011 [2a]) studied physicians, both in high stress environments. Studies that implemented a resiliency education program showed a significant increase in positive affect and decrease in stress levels (Loprinzi et al. 2011 [2a], Sood et al. 2011 [2a], Steinhart et al. 2008 [2b], Burton et al. 2010 [4a], Pipe et al. 2012 [4a]).

Reference List (Evidence Level in []; See [Table of Evidence Levels](#))

Burton, N., Pakenham, K., Brown, W. (2010). Feasibility and effectiveness of psychosocial resilience training: A pilot study of the READY program. *Psychology, Health, and Medicine*, 15 (3), 266-277 [4a].

Loprinzi, C., Prasad, K., Schroeder, D., Sood, A. (2011). Stress management and resilience training (SMART) program to decrease stress and enhance resilience among breast cancer survivors: A pilot randomized clinical trial. *Clinical Breast Cancer*, 11 (6), 364-368 [2a].

Pipe, T., Buchda, V., Launder, S., Hudak, B., Hulvey, L., Karns, K., Pendergast, D. (2012). Building personal and professional resources of resilience and agility in the healthcare workplace. *Stress and Health*, 28, 11-22 [4a].

Sood, A., Prasad, K., Schroeder, D., Varkey, P. (2011). Stress management and resilience training among department of medicine faculty: A pilot randomized clinical trial. *Journal of General Internal Medicine*, 26(8), 858-861 [2a].

Steinhart, M. & Dolbier, C. (2008). Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. *Journal of American College Health*, 56 (4), 445-453 [2b].

Waite, P. & Richardson, G. (2003). Determining the efficacy of resiliency training in the work site. *Journal of Allied Health*, 33, 178-183 [2b].

IMPLEMENTATION

Applicability Issues

To implement a resiliency program many things are needed. The chosen program will need to be developed from appropriate sources, and an educator trained in the appropriate chosen program would be needed. Time to implement the program may fit into the regularly scheduled orientation program, which already requires classroom time for skills and education. Resiliency education may also be implemented as multiple, short sessions with follow up as appropriate.

Relevant CCHMC Tools for Implementation

No CCHMC Tools for Implementation were found.

Outcome or Process Measures

Resiliency education may be tracked and evaluated within the orientation process. Criteria that may be monitored include job satisfaction, perceived stress, positive outlook and job turnover. Job satisfaction is already measured yearly, via nurse satisfaction surveys. Stress and positive outlook will be measured using published scales that have been tested in the literature. Job turnover will be measured from data already collected by management as part of unit outcomes.

SUPPORTING INFORMATION

Background/Purpose of BEST Development

The Bone Marrow Transplant Unit is an environment of high stress and difficult situations. Bone marrow transplant nurses are the front line in dealing with critically ill and sometimes dying patients. They also must be prepared to work with frustrated parents in an already demanding environment. The dynamic of family centered care can often be overwhelming and taxing on the new transplant nurse.

The most recent and costly problem is a high rate of nurse turnover to other departments or other facilities. This high stress environment also attributes to low morale, dissatisfied employees, and a negative outlook on life. As nurses start on the unit, it is often difficult to find coping strategies to help deal with the stress of the job. Stress management, resiliency techniques, and positive psychology are often overlooked in nursing education; however knowledge of these skills should benefit nursing in stressful situations. Implementing a resiliency training program during orientation, will help nurses learn coping skills and other techniques that will greatly impact the environment and patient care on the unit.

Definitions

Resiliency Training: a program to educate nursing staff on skills that will improve their coping skills and personal resiliency.

Standard Orientation: Orientation program already in process on the unit which includes education on skills and disease processes but lacks personal coping mechanisms.

Search Strategy

Databases: Medline/PubMed, CINAHL

Search Terms: Resilience, job satisfaction, new graduate nurses, resilience education, nurse turnover, nurses, and resilience intervention

Limits, Filters, Search Dates: 1/2012-7/2012; No filters or limits used

Date of last search: 7/17/2012

Relevant CCHMC Evidence-Based Documents

None were found

Group/Team Members

Team Leader/Author: Pamela Copass, MSN, RN, CNL, CPN, Blood and Marrow Transplant

Support/Consultant: Mary Ellen Meier MSN, RN, CPN, Center for Professional Excellence; Evidence-Based Practice Mentor

Ad Hoc/Content Reviewers: Laura Flesch, MSN, RN, CNP, Blood and Marrow Transplant; Clinical Director

Conflicts of Interest were declared for each team member and:

- No financial or intellectual conflicts of interest were found.
- No external funding was received for development of this BEST.
- The following conflicts of interest were disclosed:

Note: Full tables of the [LEGEND evidence evaluation system](#) are available in separate documents:

- [Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality](#) (*abbreviated table below*)
- [Grading a Body of Evidence to Answer a Clinical Question](#)
- [Judging the Strength of a Recommendation](#) (*dimensions table below*)

Table of Evidence Levels (*see note above*):

Quality level	Definition
1a [†] or 1b [†]	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

[†]a = good quality study; b = lesser quality study

Table of Language and Definitions for Recommendation Strength (see note above):

Language for Strength	Definition
It is strongly recommended that... It is strongly recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. (or visa-versa for negative recommendations)
It is recommended that... It is recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation...	
<i>Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group. (Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)</i>	
Rationale for judgment and selection of each dimension:	
1. Grade of the Body of Evidence	<input type="checkbox"/> High <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Low <i>Rationale:</i>
2. Safety/Harm (Side Effects and Risks)	<input checked="" type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <i>Rationale:</i>
3. Health benefit to patient	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Minimal <i>Rationale: Nurse job satisfaction can improve quality of care delivered to patient.</i>
4. Burden on patient to adhere to recommendation	<input type="checkbox"/> Low <input type="checkbox"/> Unable to determine <input type="checkbox"/> High <i>Rationale: not applicable</i>
5. Cost-effectiveness to healthcare system	<input checked="" type="checkbox"/> Cost-effective <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not cost-effective <i>Rationale:</i>
6. Directness of the evidence for this target population	<input type="checkbox"/> Directly relates <input checked="" type="checkbox"/> Some concern of directness <input type="checkbox"/> Indirectly relates <i>Rationale:</i>
7. Impact on morbidity/mortality or quality of life	<input checked="" type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <i>Rationale:</i>

Copies of this Best Evidence Statement (BEST) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.

Website address: <http://www.cincinnatichildrens.org/service/i/anderson-center/evidence-based-care/bests/>

Examples of approved uses of the BEST include the following:

- Copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- Hyperlinks to the CCHMC website may be placed on the organization's website;
- The BEST may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- Copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at EBDMinfo@cchmc.org for any BEST adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

Please cite as: Copass, P; Cincinnati Children's Hospital Medical Center: Best Evidence Statement Building Resiliency in Nurses, <http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm>, BEST 144, pages 1-5, 10/31/12.

This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BEST has been in place for five years, the development team reconvenes to explore the continued validity of the guideline. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff perform a quarterly search for new evidence in an horizon scanning process. If new evidence arises related to this BEST, authors are contacted to evaluate and revise, if necessary.

For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at EBDMinfo@cchmc.org.

Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.