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Evaluating The Use Of Reflective Practice Principles To Support Nurse Manager Well-Being During A Period Of Chronic Distress

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Evaluating the use of reflective practice principles to support nurse manager well-being during a period of chronic distress

Submitted to the Faculty
Yale University School of Nursing

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

Amy A. Martone, MBA, BSN, RN, NPD-BC

May 22, 2023

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This DNP Project is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.

Joan A. Kearney, PhD, APRN, FAAN

Date _____

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May 22, 2023

Acknowledgements

Thank you to my project advisor Dr. Joan Kearney, for your unwavering commitment to my academic excellence. It was a privilege to work alongside you and to learn from you. And thank you to my 2023 DNP cohort colleagues. You are each an amazing nurse leader in your own special way - and the world is a better place because you are in it.

Special thanks to the wonderful nurse leaders that guided me toward and through the DNP Program. This includes my mentor Dr. Betsy Hassan, my leader Cathy Cunningham, and my colleagues and nurse experts Dr. Sarah Billings-Berg, Dr. Jill Markowski, and Meg Oakes. Your mentorship and support were key to my success. I appreciate you believing in me and showing up when I needed your expertise and support.

I want to acknowledge and thank my loving family. To my mother Wendy Andrews, for raising me to have big dreams and teaching me to work hard to achieve them. You always made sure that I had what I needed to succeed, and you have been my greatest cheerleader. To my husband Chris, for loving me unconditionally and always making my dreams feel like they are your own. You are the greatest partner in life and the accomplishment of completing this project is ours together. And to my daughters Sadie (8) and Erin (4), you will always be my most magnificent achievement. I hope that I have shown you anything is possible with passion and hard work, and that I have made you proud.

Dedication

This project is dedicated to the incredible team of admirable nurse managers and assistant nurse managers that participated in implementation. It was my honor to get to know you - to hear you, and see you, and to understand your lived experience. You are the lifeblood of your teams and the epitome of nursing leadership, care, and dedication. I am thankful that this project had a positive impact on your joy in work, and I promise to continue to move this work forward as a formidable advocate for nurse managers everywhere - to provide better practice environments that support you, your teams, and the communities you serve.

Abstract

Evaluating the use of reflective practice principles to support nurse manager well-being during a period of chronic distress

The COVID-19 pandemic brought forward a crisis that the current U.S. healthcare system was not prepared for. This increased the risk for burnout of teams and individuals, including the nurse leader. Nurse managers were selected as the target audience for support because they are key clinical leaders at the unit and staff level, yet they report feeling undervalued and are at higher risk for turnover than other leaders. This project developed a program that used reflective practice principles to support nurse manager well-being during periods of chronic distress.

The curriculum was guided by the Dimensions of Leadership as framework for nurse managers to engage in reflective practices to increase Joy in Work and support well-being. It was delivered to two cohorts over a period of 13 weeks; one cohort received live training on campus, and another cohort received pre-recorded and on demand modules. Knowledge of reflective practice principles and self-reported Joy in Work was measured pre and post program participation. A program evaluation was used to assess subjective feedback.

The two cohorts were small, however, analysis demonstrated that there was statistical significance in the outcomes measured and there was an increase in both knowledge and Joy in Work. A thematic analysis of the program evaluations found that nurse managers appreciated the offering that was designed exclusively for their unique role, they enjoyed the opportunity to gather and learn with peers, and that they desired more time to engage with the facilitator and each other.

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Part 1

Evaluating the use of reflective practice principles to support nurse manager well-being during a period of chronic distress

The COVID-19 pandemic that began in 2019 brought forward a crisis that the current healthcare system was not prepared for. Perhaps the most challenging component of this pandemic for many, including healthcare workers, was that it was ongoing and of an unknown duration. The psychological impact of exposure to trauma in healthcare had been studied for decades and there is a well-documented clinical understanding of how individuals that are exposed to an acute crisis may develop post-traumatic stress disorder (Beck, 2011). However, the impact of a sustained period of crisis on healthcare workers is still unknown and the literature on how to support organizations, systems, and individuals during long-term exposure to crisis is limited (Heath, Sommerfield, & von Ungern-Sternberg, 2020).

Prior to the 2019 pandemic, it was known that all organizations are vulnerable to chronic distress (Bloom, 2010). Examples may include recovery from national disasters, uncertainty during prolonged acquisitions or mergers, and contractual disagreements that led to sustained periods of a staffing strike. Despite the knowledge that organizations, systems, and individuals in healthcare are vulnerable to events that expose them to chronic distress, the healthcare industry has failed to provide thoughtful analysis and evidence-based strategies to support healthcare providers, specifically nurse managers, in promoting and sustaining well-being during these times.

Problem Statement

Leaders can support healing and posttraumatic growth in a workforce through recognizing that trauma exists and implementing evidence-based strategies to build resilience and hope (Schimmels & Cunningham, 2021). Early recognition of the signs and symptoms indicative of chronic trauma and distress is imperative for leaders to assess and deploy strategies for interventions that will support those at risk for post-traumatic stress syndrome and

burnout. One type of healthcare professional that is at a high risk for burnout is the nurse manager and healthcare organizations should recognize the importance of supporting the workforce members in this important role (Brown et al., 2011).

Using supportive and strategic practices, leaders can enhance the motivation and well-being of the individuals and teams within a system that is experiencing chronic distress (Corey et al., 2021). One strategy for managing the workforce through periods of chronic distress includes creating a culture where the workforce feels supported, informed, and involved (Bloom, 2010). This can be achieved through initiatives that engage groups within categories that are known to increase employee engagement and satisfaction, including offering rewarding work, providing a sense of community, and ensuring consistent organizational values (Baugh & Raja, 2021). Research has demonstrated that nurse managers share it is most important for them to feel valued by staff, peers, and the organization. Organizations with higher valued nurse managers experience better performance (Brown et al., 2011).

This DNP project developed a program that used reflective practice principles to support nurse manager well-being during a period of chronic distress. The project provided a framework for nurse managers to engage in self-reflection as a strategy for healthy coping, to create community, and build resilience. This reduced the risk for burnout of the nurse leader in an acute care medical center setting where despite the state-wide statistics, the hospital staff have experienced a state of chronic distress with the preparations for possible case surge, financial uncertainty within the organization, service line reorganization, and travel and time off restrictions. As the COVID-19 pandemic transitioned to an endemic, this project provided a program that could help healthcare workers in recovery from the trauma that they had experienced and could provide motivation to support the systems, teams, and individuals that were experiencing chronic distress.

Significance

Chronic stress in a healthcare system can lead to burnout of teams and individuals. Burnout is defined as a state of mental and physical exhaustion and is prevalent in healthcare workers due to the increased risk for exposure to traumatic events and sustained periods of chronic distress (Schimmels & Cunningham, 2021). According to White, Meier, and Saint (2021), greater than 50 percent of physicians and 30 percent of registered nurses report symptoms of burnout. This is problematic because healthcare workers that experience burnout are at higher risk of anxiety, depression, and substance abuse (Heath, Sommerfield, & von Ungern-Sternberg, 2020). These health issues have a financial impact that is estimated to cost up to $190 billion annually in the United States alone (White, Meier, & Swint, 2021). Every year, healthcare organizations experience financial losses resulting from absenteeism, sick leave, and turnover that can be attributed to burnout (Awa, Plaumann, & Walter, 2009).

Burnout in healthcare workers is attributed to decreased employee engagement and job satisfaction that can lead to retention impact and a depleted workforce. In one recent study, it was found that chronic stress and burnout are the driving force behind the statistic that one in every five nurses plans to leave the job within one year (Monroe et al, 2020). In a recent estimate, Adams, Hollingsworth, and Osman (2019) found that each registered nurse vacancy can cost an organization up to $88,000 per position. Based on that figure, a single healthcare organization can expect an overall annual estimated cost of turnover up to $8.5 million (Adams, Hollingsworth, & Osman, 2019).

Healthcare worker burnout also impacts patient care. In 2019, the ECRI Institute named Burnout as the third of the top 10 patient safety concerns in its Executive Brief, citing a correlation between burnout and patient safety and quality. The Occupational Safety and Health Administration (OSHA) found that healthcare worker stress, often related to burnout, was correlated to higher risk for adverse patient events such as acquired infections and medication errors (Crane & Ward, 2016).

In a 2014 study of nurse managers, 62 percent reported their intent to leave their current position in the next five years and cited burnout as the top reason for leaving (Warshawsky & Havens, 2014). The impact of nurse manager burnout on staff and patients should not be underestimated. Nurse managers are instrumental in staff nurse recruitment and retention (Brown et al, 2012). Nurse managers that report intent to leave due to burnout are unlikely to positively promote the role of the nurse manager and may deter others from pursuit of a career in nurse leadership (Warshawsky & Havens, 2014). These nurse managers are also essential to the success of the healthcare organization's strategic initiatives by supporting the implementation at the unit level. The nurse manager's involvement in such initiatives directly impacts the unit's ability to reach goals and objectives for high-quality patient care delivery (Brown et al., 2012).

By providing organizations with the tools to support nurse managers using strategies to build resilience and reduce burnout, senior leaders can support the entire healthcare workforce to experience higher employee engagement, quality work life, increased job satisfaction, and retention of talent (Lee et al., 2019).

Background

Search Strategy

Scopus, PubMed, and OVID literature databases were searched. The search strategy was designed to identify sources regarding leadership in stressed organizations, best practices for reducing burnout in healthcare workers, and the value of using self-reflection as a self-care practice in nursing. Keywords and phrases used were organizational trauma, trauma informed care, leading a distressed workforce, nurse burnout, healthcare costs associated with burnout, chronic distress in organizations, nurse leadership, nurse manager support, and self-reflection in nursing. Inclusion criteria were English language, articles published from 2008 to the present. Exclusion criteria were an article published in a language other than English, published more

than 15 years ago, and studies that recruited subjects outside the healthcare or similar industries.

The initial search returned 680 articles within 10 years of publication. Following duplicate removal and exclusion of 602 for relevance, 78 articles remained for title and abstract review. This review yielded 60 articles for full text review. A final 51 articles were selected for review of literature with 6 articles for the Evidence Table. See Appendix A for the Prisma Study Flowchart.

Synthesis of the Literature

Fifty-one articles were selected to provide context for how systems, organizations, and individuals experience chronic stress. Study designs included retrospective study, systematic review, rapid realist review, and quality improvement project implementation. The sources provide examples of the symptoms of trauma and how to identify systems at risk. Sources also provide strategies for leadership teams to address burnout resulting from chronic stress and build resilience in systems, teams, and individuals. The themes of the literature were that all organizations are vulnerable to chronic distress (Bloom, 2010). The impact of a sustained period of crisis on healthcare workers is still unknown and the literature on how to support organizations, systems, and individuals during long-term exposure to crisis is limited (Heath, Sommerfield, & von Ungern-Sternberg, 2020).

Systematic reviews of studies provided evidence that burnout is prevalent in healthcare workers due to the increased risk for exposure to traumatic events and sustained periods of chronic distress, such as the articles published by both Schimmels & Cunningham (2021), and Heath, Sommerfield, & von Ungern-Sternberg (2020). Additional systematic reviews by Jackson, Firtko, & Edenborough (2007), and Panagioti, Geraghty, & Johnson (2018) provided evidence that group learning as a strategy to engage physicians in knowledge acquisition, self-reflection practice, and social connection to colleagues. Kosher et al. (2017), Pai (2015), and

Edward & Hercelinskyj (2006) all author articles that support the use of self-reflective practices for nurse and nursing student resiliency.

The levels of evidence for the literature reviewed were based on the Johns Hopkins Nursing Evidence-Based Practice Evidence Level and Quality Guide and ranged from level II to level V. The quality of the articles reviewed included high-quality A by Schimmels and Cunningham (2021) for an overview of trauma and recommendations for practice. They also included low-quality evidence with a C for Monroe et al (2020) with limited data for statistical analysis, and for White, Meler, and Swint (2021) with a small sample size and the use of unvalidated tools.

Literature Findings

Burnout

Schimmels & Cunningham (2021) note that burnout is prevalent in healthcare workers due to the increased risk for exposure to traumatic events and sustained periods of chronic distress. The negative effects of trauma on individuals are discussed using the Adverse Childhood Experiences (ACE) Questionnaire in comparison groups of people with higher ACE scores and the subsequent health consequences such as obesity, cardiovascular disease, and autoimmune disorders. (Felitti et al., 1998).

In the systematic review by Heath, Sommerfield, & von Ungern-Sternberg (2020), the authors note that during the current pandemic, adverse psychological outcomes were identified in healthcare workers where 57% of workers in one study who reported emotional distress. Healthcare workers who experience burnout are at higher risk of anxiety, depression, and substance abuse. According to the findings of this review, when emotional distress is not addressed, healthcare workers are at risk for providing lower quality patient care, increased occurrence of absenteeism, and substance abuse. There is an emphasis on the early identification of burnout during a sustained crisis to manage the individual toward psychological growth instead of injury.

Impact of Burnout

The ECRI Institute has identified burnout as one of the top ten patient safety concerns in its 2019 Executive Briefing. The publication cites the relationship between healthcare worker burnout and diagnostic errors, hospital-acquired infections, and low patient satisfaction (ECRI Institute, 2019). This ranking is further supported by findings published by OSHA demonstrating that healthcare worker stress was positively correlated with patient safety events such as medication errors (Crane & Ward, 2016).

According to Monroe et al. (2020), in a recent study where one in every five nurses reported a plan to leave their job within one year, burnout in healthcare workers is attributed to decreased employee engagement and job satisfaction, thus directly impacting retention. A systematic review conducted by Brown et al. (2012), found that over a 10-year period, fewer nurse managers reported an intention to stay in their manager role in Canada, Australia, and the United Kingdom, citing job satisfaction as one key indicator of a nurse mangers decision to stay with an organization or separate from it. The authors found that feeling not valued by the organization, lack of support for work/life balance, and undefined roles and responsibilities led to burnout of the nurse manager (Brown et al., 2012).

Adams, Hollingsworth, and Osman (2019) state that a registered nurse vacancy can cost an organization up to $88,000 and estimate that a single healthcare organization can expect an overall estimated cost of turnover up to $8.5 million. In addition to the cost of patient safety events and turnover, worker burnout also generates financial losses to organizations through absenteeism, paid sick leave, and employer insurance costs for employee illness (Awa, Plaumann, & Walter, 2009).

General Approaches to Organizational Stress and Trauma

Trauma Informed Care. Schimmels & Cunningham (2021) discuss the importance of using trauma-informed care (TIC) strategies to transform the culture of the environments where healthcare workers practice to preserve the workforce. The article is focused on advance

practice registered nurses, but practice recommendations to support healing and posttraumatic growth can apply to individuals throughout the entire healthcare workforce. The authors note that by recognizing that trauma exists and implementing evidence-based strategies to build resilience and hope, leaders can increase resilience and reduce burnout.

The authors emphasize the importance of education on TIC for both providers and patients in their paper. Moreover, they discuss the need for collaboration between leaders, healthcare workers, and patients to support each other in strategies for post-traumatic growth to transform the culture at their organization. This is proposed so that each individual within the organization can have a better experience and continue to thrive in the face of adversity. Purposeful wellness is highlighted as a key strategy for reducing burnout and building resilience.

Group Psychological First Aid. According to Corey et al. (2021), Group Psychological First Aid (GPFA) is one strategy to support the emotional well-being of individuals that have been exposed to distress or trauma. The study focuses on humanitarian workers that are exposed to political unrest, outbreaks, and natural disasters that occur in the environments where they are deployed to work. All three examples of the potential exposure to trauma can also be present in the environments that healthcare workers practice.

The study included a rapid realist review of the literature, which is defined as a streamlined review where the knowledge is synthesized using a realist approach often through a group of stakeholders that may include a lay person. This review included an expert panel to evaluate program theories that support GPFA to provide context-specific recommendations. The authors found that GPFA was one strategy to support the emotional wellbeing of humanitarian workers during times of distress. It did this by supporting individuals to understand the impact of the stressors and develop appropriate coping mechanisms within a group setting of their peers. Although GPFA has not been widely studied in this context, it is recommended as one supportive strategy to address the impact of long-term stress and trauma on workers that are at risk for PTSD and burnout.

Employer Initiatives. Heath, Sommerfield, & von Ungem-Sternberg (2020) provided a systematic review of thirteen strategies and interventions to offer support, reduce risk for burnout, and build resilience in a workforce facing chronic trauma or distress. In the article, they provide recommendations for proactive employer initiatives where they found evidence for supporting the psychological well-being of healthcare workers during a pandemic event. One of the most significant findings was the impact of physical exercise on decreasing burnout where one study demonstrated an improvement in burnout scores for physicians that participated in a 12-week incentivized physical activity program (Weight et al., 2013).

Another significant finding was that healthcare workers with strong personal and professional relationships were at lower risk for burnout, therefor, organizations are encouraged to ensure a culture that fosters healthy professional relationships to increase social support for employees (Callahan, Christman, & Maltby, 2018.) In the review, the authors also found that organizations may support psychological well-being by providing education on self-reflection practice and engaging with peers through small group interactions to find meaning in work. One study showed significant burnout reduction in providers following engagement in a 9-month program where participants took part in small group sessions that taught mindfulness and self-reflection to find meaning in work (West et al., 2014).

The American Psychiatric Association's Center for Workplace Mental Health (2021) provides three levels of intervention that guide organizations in supporting employees that are experiencing excessive stress. First is the Prevention Level where an employer develops organizational policies and practices that provide strategies to reduce stress, ensure safe working conditions, fair compensation, reasonable workloads and expectations, and provide work-life balance. The second level is the Targeted Early Identification and Intervention Level where the organization utilizes screenings for stress and implements effective interventions for stress management, along with programming that improves resiliency. The last level is the Intensive Individualized Support Level where the organization and its leaders initiate active

outreach to employees in need and assist in providing appropriate care and support. This includes offering accommodations for team members to maintain employment and supportive return to work practices.

The three levels of intervention provided by the American Psychiatric Association's Center for Workplace Mental Health are further supported by the ECRI's Executive Brief that emphasizes a proactive systems approach to burnout mitigation, engaging staff in improving workflows and implementing changes, and providing the time and space for frontline staff to participate in interventions (ECRI, 2019).

The Role of Nursing Leadership during Organizational Stress and Trauma

Leadership in a Stressed Organization.

Servant Leadership Theory and Practice. According to Northouse (2019), the concept of Servant Leadership was first introduced in the 1970s and later researched and synthesized by leadership experts to define it into a theory. There are still a broad range of concepts used to define servant leadership as well as disagreement amongst researchers about the absolute characteristics of servant leaders, however, theory underpinnings describe servant leaders as leaders that place their followers first, practice empathy to understand different perspectives, and lead with the intention to serve the community (Northouse, 2019). Servant leadership has limitations, such as a paradoxical name and potential for lack of followers, but it has been recognized as a preferred theory in times of crisis where the flexibility, passion, communication, and empathy of the servant leader is preferred to support teams during periods of distress (Wankhade, Weir & van Bunt, 2015). Hu, He, and Zhou (2020) found through research that servant leadership was a crucial practice in leading teams during the COVID-19 pandemic.

Strategies for the Nurse Leader to Engage Frontline Staff. According to Adams, Hollingsworth, and Osman (2019), there are solutions to creating a more positive work environment for healthcare workers including leadership involvement and support. Practices such as nurse leader rounding on units to engage with frontline staff and an open-door policy

contribute to a supportive workplace culture. The authors emphasize the importance of leadership practice to include frontline staff in any decision-making process that relates to the practice environment, such as staffing models (Adams, Hollingsworth, & Osman, 2019). This recommendation is because nurses experience stress when they feel that they have limited control over their workload, practice environment, or organizational role, nursing leaders can have considerable impact on the development of supportive programming for staff nurses (Chan & Perry, 2012).

Literature also recommends that nursing leaders engage frontline nursing staff in financial incentive and employee recognition decisions. For example, ideas such as a kudos board, thank you card campaign, or employee of the month program can be very successful in improving the work environment when implemented with staff input (Adams, Hollingsworth, & Osman, 2019). The implementation of peer-to-peer support programs have also shown to be protective against burnout and have been successfully adopted with frontline staff engagement (Awa, Plaumann, 7 Walter, 2009). It is suggested that nursing leaders should engage frontline staff in the creative ideas to promote and reward self-care practices among team members, such as recognizing a self-care action that a staff member has shared and supporting other team members in adopting the practice (Crane & Ward, 2016).

The Role of the Nurse Manager in Health Promotion. Nurse leaders are role models for change and can serve a very important role in health promotion among their teams and other healthcare workers in the organization. The nurse manager is the most equipped leader to understand high-level organizational decision-making and the impact it has on direct care staff (Doucette, 2017). Nurse managers should be encouraged to foster workplace cultures that are safe for all staff members to discuss concerns about stress and burnout as well as creative strategies for stress management and self-care (Ross et al, 2017). This may include the adaption of a physical space where frontline staff can get away from the patient care environment to enjoy peace and quiet for debriefing and deescalating (Crane & Ward, 2016).

This may also include the use of self-reflection to cope with challenges and build resiliency during periods of distress.

Nurse Executive Considerations to Support the Nurse Manager. Belasen & Belasen (2016) emphasize the value of the middle-manager in healthcare and advocate for programs that support the professional development of managers as a key contributor to healthcare operations. The authors argue that managers in healthcare are the key leaders for translation of strategic goals and initiatives into implementation at the unit and staff level, yet they report feeling undervalued and are at higher risk for turnover than leaders at other levels (Belasen & Belasen, 2016). Doucette (2017) identifies the nurse manager role as "one of the most difficult roles in nursing leadership" recognizing that the nurse manager must be an expert in strategy and leadership while still engaging in unit operations such as staffing and patient care. The author recognizes that nurse manager is often the entry level role for nurse leadership and encourages nurse executives to make supporting, coaching, and mentoring of the nurse manager a priority (Doucette, 2017). Berken, Lee, & Weiner (2012) discuss that managers in healthcare serve the important role between strategy and day-to-day operations arguing that engaging them in strategic initiatives, such as wellness and resiliency programs, is essential to ensure successful implementation. This supports the selection of the nurse manager for the DNP Project.

Conscious Leadership Concepts Applied in Servant Leadership Theory. Crane and Ward (2016) discuss the concept of "conscious leadership." Conscious leadership is leadership practiced with the presence to be aware of the feelings of the nurses around the leader and to understand how to support those nurses. A conscious leader brings awareness to the importance of self-care and self-healing and nurtures the nurses around them to seek healthy practices while providing these tools for self-care techniques (Crane & Ward, 2016).

The concept of conscious leadership is closely tied to the underpinnings of servant leadership theory. According to Northouse (2019), the servant leader nurtures their followers

through the ten characteristics defined by Greenleaf; they include listening, empathy, awareness, and foresight. These four particular characteristics of the servant leader require emotional intelligence that is supported by the concepts of conscious leadership and can potentially be developed and enhanced through reflective practice exercises.

This suggests that in addition to eating healthy meals, participating in exercise, and spending quality time outside of work, nurse leaders can model and support creative health promotion strategies for stress management and self-care through conscious leadership supported by situational awareness and self-reflective practice (Ross et al., 2017).

Additional Strategies for Support

Facilitating Reflective Practice. Reflection is a proven strategy for individuals to evaluate experiences and then develop an insight and understanding that can be applied to future situations to produce a more positive response (Jackson, Firtko & Edenborough, 2007). According to Koshy et al. (2017), self-reflection in clinical practice can support learning, motivation, and quality of care provided. In nursing students, self-reflection has been shown to decrease stress and increase competency (Pai, 2015). Using self-reflection, the nurse may spend time exploring, uncovering, and analyzing their work to make sense of their experience and develop strategies to enhance their professional practice (Edward & Hercelinskyj, 2006). The skill of self-reflection for nurse managers can be taught and promoted through education by healthcare organizations (Pai, 2015).

In a systematic review by Kumar (2016), the author discusses an American study where significant improvement in burnout was reported by a cohort of physicians that participated in a formal program that supported mindfulness and self-awareness. In another review by Panagioti, Geraghty & Johnson (2018), the authors describe facilitated group training that includes reflection as an effective strategy to reduce provider burnout. Rabow and McPhee (2001) discuss the success of a self-reflection group learning program called Doctoring to Heal that was implemented with cohorts of physician at the University of California, San Francisco,

Medical Center. In the article, the authors describe the self-reflection program as an effective tool for physician well-being where participants report benefits such as feeling connected to colleagues and learning from other's experiences (Rabow & McPhee, 2001).

Self-care. Nursing is a stressful profession and nurses take pride in the high level of care that they provide to others, however, they do not always treat themselves in caring ways (Iacono, 2010). Iacono (2012) urges nurses to care for themselves so that they may care for others. The literature and educational resources available to registered nurses for self-care are abundant, including the American Nurses Association's Healthy Nurse Healthy Nation campaign and the American Psychiatric Nurses Association Self Care Tip Sheet for Nurses (ANA Enterprise, 2021 & American Psychiatric Nurses Association, 2021).

The American Psychiatric Nurses Association (2021) recommends that nurses dedicate time for self-care and schedule self-care activities into their week. Exercising with a walk or run outdoors and focusing on preparing healthy and nutritious meals are two ways to promote health and wellness (American Psychiatric Nurses Association, 2021). Physical self-care techniques are simple yet powerful tools for reducing stress and promoting health. Techniques such as meditation, mindfulness, yoga, and deep breathing can be used to activate the parasympathetic nervous system and reduce cardiovascular stress (Crane & Ward, 2016).

The ANA Enterprise Healthy Nurse Healthy Nation campaign guides nurses with a focus on five areas of health including self-care through activity, rest, and nutrition. The free program offers nurses the opportunity to engage in wellness challenges after completing a health assessment survey to identify areas with the highest heath risk. Once enrolled, nurses can connect with others in the program for support (ANA Enterprise, 2021).

Project Model

This DNP project used Ronald Lippitt's Seven-Step Change Theory as the project change model. Lippitt's theory is based on the three steps in Kurt Lewin's Change Model and adds an additional four steps to expand on the role and motivation of the change agent in a

planned change (Gorbunoff & Kummeth, 2014). This expanded theory was selected because the additional steps were used to further incorporate an understanding of the motivation of the nurse manager as the change agent to ensure the planned change is successful with implementation. In Phase 3, there was an assessment of the motivation of the nurse manager as an internal change agent.

Lippitt's Theory was also selected because it aligns closely with the steps in the nursing process of assessment, planning, implementation, and evaluation (Mitchell, 2013). Using a thought process and language that is familiar to the nursing leader further supported them in the successful implementation of the planned change. Phases 1 through 3 was based on assessment, phases 4 and 5 included planning, phase 4 was implementation and phase 5 served as evaluation. See below as well as Appendix B for graphic depiction.

Phases 1 through 3 are based on Lewin's Unfreezing and the assessment component of the nursing process. In Phase 1, diagnose the problem, the senior leader determined that nurse manager and their staff have experienced a period of chronic distress and understand the cause of distress such as the COVID-19 pandemic. In Phase 2, assess motivation and capacity for change, the senior leader evaluated if the nurse manager was ready to transition forward and willing to engage in programming that would support their post-traumatic growth and recovery. In Phase 3, assess the change agent's motivation and resources, the nurse manager recognized the opportunity to support their teams in healing from the trauma they have experienced as health care workers and connect to the purpose of leadership in change management as their motivation.

Phases 4 and 5 are based on Lewin's Moving and the planning component of the nursing process. In Phase 4, select change objective, the nurse manager correctly defined the objective of the project is to provide support for nurses to recover from a period of chronic distress. In Phase 5, choose the role of the change agent, the nurse manager identified as the change agent and accepted the responsibility for change implementation and success. Phase 6,

maintain change, is based on Lewin's Moving and the implementation of the nursing process. In this phase, the nurse managers engaged with the nursing team as the change agent and participated in the strategies to support post-traumatic recovery.

The final phase, Phase 7, is based on Lewin's Refreezing and the evaluation component of the nursing process. In Phase 7, terminate the helping relationship, the nurse manager continued to engage in the support strategies provided by the team and senior leader. During this phase, the participants demonstrated post-traumatic healing and growth through self-reported increased engagement and knowledge acquisition. Also in this phase, the results from the program evaluation were be used to identify opportunities for improvement that were considered for future program implementations.

Organizational Assessment

An academic medical center in the northeast region of the U.S. was selected for project implementation. It was selected as an acute care hospital affiliated with a network that employs nearly 10,000 healthcare professionals and provides care to over a million community members across the region. The medical center reported that the financial impact of the first year of the COVID-19 pandemic resulted in a multi-million-dollar loss, despite receiving millions in CARES Act funding. The medical center attributed this loss to the inflation in cost of wages, products, and services, including the high rates of pay for contract nursing staff. Despite the recent financial challenges, the organization remains committed to providing high-quality and patient-centered care to patients by offering a dynamic and engaging practice environment to all healthcare professionals, including the nurses.

The northeast region of the U.S. had fared better than other regions in the country during the COVID-19 pandemic with lower infection rates, hospitalizations, and deaths. As of January 2022, the highest reported infection rate in this area was reported at 500 per 100,000 with a peak in hospitalizations at 125 patients. At that time, there was only a reported 523 COVID-19 deaths since the start of the pandemic in comparison with the 1 million reported COVID-19

deaths for the U.S. Despite the favorable statistics, the medical center's staff have still experienced a state of chronic distress with the preparations for possible case surge, financial uncertainty within the organization, service line reorganization, and travel and time off restrictions. As the COVID-19 pandemic transitioned to an endemic, the organization was ready to explore a program that can help its healthcare workers in recovery from the trauma that they had experienced.

The project had been approved by the Chief Nursing Officer (CNO). The CNO had offered organizational support and resources to implement the project.

Strength, Weakness, Opportunity, and Threat (SWOT) Analysis

A Strength, Weakness, Opportunity, and Threat (SWOT) analysis was conducted for this project. See below as well as Appendix C for graphic depiction.

Strengths. The medical center is on the Magnet journey. It is an affiliate of a nursing school and supports nursing education. The organization boasts a culture of nursing excellence that supports nurse autonomy, shared governance, and professional development. In 2020, sixty percent of nurses had a BSN or higher degree in nursing and the board certification rate for nurses was 40 percent. The shared governance structure was comprised of global, service line, and unit-based nursing councils with nursing members from all practice settings across the organization. The medical center provided a Nurse Residency Program to all new graduate nurses and offered a clinical ladder for all registered nurses. The strengths of their nursing culture supported the implementation of a planned change project.

Weaknesses. At the time of project implementation there was no formal caregiver support program for registered nurses. An Employee Wellness Center and Employee Family Assistance Program provided a menu of services to support caregiver well-being such as one-on-one wellness coaching and referrals to mental health counseling, but employees had to personally engage with these services due to limited outreach from both programs. There was no on call structure for emotional support and there was no peer-to-peer support program.

Opportunities. Prior to the COVID-19 pandemic, Doucette (2017) advised that nurse executives place priority on the opportunity for supporting, coaching, and mentoring the nurse manager because the nurse manager was often an entry-level nurse leader that was typically promoted with little preparation. The recent global pandemic had created a period of chronic stress for the entry-level nurse leader, spanning over a year. In one recent survey conducted by AONL where 82% of respondents were nurse leaders, 26% specifically nurse managers, it was identified that nurse leaders will continue to need support as they cope with the ongoing pandemic (Joslin & Joslin, 2020). This created an environment that was an opportunity for program implementation.

Threats. The medical center was encouraged to consider offering programing that is dynamic and supportive of the workforce to counter the financial incentive for nurses and nurse leaders to pursue other employers that may offer higher pay. According to Filskov (2021), the state nursing pay ranked 47th in the nation. Anecdotally nurse managers have left their full-time leadership positions to pursue agency work that can pay up double the rate of a nurse manager, with less responsibilities to manage. The medical center was one of up to 20 hospitals competing to employ nurses in a region where there is a limited number of healthcare professionals. In 2017, there were 8,457 registered nurses in the state and 6,895 reported working part or full-time in a nursing position. Sixty three percent of those nurses reported working as a staff nurse; and of the 63 percent, only 24.1 percent (2,041 nurses) reported working in an inpatient hospital setting. This low prevalence of nurses that report working in the hospital setting demonstrated a small talent pool of nurses available, decreasing the opportunity for succession planning and recruitment of qualified nurse managers. The survey also noted that there was an increase in nurses reporting telehealth as their primary practice setting from 2015. This shift in nursing practice environments offered remote work opportunities to nurses and nurse managers where nurses could work from home and often with a better schedule. This was a direct threat to the inpatient hospital setting practice and the organization's ability to

safely staff the nursing units with nurses at all levels, including nurse managers. Geographic location was also considered relevant to project implementation. Resources such as external experts and change agents were not available locally and there were limited potential partnerships in program implementation.

Project Goal & Aims

This DNP project developed a program that used reflective practice principles to support nurse manager well-being during a period of chronic distress. The project provided framework and strategies for nurse managers guided by the Dimensions of Leadership developed by the Center for Nursing Leadership.

The project aims were:

1. To develop a program for nurse managers to engage in reflective practice principles to reduce burnout during a period of chronic distress.
2. To implement and evaluate the program.
3. To make recommendations for scaling and sustainability of this program in a relevant context.

Part 2

Methods

Overview of Methods

This performance improvement project developed a program to address a nurse manager workforce that is experiencing chronic distress. It was a DNP project that included program development guided by the nine Dimensions of Leadership for reflective practice developed by the Center for Nursing Leadership (AONE, AONL, 2015). The program was delivered to two cohorts of nurse managers and assistant nurse managers that were working in the acute care setting. Participation was voluntary and scheduled during work hours.

Project Goal and Aims

This DNP project developed a program that used reflective practice principles to support nurse manager well-being during a period of chronic distress.

The following were the project aims:

1. To develop a program for nurse managers to engage in reflective practice principles to reduce burnout during a period of chronic distress.
2. To implement and evaluate the program.
3. To make recommendations for scaling and sustainability of this program in a relevant context.

Aims and Associated Methods

Aim 1*:* To develop a program for nurse managers to engage in reflective practice principles to reduce burnout during a period of chronic distress.

- The project was presented to executive and senior leaders for stakeholder buy-in and to secure resources. This group of stakeholders included the Chief Nursing Officer, Director of Nursing Education and Professional Practice, and Nurse Director Group. This was to ensure support for the project and participation by nurse managers with support by senior Nursing administrators.

- Following the initial meeting, there was a series of ongoing weekly meetings with the Director of Nursing Education and Professional Practice to inform the leadership team while planning and to discuss any problems that would arise. During the weekly meeting, stakeholders were informed of the current curriculum topic, the number of attendees at the weekly session, and any issues with training resources such as availability of classroom space and technology used to deliver the program.
- The program was developed using evidence-based practice recommendations for reflective practice guided by the nine Dimensions of Leadership for reflective practice developed by the Center for Nursing Leadership and published in the AONE Nurse Manager Competencies (AONE, AONL, 2015). See Appendix D for the AONE Reflective Practice Reference Behaviors/Tenets. Curriculum components included subject matter expert presentations with facilitated participant dialogue. The curriculum consisted of five modules, delivered in a series of five sessions. Cohort A was offered in-person 30-minute sessions conducted weekly, for five weeks duration, and scheduled during work hours. Cohort B was offered pre-recorded virtual 10-minute sessions offered via email for on demand viewing over a period of two weeks.
- For Cohort A, facilitated dialogue was organized around the story stem method in order to maximize and focus discussion time on the topic of the session. According to Kelly and Bailey (2021), story stem methodologies have been well-studied in children and recently expanded to include adults. The research suggests that the use of story stems provides a context for discussion and exploration that removes social pressure and individual biases to support participants with speaking about difficult topics without sharing personal experiences (Clarke et al., 2019). One version of story stem is the story completion technique. This includes the sharing of a story beginning as a cue for participants to complete the story using verbal or written narratives (Kelly & Bailey 2021).

This technique can be used in the setting of a cohort of healthcare leaders that are participating in facilitated dialogue to engage in self-reflection.

- The selected topics for each session were as follows: Session 1- Overview of Nurse Manager Competencies and ground rules for group participation to ensure inclusivity, mutual respect, and clear boundaries; Session 2- Tenet 4: Holding Multiple Perspectives Without Judgement; Session 3- Tenet 9: Keeping Commitments to Oneself; Session 4- Tenet 8: Nurturing the Intellectual and Emotional; Session 5- Tenet 2: Appreciation of Ambiguity (AONE, AONL, 2015).
- The topics for each didactic session were selected in collaboration with a nurse executive and nurse leader team of 12 directors at a local community medical center, as well as through discussion with nurse leader DNP colleagues. The four tenets selected for relevance to the acute care clinical nurse manager practice that are projected to have the greatest impact are as follows: Tenet 4: Holding Multiple Perspectives Without Judgement; Tenet 9: Keeping Commitments to Oneself; Tenet 8: Nurturing the Intellectual and Emotional Self; and Tenet 2: Appreciation of Ambiguity (AONE, AONL, 2015).
- The tenets were ordered in the curriculum based on comprehensive review with the project external expert and their feedback, with the goal to promote engagement and growth for participants where the first session was offered to create a foundation that the remaining sessions will build upon.

    Tenet 4 is titled *Holding Multiple Perspectives Without Judgement* and facilitates reflective practice for the nurse manager in the creation and holding of a space so that multiple perspectives are entertained before decisions are rendered.

Tenet 9 is titled *Keeping Commitments to Oneself* and facilitates reflective practice for the nurse manager to create the balance that regenerates and renews the spirit and body so that it can continue to grow.

Tenet 8 is titled *Nurturing the Intellectual and Emotional Self* and facilitates reflective practice for the nurse manager to constantly increase their knowledge of the world and the development of the emotional self.

Tenet 2 is titled *Appreciation of Ambiguity* and facilitates reflective practice for the nurse manager learning to function comfortably amid the ambiguity of the environments.

- An expert panel comprised of three nurse executives from academia and local health systems was be used to evaluate curriculum and feasibility. The expert template panel was used.
- Survey development:
    - Pre and post knowledge acquisition assessments on the components of the curriculum were be developed. They each contained ten multiple choice questions, two to three questions assessing each category on the curriculum. Each correct answer was be scored at ten points, for a total score of 100 points.
    - A program evaluation form was developed and contained five Likert scale questions scored from 1 (low) to 5 (high) with accompanying comments for each question along with additional open-ended questions.
    - The pre and post knowledge acquisition assessments were coded by numeric identifiers with a link to participant information known only to the project manager. The linking document was kept in a locked file on an encrypted computer in the project manager's office.

Aim 2: To implement and evaluate the program.

Implementation

Recruitment

- Recruitment for both cohorts was conducted via an email communication using medical center emails from the Director of Nursing Education and Professional Practice to all eligible nurse managers and assistant nurse managers. The email communication included a brief explanation of the project with the expectations and possible benefits to participants. Cohort A was recruited in October 2022 and Cohort B was recruited in January 2023. Participation was voluntary and respondents replied directly to the Director of Nursing Education and Professional Practice to enroll.
- Recruitment of participants for both cohorts continued for one week. The project manager contacted the nurse managers and assistant nurse managers who responded to enroll in a cohort for this project. The project manager sent specific information through the medical center email server regarding the time, place, length of meetings and duration of program.

Orientation

- Following recruitment, there was a one-week period for orientation. Participants were sent an email from the project manager through the medical center server with orientation instructions that will consisted of an introduction to the presenter, a program overview and curriculum outline, and expectations of the participant.

Program Implementation: Cohort A:

- Participants in Cohort A attended a series of five 30-minute sessions, weekly, for five weeks duration. The sessions were held on campus at the medical center in the Training and Education Department. The Training and Education Department was equipped with classrooms containing audiovisual equipment for PowerPoint

presentations. The schedule for these meetings was developed with the leadership team in consideration of nurse manager needs and systems resources.

- The sessions were voluntary, provided in-person, and scheduled during scheduled work hours. Sessions were scheduled at the same weekday and time for all five offerings, on Wednesdays from 1200-1230, to provide ease of scheduling at a time that was identified as most convenient by leadership. There was an attendance sheet for sign in at each session to track participants.
- The first session was an introductory session with an overview of Nurse Manager Competencies and ground rules for group participation to ensure inclusivity, mutual respect, and clear boundaries. The ground rules included:
    - Please listen respectfully and actively, do not listen only to respond, and do not interrupt. Please allow each person to speak and be open to different perspectives. The program is delivered in a safe space and all participants are asked to be respectful of each other at all times, avoid blame, judgement, and inflammatory language. Please keep all information shared during the program confidential; and if, at any time, a participant feels triggered by the content, please notify the facilitator for recommended resources such as EAP.
- Following the completion of the first session, participants were given time to complete the pre-program assessment. Each participant used an ID code that was a confidential identifier to link the pre and post documents. The ID code was comprised of their middle initial followed by their day of birth. Completed pre-surveys will were submitted to the Project Manager before participants leave the room.
- Each of the following four sessions were be comprised of a 20-minute lecture on a selected four of the nine Dimensions of Leadership for reflective practice by a subject

matter expert, followed by 10-minutes of facilitated dialogue using story stems as a guide.

Program Implementation: Cohort B:

- Participants in Cohort B were provided the series of five pre-recorded 10-minute sessions to access virtually on demand at their convenience. The sessions were emailed to those enrolled and participants were given two weeks to complete the sessions and electronic surveys.
- The sessions were voluntary and available to be completed during scheduled work hours. Following the completion of the first session, participants were asked to complete the pre-program assessment via a Qualtrics survey. Each participant used an ID code that was a confidential identifier to link the pre and post documents. The ID code was comprised of their middle initial followed by their day of birth.

Administration of Post-Program Assessments: Cohort A:

- At the end of the final session, participants were given time to complete the post-program assessment that is a knowledge acquisition survey and the program evaluation survey using hardcopy and pen in the classroom. They again used numeric identifiers and submitted the surveys to the Project Manager before leaving the classroom.
- All completed surveys were placed in a sealed envelope and secured in a locked drawer in the locked the project manager's office until the program was completed. The project manager maintained custody of the surveys in the sealed envelopes until they were evaluated statistical analysis. Following data analysis of the de-identified pre and post knowledge acquisition surveys, the surveys were destroyed.

Administration of Post-Program Assessments: Cohort B:

- Following completion of the final session, participants were asked to complete the post-program assessment that is a knowledge acquisition survey and the program evaluation through Qualtrics. They again used numeric identifiers to document pre and post completion status.

Evaluation

- Results for both cohorts were analyzed using descriptive and bivariate statistics and qualitative description.
    - Pre and post knowledge acquisition assessments were analyzed using a paired t-test. The result of the paired t-test was used to assess knowledge gained by participants during the program.
    - The Program Evaluation surveys were analyzed using descriptive statistics; open ended comments were assessed qualitatively. This survey was used to seek feedback from participants regarding their perception of the program, its impact on the participants, its usefulness to their practice, strengths, weaknesses, and suggestions for improvement.

Aim 3: To make recommendations for scaling and sustainability of this program in a relevant context.

Sustainability

Findings were reported to the senior leadership team comprised of the Chief Nursing Officer and Director of Nursing Education and Professional Development. Based on findings, recommendations included that the organization institutionalize the training program, to make it available for all new nurse managers to engage in. This included devoting resources such as non-productive time, classroom space, and executive-level support to deliver a train-the-trainer program. This would ensure the ongoing success of the program with annual offerings for cohorts of newly promoted nurse managers and seasoned nurse managers that are new to the

organization. Modifications such as a hybrid offering, multiple synchronous in-person sessions, and an online platform for virtual delivery will also be considered to support higher participation and completion. Participant feedback to increase the duration of each session will inform a change to modify the 30-minute offering to extend to 45-minutes. Requests to expand the content to include all nine tenets will also be considered as a method to enhance the offering and add value to participants.

Scaling

Recommendations were made for scaling to support broad program implementation that will be utilized by other organizations in the health system. Following implementation at the system level, recommendations for scaling supported the program at other organizations in the region. This included both medical center and professional nursing organizations.

Dissemination

This DNP project is to be presented to internal and external audiences. A poster presentation was made at the Yale School of Nursing Scholar's Day. An abstract is to be submitted for publication with the Journal of Nursing Administration.

Statement Related to Human Subjects

This project has been deemed to be quality improvement by the Yale IRB. There is minimal risk to participants.

Part 3

Systems, Policy & Business Implications

Systems Overview: Leadership, Business, Policy

This DNP project aligned with the Mission and Vision of the medical center where the project used an evidence-based framework to deliver a program that supported nurse manager well-being during a period of chronic distress through the use of reflective practice principles. The project provided nurse managers and assistant nurse managers with the skills and knowledge to engage in self-reflection as a strategy for healthy coping, creating community, and building resilience. This DNP project aligned with the Philosophy of the medical center's Nursing Service Line and beliefs where the program delivered an opportunity for professional development that incorporated knowledge and skill to guide practice.

The Business Case and Leadership Engagement

Leadership & Stakeholder Engagement

The medical center's Director of Nursing Education and Professional Practice was the project sponsor. The project was also supported by the CNO, and additional stakeholders identified including the Nurse Director group and the nurse managers and assistant nurse that would be engaged in recruitment. There was an initial 30-minute meeting of stakeholders to present the project and engage the team, through a presentation that clearly described the project, the expected outcomes, and the stakeholder roles. A series of ongoing 30-minute meetings were provided to inform leadership team members while planning and to secure resources and discuss any problems that had arisen.

Business/Financial Considerations

The medical center had reported financial losses year over year as a result of the pandemic response and inflation; however, they continued to serve the community members throughout the region. State and federal funding, along with a rate increase that was approved

by the governing board in 2022 supported the financial feasibility of the organization but focus on contract nurse reduction through recruitment and retention initiatives was necessary to maintain fiscal viability. This DNP project offered potential cost savings by engaging nurse managers in education delivery to promote well-being and engagement.

A return on investment (ROI) was calculated assuming that the project would engage one nurse manager through increasing self-reported joy in work to prevent resignation. The potential cost savings to the organization was projected as $80,000 per new nurse manager onboarding to replace a vacancy.

Risk Assessment & Risk Mitigation Plan

The implementation of this DNP project was a low-risk initiative for the medical center. A risk assessment found that the greatest threat to successful implementation was participant attrition. The scope and responsibility for the nurse manager and assistant nurse manager role in an acute care setting creates unpredictability in scheduling the workday. Competing priorities such as staffing issues or a patient event could prevent the nurse manager from attended the scheduled session. To mitigate this, the program was designed to delivery content in 30-minute intervals, over five weeks on a recurring basis. This allowed the participants to understand the commitment at the time of recruitment and minimize the length of time that the nurse manager must commit. Sessions were delivered in person to create peer accountability for attendance. A second cohort that provided a virtual and on demand offering was also provided.

The most significant mitigation strategy was stakeholder buy-in and support for the project. By engaging the CNO and Nurse Director group in advance and providing regular communication throughout the implementation, the senior leadership team would play an essential role in supporting participants with attending the session and placing accountability for completing both the five-week session for Cohort A and the virtual on demand sessions for Cohort B. The nurse directors were responsible for providing the participants with the non-

productive work time to attend each session and supported the facilitator with follow-up in the event that a participant did not attend as planned.

In the first session, participants were advised of the importance that they attend and/or view 100% of the programming, based on their cohort. In order to support the participation of a minimum of 20 managers, the Director of Nursing Education and Professional Practice was advised of attendance to follow up directly with any manager that missed a live session. Make-up session were arranged for a total of four participants when they could not attend one in-person session.

Part 4

Results

Participants

Recruitment emails were sent to sixty eligible nurse managers and assistant nurse managers for both cohorts. Thirty-one (52%) nurse managers and assistant nurse managers enrolled, twenty (30%) participated, and a total of sixteen (27%) participants completed the full program in Cohort A or B. For Cohort A, 5 enrolled participants never participated in any sessions, 10 completed the Introduction session and pre-program assessment, 2 attended less than 3 the sessions without any of the make-up offerings. Three missed 1 session but participated in a make-up session offering where the facilitator met virtually to deliver the content one on one. Eight completed the post-program assessment and program evaluation. For Cohort B, 6 enrolled participants never completed any of the virtual activities, 10 participants completed the pre-program assessment, 8 completed the post-program assessment and program evaluation. See Table 1.

Table 1. Enrollment, participation, and completion rates for Cohort A and Cohort B.

	ENROLLED	PARTICIPATED	COMPLETED
COHORT A (Live, in person)	15	10	8
COHORT B (Virtual, on demand)	16	10	8
TOTAL	31 (52%)	20 (30%)	16 (27%)

Joy in Work Findings

All participants completed a pre-program and post-program assessment that included a self-reported rating of Joy in Work. Joy in Work was defined as intellectual, behavioral, and emotional commitment to meaningful and satisfying work. Participants used a Likert scale from 1 (lowest) to 5 (highest), to rank their current Joy in Work. Pre and post scores were

categorized by cohort. The mean pre-program scores for Joy in Work varied by cohort. Cohort A had a pre-program mean of 3.0 and Cohort B had a pre-program mean of 3.25. Both cohorts had a post-program mean of 3.625. Due to small cohort sizes, a pooled analysis was conducted for Cohort A and Cohort B demonstrating that there was a significant ($t = -2.782$, $p = .014$) increase in post program Joy in Work scores across cohorts, see Appendix E.

Findings Regarding Knowledge of Reflective Practice

The pre-program and post-program assessment also included a 10-question quiz to measure participant's baseline knowledge on reflective practice prior to starting the program and after completion. Participants were asked to complete the multiple-choice assessment and responses were graded with each question valued at ten points. Pre and post scores were categorized by cohort and compared. The mean pre- and post-program scores varied by cohort. Cohort A had a pre-program mean of 88.75 and a post-program mean of 98.75. Cohort B had a pre-program mean of 91.25 and a post-program mean of 92.5. Due to the small size of the cohorts, a pooled analysis was conducted for Cohort A and Cohort B demonstrating that there was a significant ($t = -2.522$, $p = .023$) increase in knowledge acquired across cohorts, see Appendix F.

Program Evaluation

All participants completed a program evaluation comprised of five statements about the program. Participants rated each statement using a Likert scale from 1 (lowest) to 5 (highest). The responses were categorized by cohort and compared using the mean scores. Cohort A reported a higher score for "I learned something new" and "I learned to apply new concepts." Cohort B reported a higher score for "The content was useful to my practice." Both cohorts reported a mean of 4.75 for "Time spent was worthwhile to me" and a mean of 4.5 for "Likelihood to recommend."

Participants were surveyed to provide subjective feedback for things that the program did well and opportunities for improvement. Cohort A provided 20 (65%) comments and Cohort

B provided 11 (35%) comments. Responses were categorized by cohort and a thematic analysis was completed. Themes were identified upon saturation.

For things that the program did well, Cohort A commented about being in-person (29%), the knowledge and attitude of facilitator (24%), organization of the offering (24%), appreciation of snacks (12%) and curriculum content (12%). Cohort B commented about curriculum content (50%), appreciation of the offering (38%), and the format for delivery (13%). For opportunities to improve, Cohort A commented about wanting more time in each session to engage in dialogue with peers and facilitator (74%), request for slides to be provided (13%), and more variety of snacks (13%). Cohort B had one comment that they would have liked to attend the in-person cohort (100%), see Appendix G.

Evaluation results for Cohort A and Cohort B were pooled for overall program evaluation. Participants scored each of the five statements between 4 and 5 with mean scores ranging from 4.13 for “I learned something new” to 4.75 for “Time spent was worthwhile to me.” Subjective feedback analysis yielded that the program content and format were done well (47%) and that the greatest opportunity for improvement is adding more time for each session (60%), see Appendix G.

Part 5

Discussion & Conclusion

Participant recruitment suggests that nurse managers and assistant nurse managers are eager to engage in professional development offerings. Fifty two percent of the nurse managers and assistant nurse managers that received the recruitment emails were enrolled. When the program was initially offered, 30 percent of all nurse managers and assistant nurse managers completed the pre-program survey and engaged with the introduction session. Twenty seven percent completed the full program in Cohort A or B, with half of the participants enrolled in each cohort.

Participant attrition had the greatest impact on implementation. For both cohorts, only half of the enrolled participants completed the full program. This is consistent with the observation that nurse managers have a broad scope of clinical and leadership responsibilities that include competing priorities such as staffing and patient care. These responsibilities are often prioritized over nurse manager participation in professional development or wellness initiatives. Nurse managers need support from their senior leadership teams to prioritize participation in wellness offerings. This can be achieved when the senior leaders establish a culture where employee wellness is given utmost importance and resources are allocated to allow nurse managers the non-productive time to focus on wellness initiatives.

In addition to senior leadership prioritizing nurse manager participation in wellness programs and offering resources to support them, additional considerations for program delivery should be discussed. This program was delivered in two structured formats, and the structures offered little flexibility for participants. Considerations for more flexible offerings should be made. Virtual and on-demand offerings may be simpler to implement and more cost-effective, however, the results of the program evaluations suggest that participants value the opportunity to engage in person with the facilitator and their peers. Future implementation should consider using live instruction delivered virtually to a cohort that is gathered in person, with multiple

offerings. This would reduce cost and resources for content delivery but still provide participants with the opportunity to connect with peers in person. Other modifications for future implementation could include a hybrid offering where the cohort can meet in person for a portion of the offerings and then virtually for the remaining offerings.

Only half of the enrolled participants successfully completed the program, however, analysis demonstrated that there was statistical significance in the outcomes measured. There was evidence to support that nurse managers who participated in the program experienced an increase in both knowledge and Joy in Work. Those that completed the full program shared feedback that the content was useful to their practice and that they felt the time spent in the program was worthwhile. Most subjective comments from Cohort A were about the value of being in person and wanting more time in each session to engage in dialogue with peers and facilitator. Subjective comment from Cohort B provided insight that virtual participants would have preferred to attend the in-person sessions. Additional feedback was that nurse managers appreciated the offering that was designed exclusively for their unique nurse leader role.

Future Recommendations

Future implementation of a cohorts where the facilitator is virtual and participants are in person, and cohorts delivered in a hybrid offering will provide additional information about impact. This can be used to inform future offerings to healthcare partners. With all four cohort options developed and studied, organizations can select the option that is best suited for delivery to its stakeholders. Recommendations to collect demographic information for participants could offer additional insight into impact based on age, gender identity, education level, and years served in the assistant nurse manager or nurse manager role.

Limitations

The results of this DNP Project are limited due to small cohort size (n=16). The greatest challenge for implementation of this program was attrition. Enrolled participants self-reported

that attending a voluntary wellness offering was often de-prioritized over other competing clinical and leadership responsibilities.

Modification for Sustainability

Evaluation and analysis suggest modifications for program delivery. A hybrid offering, multiple synchronous in-person sessions, and a dedicated online platform for virtual delivery would address the attrition challenges and support participation and completion. A train the trainer program would allow organizations to designate subject matter experts as facilitators to offer the program internally at their own cadence.

Recommendations for Scalability

Based on evaluation and analysis, participants recommended that the duration of each session be increased from 30 minutes to 45 minutes to provide additional time for dialogue with the facilitator and peers. Additional recommendations included to expand the content to include all nine tenets to further enhance the offering and expand the learning opportunities for participants. Requests to deliver the program across the health system and state-wide have been considered.

Policy and Broader Healthcare Systems Implications

Nurse managers are key leaders on the healthcare team, and they are at high risk for burnout. The skilled and knowledgeable nurse manager's contribution to leadership, operations, and patient care is essential to the success of any healthcare organization. While organizations scramble to recruit and retain staff, the role of the nurse manager in employee recruitment and engagement cannot be underestimated. Amidst the vast amount of post-pandemic resiliency and wellness offerings, few are tailored to support the unique challenges that face the role of the nurse manager.

Recruitment for this program demonstrates that nurse managers are eager to engage in professional development offerings that support well-being and resiliency. The project results indicate that providing nurse managers and assistant nurse managers with the opportunity to

learn about self-reflective practices was well-received by stakeholders and had a positive impact on learning and Joy in Work. The ability for participants to reserve 10 to 30 minutes per week to participate was impacted by staffing challenges and competing organizational or unit-based priorities. Organizations that offer professional development and well-being initiatives must have senior leaders that are committed to making the initiatives a high-priority item and guaranteeing support for participants to engage and complete the program.

Conclusion

Nurse managers were selected as the target audience for this DNP Project because they are key clinical leaders at the unit and staff level, yet they frequently report feeling undervalued. They are also at higher risk for burnout and turnover than healthcare leaders at other levels. A program developed exclusively for nurse managers using framework from the AONL Nurse Manager Competencies was an effective way to deliver education about self-reflective practices that can be used to support well-being, especially during periods of chronic distress. The two cohorts in this DNP Project were small, however, analysis demonstrated that there was statistical significance in the outcomes measured and there was an increase in both knowledge and Joy in Work. The thematic analysis of the program evaluations found that nurse managers appreciated the offering that was designed exclusively for their unique role, they enjoyed the opportunity to gather and learn with peers, and that they desired more time to engage with the facilitator and each other. As hospitals and health systems struggle to recruit and retain nursing staff, the value of the nurse manager should not be underestimated- and senior leaders can demonstrate value and support for nurse managers through offering programs and initiatives such as this DNP Project.

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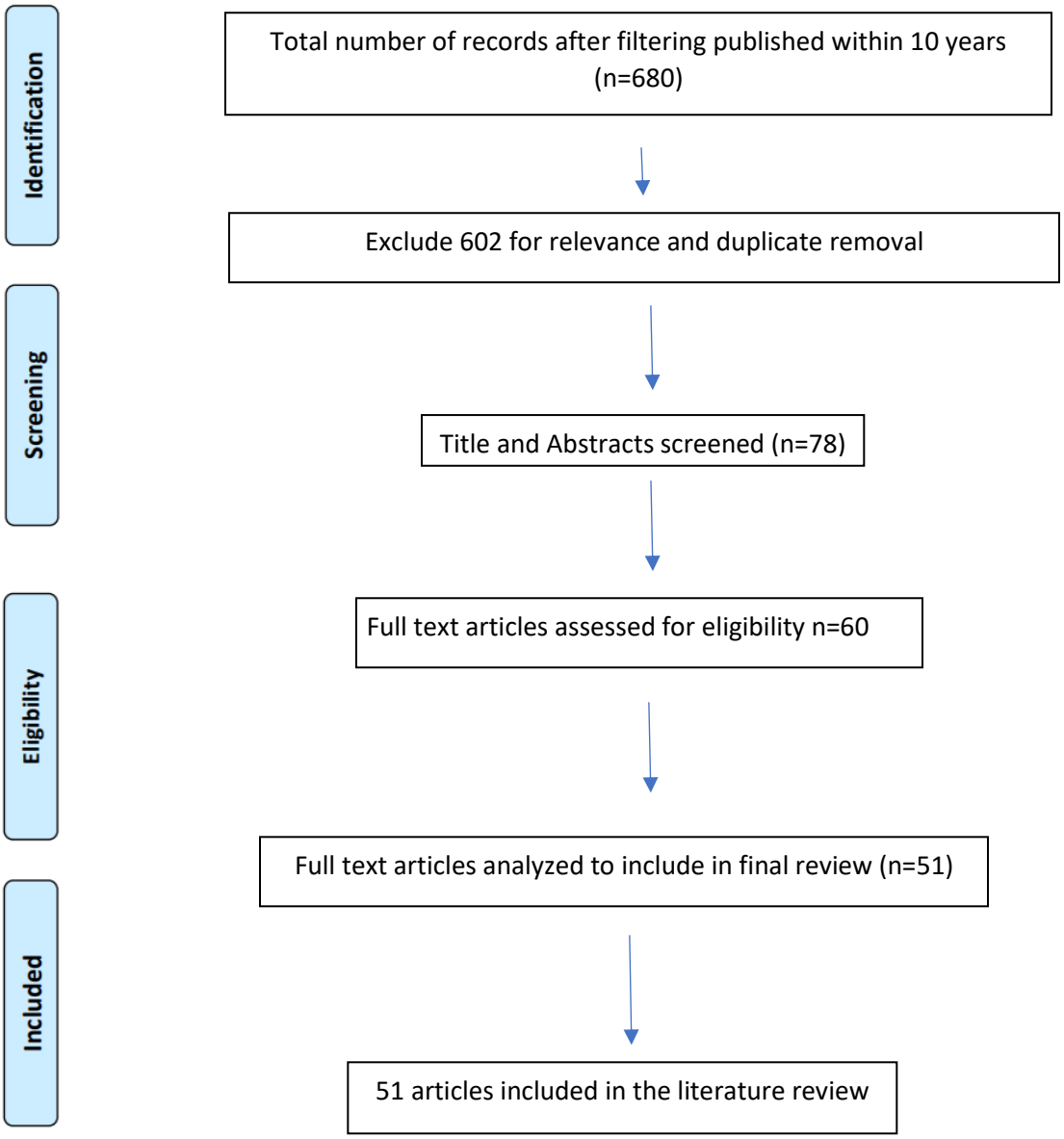
Appendix A

Prisma Study Flowchart



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Appendix B

Project Model

Lippitt's Seven-Step Change Model

Lewin's Change Theory	Nursing Assessment	Lippitt's Seven-Step Change Model	
Unfreezing	Assessment	Phase 1: Diagnose the problem	Nurse leaders have experienced a period of chronic distress during the pandemic.
		Phase 2: Assess motivation and capacity for change	As a result of the chronic distress, nurse leaders are at high risk for burnout and seeking resources to support them with building resiliency.
		Phase 3: Assess change agent's motivation and resources	Hospital systems are experiencing a workforce crisis and are motivated to provide resources that support their workforce to prevent burnout and resignation.
Moving	Planning	Phase 4: Select change objective	This DNP Project will develop a program that uses reflective practice principles to support nurse manager well-being.
		Phase 5: Choose role for the change agent	The facilitator will serve as the change agent and provide the education and facilitated dialogue for each session of the curriculum.
	Implementation	Phase 6: Maintain change	Nurse managers participate in the group learning sessions and demonstrate engagement with the learning.
Refreezing	Evaluation	Phase 7: Terminate the helping relationship	Nurse managers will complete the learning and report increased knowledge acquired, the new knowledge is applied to professional practice and leading teams. Program Evaluation results will be used to identify opportunities for modifications to future program offerings.

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Appendix C

SWOT Diagram

Appendix D

Reflective Practice Tenets

3 THE LEADER WITHIN

REFLECTIVE PRACTICE REFERENCE BEHAVIORS/TENETS

Utilizing a set of guidelines and tenants that facilitate reflective practice; these may be individually developed or can be based on specific models developed by others; below are the "Dimensions of Leadership" developed by the Center for Nursing Leadership, which offer an example of a set of guidelines/tenants that can be used as a tool to guide personal reflection of an individual's leadership behaviors.

1. **Holding the truth**
   The presence of integrity as a key value of leadership
2. **Appreciation of ambiguity**
   Learning to function comfortably amid the ambiguity of our environments
3. **Diversity as a vehicle to wholeness**
   The appreciation of diversity in all its forms: race, gender, religion, sexual orientation, generational, the dissenting voice and differences of all kinds
4. **Holding multiple perspectives without judgment**
   Creation and holding a space so that multiple perspectives are entertained before decisions are rendered
5. **Discovery of potential**
   The ability to search for and find the potential in ourselves and in others
6. **Quest for adventure towards knowing**
   Creating a constant state of learning for the self, as well as an organization
7. **Knowing something of life**
   The use of reflective learning and translation of that learning to the work at hand
8. **Nurturing the intellectual and emotional self**
   Constantly increasing one's knowledge of the world and the development of the emotional self
9. **Keeping commitments to oneself**
   Creating the balance that regenerates and renews the spirit and body so that it can continue to grow

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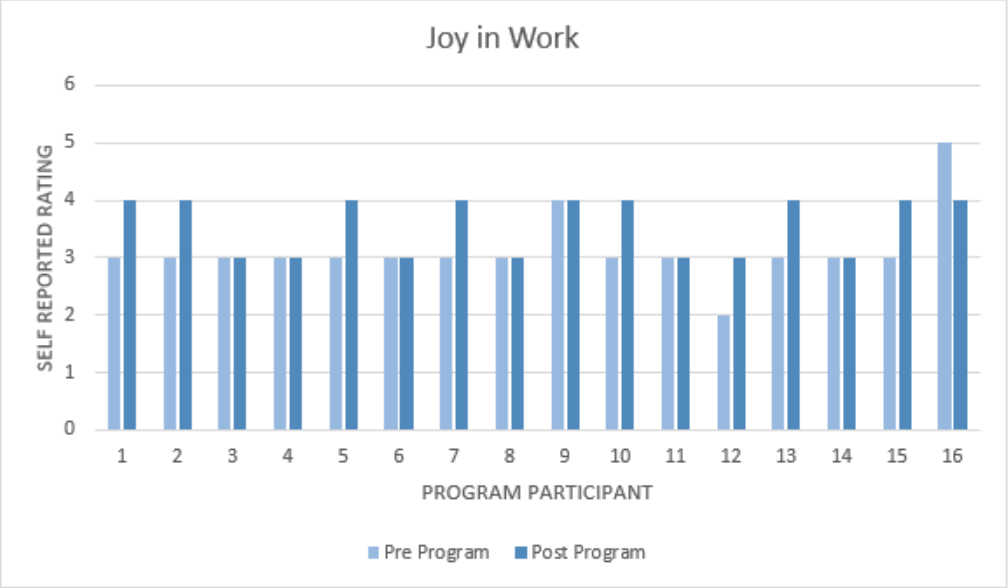
From AONE, AONL. (2015). AONL Nurse Manager Competencies. Chicago, IL: AONE, AONL. Retrieved from www.aonl.org

Appendix E

Results: Joy in Work

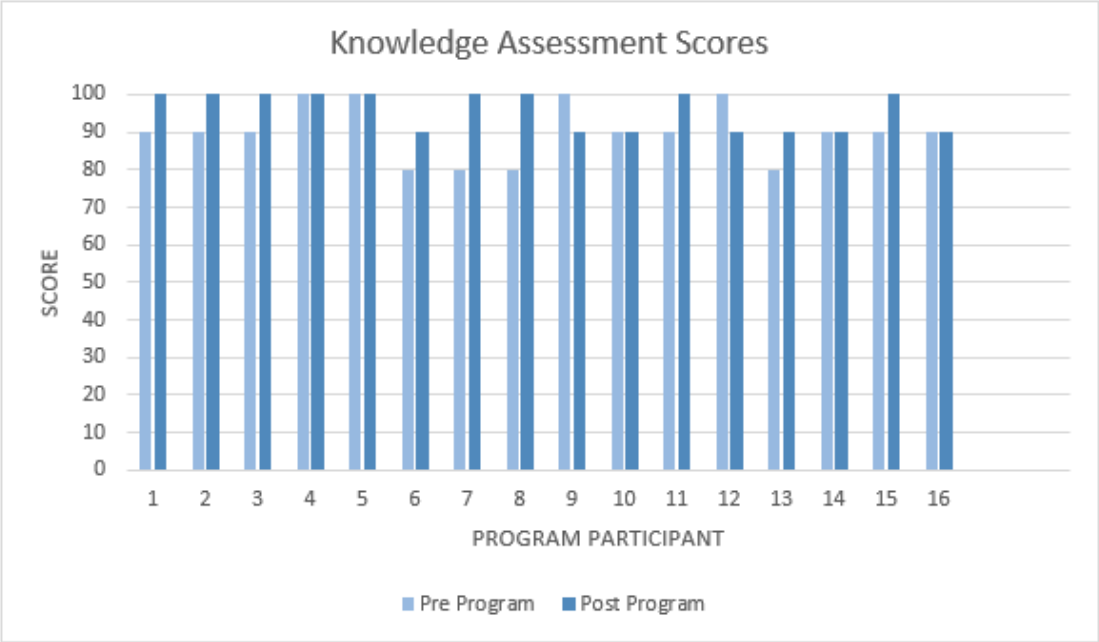


Paired Samples Statistics				
	Mean	N	Std Deviation	Std Error Mean
Pre Joy in Work	3.1250	16	.61914	.15478
Post Joy in Work	3.5625	16	.51235	.12809

Paired Samples Test							
	Paired Differences						
				95% CI of the Diff		Significance	
	Mean	Std Dev	Std Err Mean	Lower	Upper	t	Two-sided p
Pair	-.43750	.62915	.15729	-.77275	-.10225	-2.782	.014

Appendix F

Results: Knowledge Assessment Score

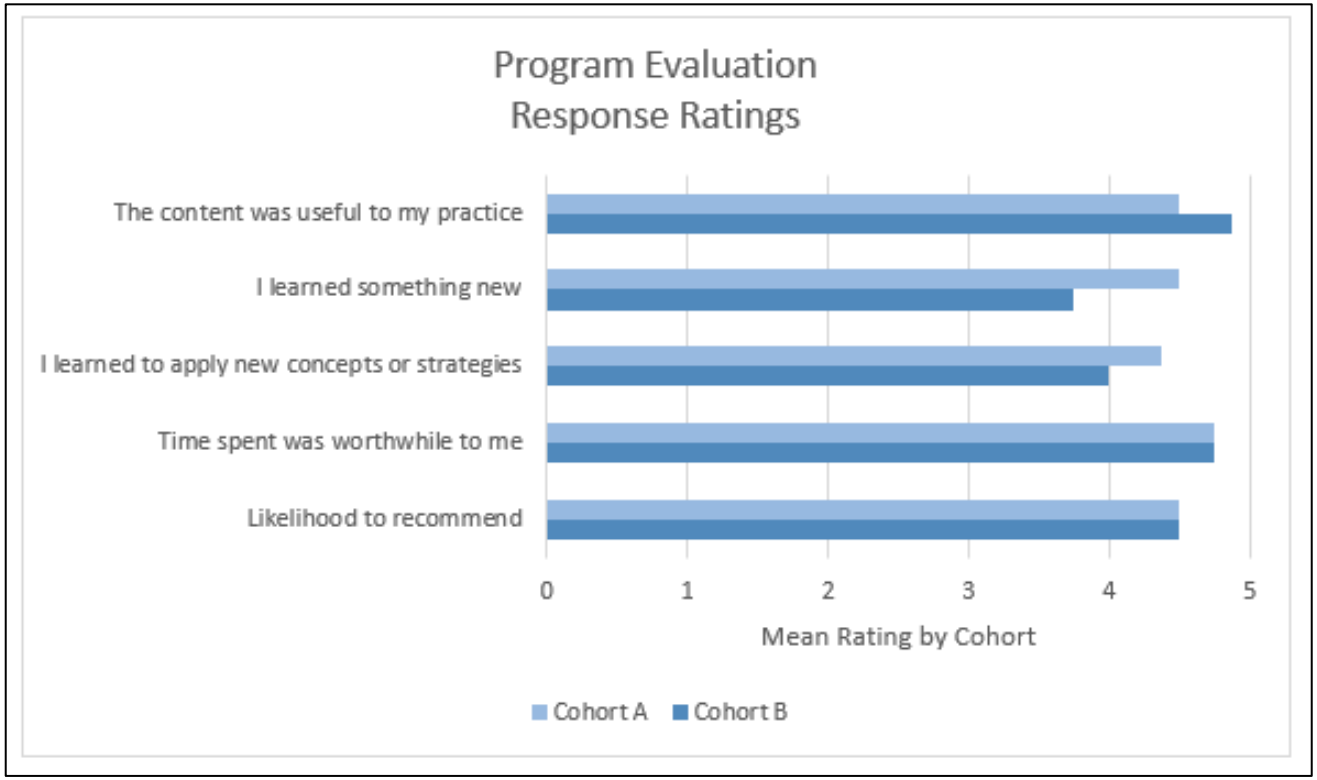


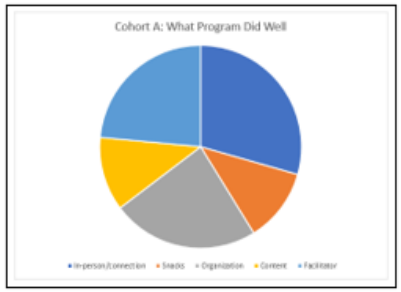
Paired Samples Statistics				
	Mean	N	Std Deviation	Std Error Mean
Pre Knowledge	90.0000	16	7.30297	1.82574
Post Knowledge	95.6250	16	5.12348	1.28087

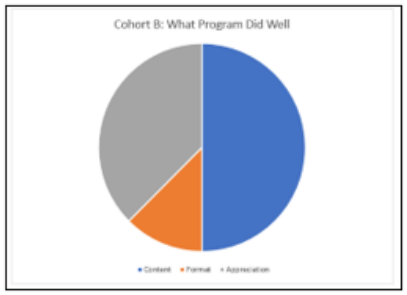
Paired Samples Test							
	Paired Differences						
				95% CI of the Diff		Significance	
	Mean	Std Dev	Std Err Mean	Lower	Upper	t	Two-sided p
Pair	-5.62500	8.92095	2.23024	-10.37864	-.87136	-2.522	.023

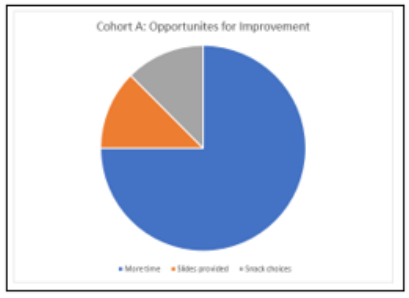
Appendix G

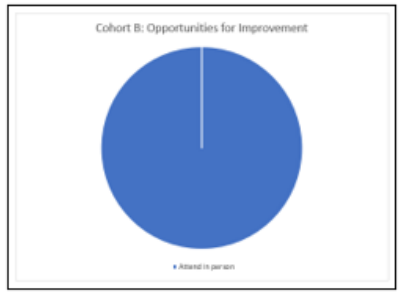
Program Evaluation

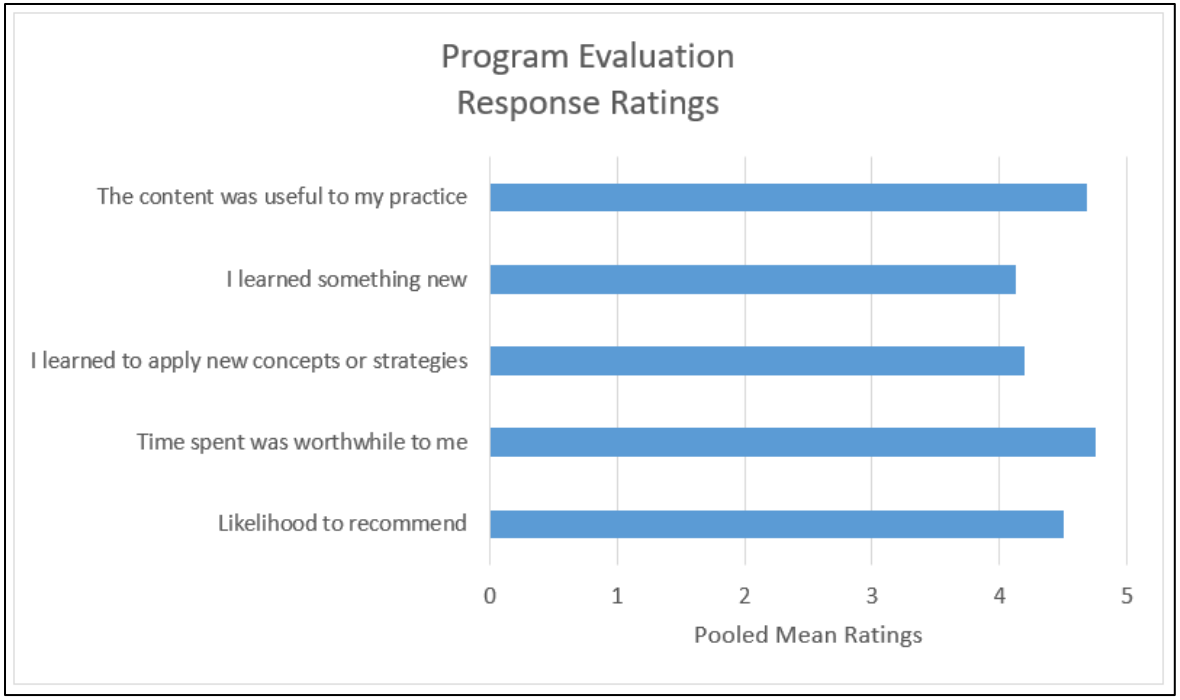


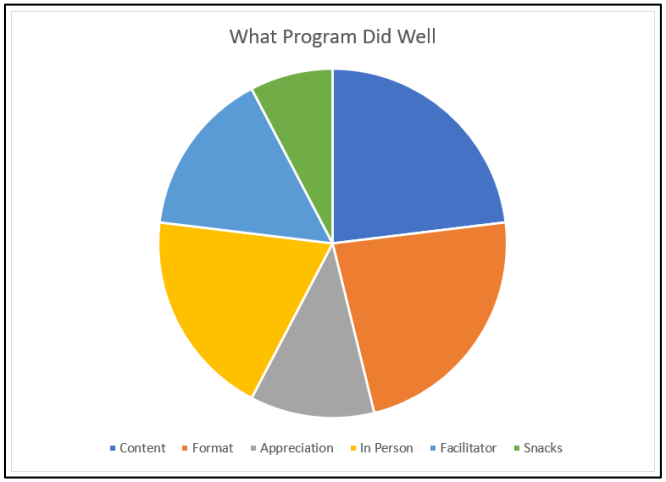


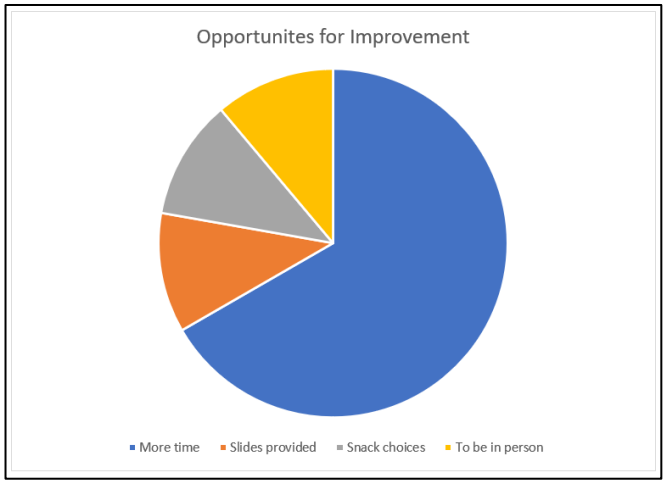







Program Evaluation
Response Ratings
The content was useful to my practice
I learned something new
I learned to apply new concepts or strategies
Time spent was worthwhile to me
Likelihood to recommend
0
1
2
3
4
5
Pooled Mean Ratings


What Program Did Well
Content
Format
Appreciation
In Person
Facilitator
Snacks


Opportunites for Improvement
More time
Slides provided
Snack choices
To be in person