

Best Evidence Statement (BESt)

Date: March 25, 2013

Title: Team Building and Mentoring for Increased Satisfaction and Retention

Clinical Question:

P (Population/Problem) Among nurses providing care or education in any care setting

(Intervention) does participation in a mentoring program and/or team building activities
(Comparison) compared to current practice (no mentoring program; no team building events)

O (Outcome) improve nurse satisfaction and retention?

Definitions for terms marked with * may be found in the Supporting Information section.

Target Population for the Recommendation:

Nurses providing care or education in any care setting

Recommendations:

It is recommended that nurses participate in a mentor program to increase job satisfaction and retention (Allen, Eby, Poteet, Lentz & Lima, 2004 [1b]; Thomas & Lankau, 2009 [4a]; Hayes et al, 2005 [5a]; Latham, Ringl & Hogan, 2011 [4a]; Cottingham, DiBartolo, Battistoni & Brown, 2011 [4b]; Greene & Puetzer, 2002 [5b]).

It is recommended that nurses participate in team building activities to increase job satisfaction and retention (Kalisch, Curley & Stefanov, 2007 [4a]; DiMeglio et al 2005 [4b]; Hayes et al, 2005 [5a]; Birx, LaSala & Wagstaff, 2011 [4b]; Barrett, Piatek, Korber & Padula, 2009 [4b]; Horak, Hicks, Peelicciotti & Duncan, 2006 [5b]; Pipe et al, 2012 [4a]; Medland, Howard-Ruben & Whitaker, 2004 [5b]).

Discussion/Synthesis of Evidence related to the recommendations:

The literature; including one meta-analysis, 2 descriptive studies, one longitudinal study, and 2 case study/expert opinions; shows that mentorship improves satisfaction and retention of nurses (Allen, Eby, Poteet, Lentz & Lima, 2004 [1b]; Thomas & Lankau, 2009 [4a]; Hayes et al, 2005 [5a]; Latham, Ringl & Hogan, 2011 [4a]; Cottingham, DiBartolo, Battistoni & Brown, 2011 [4b]; Greene & Puetzer, 2002 [5b]).

Mentoring of protégés, career-related mentoring, non-supervisory mentoring and a program called SMaRT (Support Mentorship and Respect Together in Nursing) increased nurse satisfaction and retention (Allen et al, 2004 [1b]; Thomas et al, 2009 [4a]; Hayes et al, 2005 [5a]).

Implementation of a mentor program along with shared governance, a mentor program for new nurse graduates, and a mentor program for newly hired nurses increased nurse retention rates (Latham et al, 2011 [4a]; Cottingham et al, 2011 [4b]; Greene et al, 2002 [5b]).

The literature; including 3 descriptive studies, 2 longitudinal studies, and 3 case study/expert opinions; shows that team building interventions improve satisfaction and retention of nurses (Kalisch, Curley & Stefanov, 2007 [4a]; DiMeglio et al 2005 [4b]; Hayes et al, 2005 [5a]; Birx, LaSala & Wagstaff, 2011 [4b]; Barrett, Piatek, Korber & Padula, 2009 [4b]; Horak, Hicks, Peelicciotti & Duncan, 2006 [5b]; Pipe et al, 2012 [4a]; Medland, Howard-Ruben & Whitaker, 2004 [5b]).

Formation of focus groups regarding teamwork, values, vision, and goal development and formation of guiding teams increased staff teamwork and decreased staff turnover and vacancy rates (Kalisch et al, 2007 [4a]). Team building sessions, an Oncology Nurse Leadership Advisory Group, and an ambulatory nurse retreat increased satisfaction of both new and seasoned nurses and decreased staff turnover (DiMeglio et al, 2005 [4b]; Hayes et al, 2005 [5a]).

A team building retreat for nurse faculty and a team building intervention of lateral violence and communication training for nurses increased nurse faculty and nurse satisfaction (Birx et al, 2011 [4b]; Barrett et al, 2009 [4b]). The

team building retreat for nurse faculty can be generalized for use with nurses because it focused on job satisfaction and group cohesion. Team building meetings that included team building exercises, ground rules for working together, agendas devoted to professional development and engagement, and facilitation of communication also resulted in increased nurse satisfaction as measured on an annual employee survey (Horak et al, 2006 [5b]).

Stress reduction workshops that focused on stress levels, teamwork and communication of hematology/oncology nurses had a large impact on nurse turnover decreasing it from 13.2% to 9.8% (Pipe et al, 2012 [4a]). A retreat that focused on mutual support to enhance the psychosocial wellness and coping skills of oncology nurses was recommended to increase staff retention (Medland et al, 2004 [5b]).

Team building can be provided to staff by way of various presentations and forums.

The grade for this body of evidence is low.

Reference List:

- Allen, T. D., Eby, L. T., Poteet, M. L., Lentz, E., & Lima, L. (2004). Career benefits associated with mentoring for proteges: A meta-analysis. Journal of Applied Psychology, 89(1), 127-136 (1b)
- Barrett, A., Piatek, C., Korber, S., & Padula, C. (2009). Lessons learned from a lateral violence and team building intervention. Nursing Administration Quarterly, 33(4), 342-351 (4b)
- Birx, E., LaSala, K. B., & Wagstaff, M. (2011). Evaluation of a team building retreat to promote nursing faculty cohesion and job satisfaction. Journal of Professional Nursing, 27(3), 174-178 (4b)
- Cottingham, S., DiBartolo, M., C., Battistoni, S., & Brown, T. (2011). Partners in Nursing: A mentoring initiative to enhance nurse retention. Nursing Education Perspectives, 32(4), 250-255 (4b)
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- Greene, M. T., & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. Journal of Nursing Care Quality, 17(1), 63-70 (5b)
- Hayes, C., Ponte, P. R., Coakley, A., Stanghellini, E., Gross, A., Perryman, S., . . . Somerville, J. (2005). Retaining oncology nurses: Strategies for today's nurse leaders. Oncology Nursing Forum, 32(6), 1087-1090 (5a)
- Horak, B. J., Hicks, K., Pellicciotti, S., & Duncan, A. (2006). Create cultural change and team building. Nursing Management, 37(12), 12-14 (5b)
- Kalisch, B., Curley, M., Stefanov, S. (2007). An Intervention to Enhance Nursing Staff Teamwork and Engagement. The Journal of Nursing Administration, 37(2), 77-84 (4a)
- Latham, C. L., Ringl, K., & Hogan, M. (2011). Professionalization and retention outcomes of a university-service mentoring program partnership. Journal of Professional Nursing, 27(6), 344-353 (4a)
- Medland, J., Howard-Ruben, J., & Whitaker, E. (2004). Fostering psychosocial wellness in oncology nurses: Addressing burnout and social support in the workplace. Oncology Nursing Forum, 31(1), 47-54 (5b)
- Pipe, T. B., Buchda, V. L., Launder, S., Hudak, B., Hulvey, L., Karns, K. E., & Pendergast, D. (2012). Building personal and professional resources of resilience and agility in the healthcare workplace. Stress and Health, 28(1), 11-22 (4a)
- Thomas, C. H., & Lankau, M. J. (2009). Preventing burnout: The effects of LMX and mentoring on socialization, role stress, and burnout. Human Resource Management, 48(3), 417-432 (4a)

IMPLEMENTATION

Applicability Issues:

Management and staff collaboration is essential to establish the criteria required to become a mentor and to design how the mentorship program will work. A process for matching new staff with a mentor and the appropriate length of the mentorship needs to be identified. The development of a guideline for managing the mentorship program is needed.

Team building sessions or retreats will need to be planned. Staff input on what the sessions should include can make the sessions more useful and successful (Kalisch et al, 2007 [4a]). A person or team to facilitate the sessions must be identified. A location and schedule for the team building sessions needs to be identified and convenient for staff to attend. Multiple sessions will need to be available for nursing staff to support the programs sustainability (Birx et al, 2011 [4b]; Kalisch et al, 2007 [4a]; Pipe et al, 2012 [4a]). The human resources department or other hospital wide staff education resources can be utilized for facilitation of team building interventions.

The planning and implementation of both interventions will require time outside of the regular schedule.

Relevant CCHMC Tools for Implementation:

None were found

Outcome or Process Measures:

Evaluation of the mentorship and team building programs' impact may be measured by staff satisfaction and job turnover tracking measures that are already in place along with the use of other valid and reliable pre/post measurements. Cost effectiveness of the programs may be measured by comparing the cost of planning and implementation with the cost of replacing a nurse who left a position.

SUPPORTING INFORMATION

Background/Purpose of BESt Development:

Nurses working on the inpatient and outpatient units within the division of the Cancer and Blood Disease Institute face many challenges due to the complexity of the patients for which they care. The overall stress of caring for such patients and their families can lead to nurses losing sight of the importance of caring for and supporting each other. Animosity between and lack of support for fellow nurses creates communication breakdown, poor collaboration, and ultimately decreased job satisfaction and high turnover.

Designing and implementing structured and formal programs that provide an opportunity for the development of high quality professional and social relationships among nurses may lead to high job satisfaction and low turnover rates.

Definitions:

<u>Mentor</u>: One who is a source of learning for a protégé who also plays a key role in the protégé's career development, self-esteem and work identity (Allen et al, 2004 [1b])

One who provides personal and emotional guidance, coaching, advocacy, career development, role modeling, strategies and systems advice, learning facilitation, and friendship (Latham et al, 2011 [4a])

An experienced and competent staff nurse who serves as a role model and resource person to a new staff member. The mentor commits to a longitudinal, one-year, supportive relationship with the new staff member (different from a preceptor) (Greene et al, 2002 [5b])

Team building: Providing a group with the means to create group cohesion

<u>Group Cohesion</u>: The way that a work group functions and rests on the ability of the members to communicate, share responsibility in getting the work done, and feel as if they belong to the group (DiMeglio et al, 2005 [4b])

A situational support mechanism that assists in problem solving and enhances personal and professional integrity (DiMeglio et al, 2005 [4b])

Current practice: Preceptors for new staff. Shared governance and staff meetings

Patient Services/Nursing Satisfaction and Retention/Team Building and Mentoring/BESt 162

Search Strategy:

Databases: Medline/PubMed, CINAHL, OhioLink, Google Scholar

Search Terms: Nurse relationships, communication, team building, group cohesion, healthy work environment, retreat,

professional socialization, nurse retention, job satisfaction, nurse, mentor(s)

Filters: English language; no date limit Search Dates: July 2012, November 2012

Relevant CCHMC Evidence-Based Documents:

BESt: Building Resiliency in Nurses

http://www.cincinnatichildrens.org/workarea/linkit.aspx?linkidentifier=id&itemid=101413&libid=101108

BESt: Retention and Staff Satisfaction on Blood and Marrow Transplant Unit

http://www.cincinnatichildrens.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88040&libID=87728

Group/Team Members:

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Conflicts of Interest were	declared for	each team	member:
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\boxtimes	No financial or intellectual conflicts of interest were found.
\boxtimes	No external funding was received for development of this BESt.
	The following conflicts of interest were disclosed:

Note: Full tables of the <u>LEGEND evidence evaluation system</u> 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
- <u>Judging the Strength of a Recommendation</u> (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):

Table of Language and Deminions I	or recommend	acion ser engen (see me	ote above,		
Language for Strength	Definition				
It is strongly recommended that			ngth of the evidence are applied	t,	
It is strongly recommended that not	there is high support that benefits clearly outweigh risks and burdens.				
	(or visa-versa for negative recommendations)				
It is recommended that	l .		ngth of the evidence are applied		
It is recommended that not	there is moderate	support that benefits are	e closely balanced with risks ar	ıd burdens.	
There is insufficient evidence and a lack of	consensus to make	a recommendation			
Given the dimensions below and that more	answers to the left	of the scales indicate sup	pport for a stronger recommend	dation, the	
recommendation statement above reflects					
(Note that for negative recommendations,			or more dimensions.)		
Rationale for judgment and selection	of each dimension	n:			
1. Grade of the Body of Evidence		High	☐ Moderate	Low	
Rationale:			-		
2. Safety/Harm (Side Effects and Risks)	<u> </u>	Minimal	Moderate	Serious	
Rationale: (See below # 3)	<u>/</u>		Woderate	i Scrious	
•				· — .	
3. Health benefit to patient		Significant	☐ Moderate	Minimal	
Rationale: Mentoring has been shown					
Mentoring can also enhance the profe			nurse retention and patient ca	re outcomes, especially as	
mentoring becomes part of the hospit					
Many of the competent, proficient, an	d expert clinicians v	vho sought out the ment	or role reported being "reinvig	orated" and less burned	
out (Latham et al, 2011 [4a]).					
Team building allows RNs to identify b			ng ineffective and negative cor	nmunication, generational	
differences, peer competence and acc				□ III:=h	
4. Burden on patient to adhere to reco	ommendation	⊠ Low	Unable to determine	L High	
Rationale:					
5. Cost-effectiveness to healthcare sys	stem	Cost-effective	⊠Inconclusive	☐ Not cost-effective	
Rationale: Consequences associated w	ith turnover, such a	s the cost of advertising	and recruiting, subsequent ret	raining of new staff, cost of	
lost productivity and organizational kn	owledge (Cottingha	ım et al, 2011 [4b]).		-	
6. Directness of the evidence for this t	arget	Directly relates	Some concern of	Indirectly relates	
population			directness		
Rationale: Literature search results inc	luded mentoring fo	r nurses, oncology nurse	s, employees in a healthcare se	etting, and general career	
protégés					
Literature search results included team building for nurses, oncology nurses, NICU nurses, and nurse faculty					
7. Impact on morbidity/mortality or q		High	Medium	Low	
Rationale: The evidence shows that te		<u>. — </u>	rategies for increasing nurse sa	tisfaction and retention	
(Allen, Eby, Poteet, Lentz & Lima, 2004 [1b]; Barrett, Piatek, Korber & Padula, 2009 [4b]; Birx, LaSala & Wagstaff, 2011 [4b]; Cottingham,					
DiBartolo, Battistoni & Brown, 2011 [4b]; DiMeglio et al, 2005 [4b]; Greene & Puetzer, 2002 [5b]; Hayes et al, 2005 [5a]; Horak, Hicks,					
Pellicciotti & Duncan, 2006 [5b]; Kalisch, Curley & Stefanov, 2007 [4a]; Latham, Ringl & Hogan, 2011 [4a]; Medland, Howard-Ruben &					
Whitaker, 2004 [5b]; Pipe et al, 2012 [4a]; Thomas & Lankau, 2009 [4a]).					

Patient Services/Nursing Satisfaction and Retention/Team Building and Mentoring/BESt 162

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/j/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: Sandfoss, E. Cincinnati Children's Hospital Medical Center: Best Evidence Statement Team Building and Mentoring for Increased Satisfaction and Retention, http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm, BESt 162, pages 1-6, 3/25/13.

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 performs a quarterly search for new evidence in a 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.