12-6-2022

Effects of Resilience Coaching on Behavioral Health Nurse Burnout

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A Dissertation Submitted to The Graduate School at the University of Missouri- St. Louis

in partial fulfillment of the requirements for the degree Doctor of Nursing Practice

with an emphasis in Psychiatric Mental Health Nurse Practitioner

May 2023

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Abstract

Background: Inpatient, staff nurse burnout negatively impacts nurses' mental and physical health, hospital nurse retention and turnover, and patient care. The Stress First Aid for Health Workers program attempts to bolster resilience and subsequently reduce burnout among mental health nurses in this project.

Method: This quality improvement (QI) project was an observational pre-post survey design and was conducted on a cohort sample of inpatient, behavioral health nurses at an urban, mid-sized, Midwestern hospital psychiatric unit to assess personal, work-related, client-related, and overall burnout utilizing the Copenhagen Burnout Inventory (CBI) tool to quantitatively measure burnout pre- and three months post-implementation of the Stress First Aid education.

Results: Due to the small sample size, with an $n = 7$, and the ordinal nature of the CBI data, the exact sign test was utilized did not indicate a statistically significant difference between pre/post survey median results for personal burnout ($p = 1.00$), work-related burnout ($p = .453$), client-related burnout ($p = 1.00$), and overall burnout ($p = .219$) However, percentage reduction indicated clinical significance with a pre/post-intervention reduction of 23.5% for personal burnout, 8.7% reduction for work-related burnout, 17.6% reduction for client-related burnout, and 13% reduction for burnout overall.

Conclusion: This QI project accomplished the aim of reducing burnout by 13% post SFA intervention after three months. Limitations of this project include small sample size, poor pairing of pre- and post-intervention data and strengths were the adaptability and cost-effectiveness of the intervention. Implications for future practice include

assessing SFA's impact on nurse retention and turnover rates and recommendations for the future include a more robust sample size, more careful pairing of data, and a follow up session among participants.

Effects of Resilience Coaching on Behavioral Health Nurse Burnout

Nursing staff burnout is related to low job retention, high nurse turnover, decreased patient safety, and decreased healthcare quality (Nevill & Havercamp, 2018; Johnson et al., 2018). Financially, low nurse retention rates have been linked to higher inpatient spending costs (Nurse Solutions [NSI], 2021). High levels of stress are being reported by healthcare professionals nationwide, thus job retention, patient safety and quality healthcare are being impacted on a broad scale (Sampson et al. 2019). Work related stress, and the adverse emotional trauma that stems from it, are strongly correlated with poor resilience (Shin et al., 2018). The literature demonstrates that resilience can be bolstered to improve nurse staff's perception of work stress. Resilience improves the quality of healthcare provided by clinicians, reduces burnout and stress related to the workplace and improves job retention (Foster et al., 2018; Nevill & Havercamp, 2019). On the individual level, resilience develops attributes of faith, hope, and insight. Resilient nurses exhibit intelligence, self-confidence, flexibility, and resourcefulness (Ramalisa et al., 2018). Therefore, enhancing resilience among nursing staff is an imperative commitment within the nursing discipline.

A nurse working in the mental health field has a workplace that is uniquely high stress (Foster et al., 2018). Though all nursing tracks encounter stressors that overlap, mental health nurses experience stressors specific to or more entrenched within the specialty. Mental health nurses encounter emotional labor of caring for the mentally ill,

higher rates of violence, guilt of involuntarily detaining patients, and higher rates of mental health illness among staff who are initially attracted to the discipline (Johnson et al., 2018). At the organizational level, mental health services obtain less financial funding relative to demand when compared to physical health services (Johnson et al., 2018).

Regionally, the North Central sector nurse turnover rates for the years 2019 and 2020 were reported as 20.0% and 23.4% respectively (NSI, 2021). The hospital of focus for this project is a 584-bed facility within the North Central region with a psychiatric staff turnover year to date rate of 58.24% as of September 2021 (SSM Health, 2021). Developing resilience of both the individual and the organization is the solution experts offer in decreasing stress related to the contemporary workplace and lifestyle and increasing nurse retention (Magtibay & Chesak, 2017; Foster et al., 2018).

The purpose of this quality improvement (QI) project is to implement a resilience training course in order to reduce nursing staff burnout on a behavioral health unit. The resilience education to be used is Stress First Aid (SFA). The project will be delivered utilizing the Institute for Healthcare Improvement (IHI) Plan, Do, Study, Act (PDSA) evidence-based practice framework. The aim of this project is to decrease burnout and increase resilience among inpatient behavioral health nurses by 5% within three months with the use of a resilience education program. The primary outcome measure of interest is subjective burnout which will be gleaned from participant Copenhagen Burnout Inventory (CBI) scores. Secondary outcome measures of interest are CBI subscale scores for personal, work-related, and client-related burnout. The study questions this QI project will answer include: In behavioral health nurses in a mid-sized, urban, Midwestern hospital:

1. What (if any) change occurred in level of burnout after implementation of a resiliency

   program?

2. Did the implementation of a resiliency program reduce personal, work-related, and client-

   related burnout?

Literature Review

A literature review was conducted using CINAHL, PubMed, and Ovid MEDLINE databases The keywords for this search: *resilience, resiliency, nurs*, retention, mental health, attrition*, and *turnover* with Boolean operators AND and OR. Inclusion criteria were articles published between 2016 and 2021, articles published in English, and full-text articles. Exclusion criteria were studies published before 2016, articles not published in English, and non-full text articles. Thirty-eight publications were reviewed and 16 met criteria for inclusion in this literature review.

Nursing shortage and burnout have become critical points of focus, and in 2019 the national average nurse turnover rate was reported as 18.7% (NSI, 2021). The mental health nursing specialty, in comparison to the national average, has an even greater nurse turnover rate with an increase from 20.6% to 22.7% between the years 2019 to 2020 (NSI, 2021). Stressors that nursing staff experience on the job increase the risk of anxiety, secondary traumatic stress, burnout, and even suicide (Cooper et al., 2020). Nurses experience higher rates of substance abuse and twice as many experience symptoms of depression in comparison to the national average (Sampson et al., 2020). Job satisfaction, self-confidence, flexibility, and resourcefulness are the results of integrating resilience into nursing practice (Ramalisa et al., 2018). Resilience lends to the professional and ethical prestige of the profession (Concilio et al., 2021).

Retention's relationship to resilience has been explored by researchers within the field of nursing and beyond. No scientific consensus has been identified regarding the definition of resilience, though it is accepted as a scientific concept (Morse et al., 2021). Resilience is a concept with psychological and ecological facets (Guo et al., 2018).

Invariably, resilience is understood by its Latin root word *resilire*, which means to spring back (Cooper et al., 2020).

Resilience must be understood based on its operation within internal and external domains. Within a social-ecological lens, resilience is viewed as a personal capacity that empowers nurses to thrive in practice, understand their life's purpose, and to commit to meaningful reflections of their practice (Foster et al., 2018). An ecological lens frames resilience as an interactional process between the nurse's social and physical environment with emphasis placed on their ability to find resources that support their well-being and that of their community (Foster et al., 2018). Resilience is ultimately viewed by Foster et al. (2018) as psychological, a dynamic and interactional process of recovery from difficulty, in which adaptive responses lead to re-establishing well-being through several internal and external environmental preservative factors and self-adjusting processes.

The literature demonstrates that resilience programs operate on the foundations of mindfulness, a process that approaches stressful situations and distressing events with detachment (Nevill & Havercamp, 2019). It is a branch within the teachings of cognitive behavioral theory (CBT). Informed by the cornerstone work of Aaron Beck, a pioneer of the theory, CBT stresses the individual's cognitive interplay of externally rousing experiences and the individual's perception, which brings about emotional and behavioral responses (Sampson et al., 2020). The practice of mindfulness is a critical self-protection tool that serves to reduce the physical impact of stress and improve life enjoyment (Cain, 2021).

Emotional intelligence, an extension of CBT and mindfulness, has been indicated in the literature as a key concept in understanding resilience. Emotional intelligence is

demonstrated by identifying, managing, and finally harnessing emotions to guide

thinking and problem solving (Foster et al., 2018). Emotional regulation and emotional

intelligence live in the realm of the internal domain. The mastery of both, by the mental

health nurse, dampens the negative aspects of emotional labor, prevents burnout,

improves mental health, and enhances practice. Nurses who are able to model emotional

regulation with clients improve healthcare quality (Foster et al., 2018). Within the

theoretical approach of each study that explores resilience, basic knowledge of the terms

CBT, mindfulness, and emotional intelligence are important as they are at the foundations

in understanding the complex concept of resilience.

     Foster et al. (2018) focused on the Promoting Adult Resilience (PAR) program,

an evidenced based program that utilized a multimodal approach to build resilience. The

PAR program's aim was to promote adult resilience, bolster mental health and well-

being, enhance relationships, mitigate conflict by increasing communication at work, and

promoting the use of stress management techniques. Participants of a piloted PAR

program demonstrated improved mental health, coping, and self-efficacy. Material for the

program was developed from a CBT philosophy and the modes of dissemination were

manualized workbooks, PowerPoint, small and large group discussions, and individual

activities. The material was broken down in seven weekly modules with focus on:

recognizing strengths and understanding resilience, interpreting, and managing stress,

challenging, and modifying self-talk, drawing strength from hardship, sustaining positive

relationships, managing conflict, formulating solutions for well-being, and finally

synthesis of all concepts presented. The program was presented by accredited facilitators

in a peer group setting.

Foster et al. (2018) found that nurses felt that the PAR program strengthened their resilience by clearly identifying the definition and concept of resilience, assisting them in recognizing resilience skills they were already using, and reminding them to continue to work on areas that could use improvement. High stress events were identified as aggression from clients both verbal and physical, staff conflict or aggression, and client suicide or self-harm; overall, emotionally charged experiences. Nurse participants of the program stated that the program improved their practice by helping them reframe stressors, generate solutions to problems, and respond effectively to challenges.

Henshall et al. (2020) conducted a study with a mixed method design conducted to determine the impact of relationships and the sharing of workplace adversity experiences in enhancing personal resilience. Pre and post surveys and interviews conducted within the study gave the researchers the insight that nurses who work in highly stressful work environments at baseline already have a level of personal resilience. The nurses were able to recognize the contributions they all make and empower one another through the nurturing environment and relationships created by the program's mentorship. Participants expressed appreciation of being a part of the network the program facilitated.

Stacey and Cook (2019) completed a scoping review to determine how the interpretation of resilience impacts interventions directed at increasing resilience. The goal of a systematic scoping review is to inform research agendas and bring forth a broad overview of evidence covering a particular topic (Stacey & Cook, 2019). This study determined that one similarity among most resilience studies were that interventions employed teaching to improve understanding and reaction to stress. Additionally, most

studies noted an improvement in resilience, or some similar abstraction, post intervention. The efficacy of the interventions was viewed as a strength within the current literature. Lack of generalizability due to small sample size and oversight in examining the contextual, individual, and organizational factors involved in shaping resilience were noted weaknesses. It was concluded that the onus of developing resilience to combat the emotional ramifications of a high stress nursing environment should be addressed at the organizational level. Though the development of resilience lies within the realm of the individual's capability; the organization's ability to facilitate dialogue, create community, and foster supportive relationships was underscored.

Multiple survey instruments have been utilized in resilience intervention studies. The ability to measure clinician resilience and well-being is paramount in generating feedback about baseline and post-intervention data. The process of improving clinician well-being is a process that begins by measuring well-being, then designing and implementing an intervention, and finally reassessment of well-being through the measurement tool again (The Joint Commission, 2019). The National Academy of Medicine [NAM] (2021), has compiled a list of valid and reliable survey instruments. Included on the list is the Copenhagen Burnout Inventory (CBI).

NAM (2021) presents the CBI scale as a 19-item survey framed with positive and negative items that covers three domains—personal, work, and client-related burnout. Overall, physical, and psychological fatigue is covered by six items to measure personal burnout. Physical and psychological fatigue is covered by seven items to measure work-related burnout. Client-related burnout is covered by an additional six items. The CBI has been used in small sample studies of healthcare providers, so current data is limited,

however, nurse turnover intention, self-reported sick absences, and intention to quit work have been health system characteristics associated with CBI scores (NAM, 2021).

The National Center for Posttraumatic Stress Disorder [PTSD], (2021) has created Stress First Aid (SFA) resources. SFA was developed to improve individual stress reactions and to assist in improving stress reactions of colleagues. The SFA model helps participants recognize stress reactions within themselves and others and diminish the impact of stress outcomes that can develop into long-term issues (The National Center for PTSD, 2021). SFA has been crafted to meet the needs of several high-stress occupations including healthcare.

Quality improvement (QI) allows for SFA to be integrated into practice on the behavioral health unit to bring about meaningful change. Melynk et al. (2019) articulates that the process of QI promotes the use of interventions to be trialed in a planned environment, to ultimately determine the interventions impact on a desired aim. The Plan, Do, Study, Act (PDSA) cycle more specifically is used to guide action-oriented learning that fuels evidence-based practice (Melynk et al., 2019). PDSA is a pillar of QI and a resulting feature of PDSA is gained knowledge of an intervention's impact (Melynk et al., 2019). Therefore, implementation of SFA on a behavioral health unit employing the PDSA cycle is an appropriate means to increase nurse resilience and decrease burnout.

Methods

Design

The overall approach used for this project was that of a quality improvement process with an observational pre-post program implementation design that was conducted on a cohort sample of inpatient, behavioral health nurses. Outcome measures

included the Copenhagen Burnout Inventory scores which served to assess change in

level of burnout one month after a resiliency program was implemented. Secondary

outcome measures included nurse burnout in personal, work and client domains. The

PDSA cycle was followed throughout this project. The project was conducted between

March 2022- October 2022.

Setting

The setting of this QI project was a 46-bed behavioral health, inpatient unit at a

mid-sized, urban Midwestern hospital that is part of a larger regional hospital system.

The unit was composed of subunits which included Intermediate, Senior, and Fragile

Care. Nurses worked 12-hour shifts, either working during the day from 7 am to 7:30 pm

or during the night from 7 pm to 7:30 am.

Sample

Participants were recruited using convenience and purposive sampling methods.

Participants were current, available behavioral health nurses employed by the hosting

behavioral health unit. Inclusion criteria for participants were: behavioral health staff

nurses, current employment on the hosting unit, and ability to complete weekly SFA

assignments. Exclusion criteria were: employment on the unit through a staffing agency,

inability to complete weekly SFA assignments, and non-behavioral health staff nurses.

Data Collection and Analysis

Demographic data was de-identified and participants created a unique identifier

that only they knew. Participants were instructed to put this identifier on each subsequent

survey for data pairing purposes. The CBI survey instrument to assess burnout and

resilience were presented before SFA implementation, and again one month after the last

SFA weekly assignment had been submitted. Once recorded, all de-identified data was saved on a password-protected computer that was only accessed by the primary investigator. Resulting data was analyzed using descriptive statistics for central tendency and inferential statistics with the exact sign test to identify any significant differences in scores.

Approval Process

Approval of this QI project was pursued by the primary investigator from the University of Missouri- Saint Louis Institutional Review Board (IRB) and the hosting hospital's IRB in November 2022. The possible risk of emotional distress, due to the primary objective of this QI effort to address personal and professional burnout, was identified and shared with both IRBs. Benefits identified and shared were improved job satisfaction and employee engagement.

Procedures

An initial meeting and presentation of this quality improvement project was given by the primary investigator with key stakeholders at the collaborating facility. Upon approval of key stakeholders, the participating hospital's IRB and the University of Missouri- Saint Louis IRB were contacted for approval.

Consent forms, demographic surveys, and pre-intervention CBI surveys were presented prior to the presentation of SFA materials to behavioral health staff nurses March 13 through 26, 2022. SFA materials were presented only by the primary investigator. Initially the SFA intervention was proposed to be delivered over the course of eight, weekly, live group sessions that would be five to eight minutes in length during pre-shift huddle report. After submission of the pre-intervention documents many

prospective participants expressed their desire for the education to be presented in a less time-consuming format. Their concern was that the sessions would affect patient care since the sessions would take them off the floor longer.

The first session was conducted live, March 27, 2022, and these participants also expressed uncertainty in their ability to attend all the sessions due to the same concerns. After consideration of the participants' apprehensions, it was decided by the primary investigator to present SFA materials as packets with written assignments for participants to complete with the packets being disseminated March 28 through April 2, 2022. Participants were instructed to submit assignments on a weekly basis in a folder kept in the locked room with no identifying information besides the unique identifiers, by Saturday of each week. Weekly topics were sequenced in the same order in each packet, so participants covered all SFA materials collectively. The duration of the SFA program was eight weeks between the dates April 3 to May 21, 2022. Finally, the post-CBI survey was administered one month after the last topic was covered between the dates of June 26 to July 8, 2022.

Results

The initial sample of this project consisted of ten behavioral health, registered nurses employed on the host unit, however, three participants' data could not be included in the data set due to improper identification of their pre- and post-results. Though participants of the project were instructed to use their unique, self-created identifiers on their pre-CBI survey, demographic survey, and post-CBI survey some were unable to remember the identifier for the post-CBI survey. Four of the ten participants used the same identifier on their pre-CBI survey and post-CBI survey. Three of the ten

participants used a different identifier on their post-CBI survey than what was used on their pre-CBI survey, but a hand-writing comparison resulted in these three sets of data being paired yet still de-identified. The remaining three sets of data could not be analyzed due to the inability to pair their CBI surveys. The sample size of participants whose data was able to be paired and analyzed totaled to seven ($n = 7$).

The sample was composed of six females (86%) and one (14%) male (see Figure 1). One (14%) participant reported being between 21 - 30 years of age, three participants (43%) reported being between the ages of 31 - 40, and one participant (14%) reported being between the ages of 71 – 80 (see Figure 2). One participant (14%) identified as black, and six participants (86%) identified as white (see Figure 3). All seven of the participants (100%) identified as non-Hispanic. Four participants (57%) marital status was reported as single, two participants (29%) were married, and one participant (14%) was divorced (see Figure 4). Of the seven participants, four (57%) worked dayshift and three (43%) worked nightshift; five participants (71%) worked full-time, and two participants (29%) worked part-time (see Figure 5); two participants (29%) reported working in behavioral health nursing one to five years, four participants (57%) worked six to ten years, and one participant worked 11 to15 years (see Figure 6). Two participants (29%) reported one – five years of behavioral health nursing experience, four participants (57%) reported six – ten years, and one (14%) reported 11-15 years of experience (see Figure 7). Of the seven participants, two participants (29%) reported having earned an associate degree as their highest level of nursing education, four participants (57%) reported having earned a Bachelor's, and one participant (14%) reported having earned a Master's degree (see Figure 8).
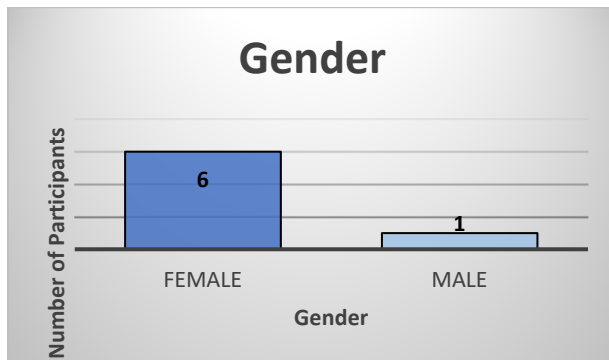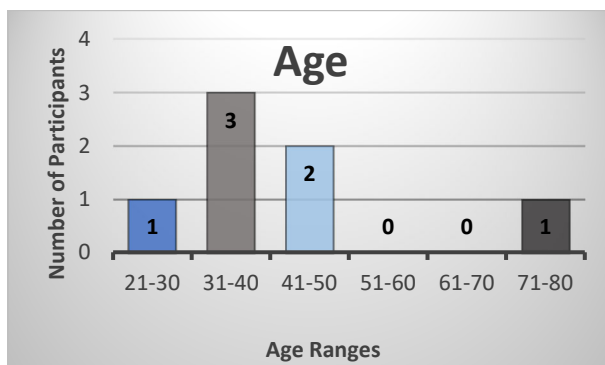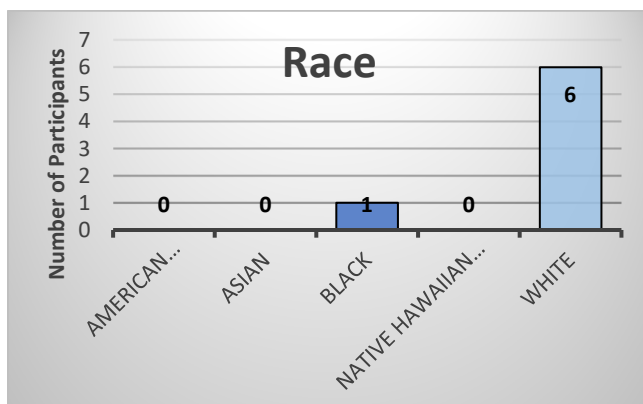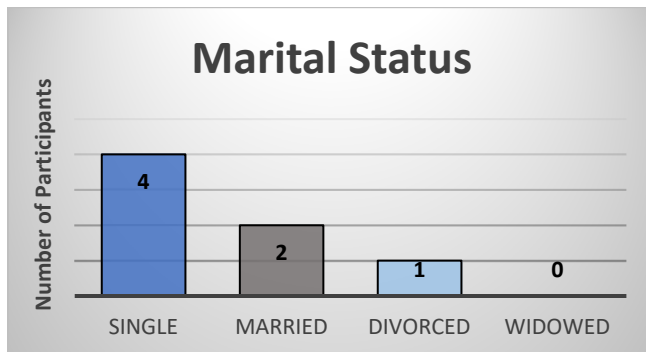
Figure 1

Gender

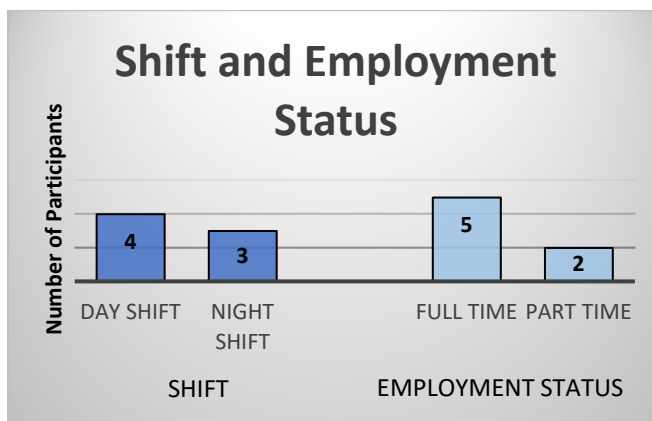
Figure 2

Age Range
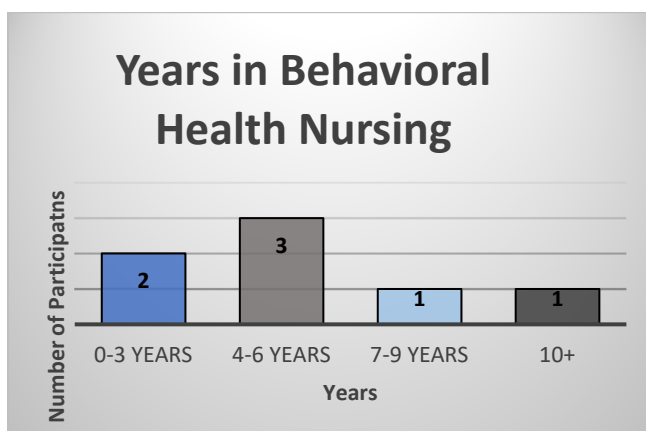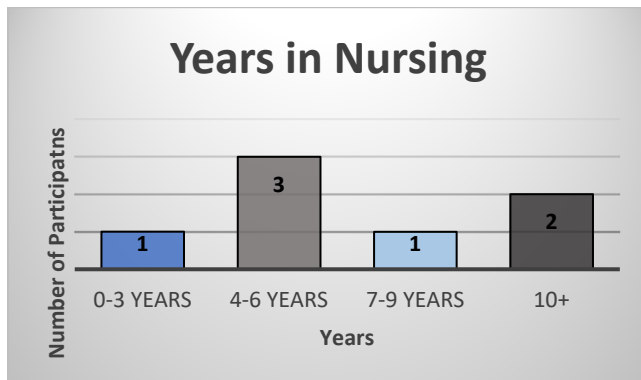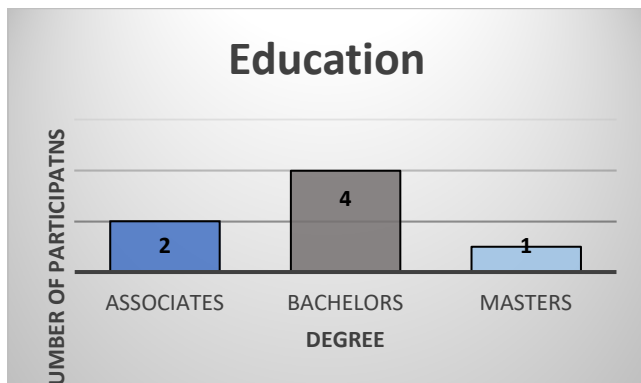

Figure 3

Race

Figure 4

Marital Status

Figure 5

Shift and Employment Status

Figure 6

Years in Behavioral Health Nursing

Figure 7

Years in Nursing

Figure 8

Education

The exact sign test was utilized for statistical analysis of the data set due to the small sample size ($n = 7$), ordinal nature, and nonsymmetric distribution of the data. The exact sign test was conducted to determine if a statistically significant relationship existed between the median of the pre- and post-CBI scores. Analysis was conducted to determine the statistical impact of the SFA intervention in four instances- total CBI score and at the three subscale CBI domain level for each participant.

Overall, of the seven participants one saw an increase in total CBI score indicating increased burnout, five saw a decrease in CBI score indicating decreased

burnout, and one experienced no change in CBI score indicating no change in burnout (see Figure 9). There was no statistically significant change in total CBI scores with a median of 54 pre-intervention and 47 post-intervention, $p = .219$ (see Figure 10). As noted, the CBI survey is comprised of three subscales, each of which were analyzed independent of the others. An exact sign test was conducted on the first subscale related to personal burnout. Data are medians unless otherwise stated. Of the seven participants, three had an increase in personal burnout score, four had a decrease in personal burnout out score, and none saw no change (see Figure 9). There was no statistically significant change in median burnout scores with pre-test median scores of 17 and post-test median score of 13, $p = 1.00$ (see Figure 10). An exact sign test was conducted on the second subscale which was work-related burnout. Of the seven participants, two experienced an increase in work-related burnout and five experienced a decrease in work-related burnout (see Figure 9). There was no statistically significant difference in median scores in this subscale with this subsection pre-test median of 23 and posttest median of 21, $p = .453$ (see Figure 10). The exact sign test was also conducted on the third subscale assessing client-related burnout. Of the seven participants, three participants' client-related burnout increased, two decreased, and two experienced no change (see Figure 9). There was no statistically significant change in the median client-related burnout scores with the subsection pre-test median of 17 and post-test median score of 14, $p = 1.00$ (see Figure 10.
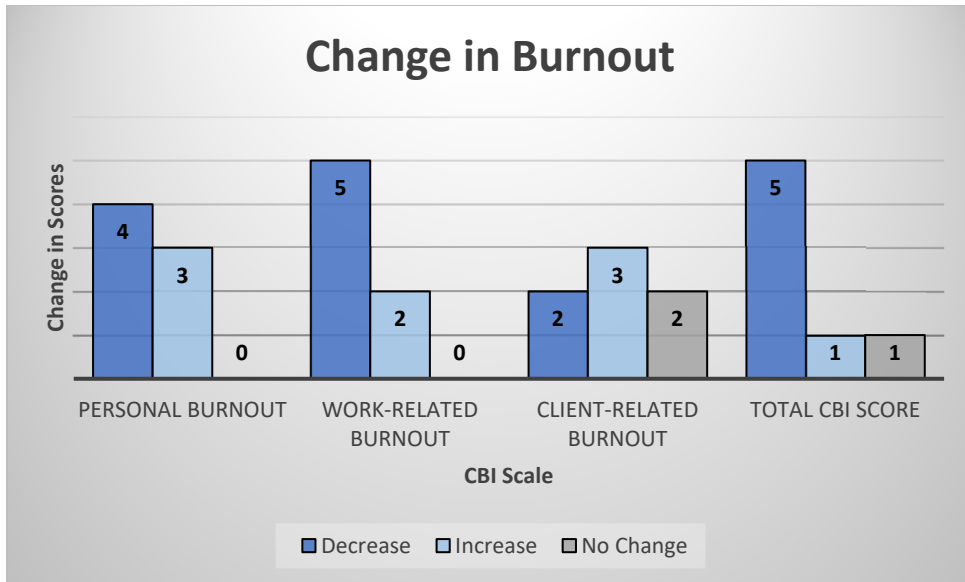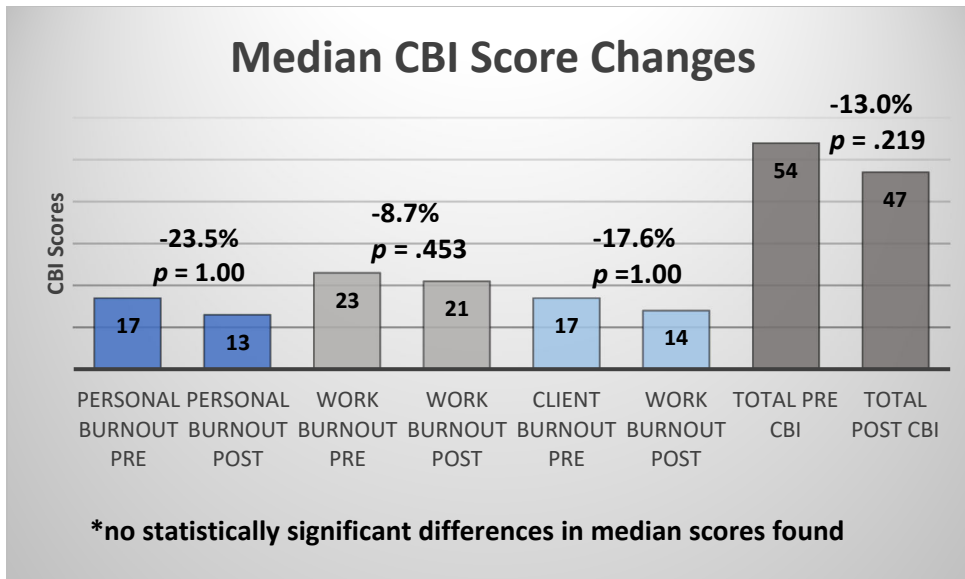
Figure 9

Change in Burnout

Change in Burnout

Change in Scores / CBI Scale

Category	Decrease	Increase	No Change
PERSONAL BURNOUT	4	3	0
WORK-RELATED BURNOUT	5	2	0
CLIENT-RELATED BURNOUT	2	3	2
TOTAL CBI SCORE	5	1	1

Figure 10

Median CBI Score Changes

Median CBI Score Changes

Scale	Score
PERSONAL BURNOUT PRE	17
PERSONAL BURNOUT POST	13 (−23.5%, $p = 1.00$)
WORK BURNOUT PRE	23
WORK BURNOUT POST	21 (−8.7%, $p = .453$)
CLIENT BURNOUT PRE	17
WORK BURNOUT POST	14 (−17.6%, $p = 1.00$)
TOTAL PRE CBI	54
TOTAL POST CBI	47 (−13.0%, $p = .219$)

*no statistically significant differences in median scores found

Statistical analysis of the data set indicated that the SFA intervention did not have a statistically significant impact on personal, work-related, client-related, or overall burnout among the seven participants. However, an analysis of the percentage reduction between pre- and post-CBI scores indicated that the intervention did have an impact that can be reflected by percentage difference (see Figure 10). Total burnout was

demonstrated to have a 13% decrease (see Figure 10). Personal burnout decreased by
23.5%, work-related burnout decreased by 8.7%. and client-related burnout decreased by
17.6% (see Figure 10). Though, the project's data set did not indicate a statistically
significant relationship between the SFA intervention and burnout reduction as
demonstrated by the exact sign test, the data did indicate a clinically significant
relationship between the two variables as demonstrated by the percentage reduction of
each burnout subscale and total burnout scores.

Discussion

Implementation of this QI project exceeded the aim of the project, which was to
reduce burnout by 5%, by reducing overall burnout by 13% among the seven nurses who
participated in the SFA education. The intervention's positive impact is encouraging for
future inferences. The primary implication for practice that this QI effort indicates that
SFA education has a clinically significant benefit in reducing burnout among behavioral
health registered nurses. Theoretically, SFA education, in its ability to reduce burnout,
could increases resilience and reduce nurse turnover as well.

One limitation of this QI project was the small sample size. The addition of a
more robust data set will allow for stronger statistical inferences to be concluded.
Another limitation of this QI project was the failure of pairing all pre- and post-CBI data
precisely. The inability to pair all the data decreased the sample size and the use of hand-
writing comparison to pair three of the data sets presents a possible degree of inaccuracy
within the resulting data analysis. Strengths of the SFA intervention includes adaptability
and cost-effectiveness. As demonstrated by the primary investigator's ability to easily
adapt the delivery of the SFA education from live sessions to written packet format SFA

is a highly adaptable intervention. Additional funds were not required to implement SFA, which speaks to its cost-effective feature.

Recommendations for future assessment include an increase in sample size, more careful pairing of data sets, and a follow-up session or survey for the participants to provide knowledge on what they valued from the SFA-education and how it has impacted their practice. The next step of implementation of this QI effort within the PDSA framework is to assess SFA's impact on nurse staff resilience, nurse turnover rate, and nurse retention rate.

Conclusion

In summary, the impact of stress and resulting burnout can lead to nurse turnover if resilience is not in place. The presence of stress, burnout, and increased turnover has been associated with poor healthcare quality, poor patient outcomes, and increased healthcare costs. There is an organizational responsibility to tackle resilience among its healthcare providers considering staff empowerment, or lack thereof, directly affects the quality of healthcare and patient outcomes. The literature demonstrates that nurses thrive in environments where they perceive organizational support exists. By implementing SFA under the guidance of the QI process there is an opportunity for the behavioral health unit to decrease burnout, increase resilience, and increase retention.

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