A Resilience Toolkit: Helping Nurse Leaders Foster Resilience Amongst Frontline Nurses

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Summary

Introduction

The COVID-19 pandemic imposed unprecedented stresses on the healthcare system, particularly on nursing. According to a 2020 survey conducted by the Washington Center for Nursing (WCN), 42% of nurses in the state of Washington considered or planned to leave nursing because of the pandemic (Washington Center for Nursing, 2021). Nurses have also reported mental health concerns such as distress, anxiety, depression, and insomnia in relation to the COVID-19 pandemic. Resilience has been identified as a foundational component needed for good mental health (Lai, C. C. et al., 2020), therefore the argument can be made that fostering resilience in the nursing workforce may contribute to improved mental health outcomes. Nurse leaders have been identified as playing an influential role in the support of frontline nurses and should offer solutions to support the mental health of their teams (Mo et al., 2020).

The American Psychological Association (2020) defines resilience "as the process of adapting well in the face of trauma, tragedy, threat, or significant sources of stress". Resilience has been found to be a protective factor in the prevention of burnout among nurses, as well as has been shown to help positively deal with challenges and manage stress (Jose et al., 2020). Resilience has also been found to help mediate the effects of stress, burnout, fatigue, depression and anxiety, and other effects of professional demands (Yu et al., 2019). Furthermore, nurses who demonstrate higher levels of resilience were found to have greater job satisfaction (Yu et al., 2019), and therefore may be less inclined to leave their position. In order to support the nursing workforce, it will be essential for nurse leaders to employ strategies to help foster the resilience of their teams.

The WCN is committed to the health and success of Washington's nursing professionals. As a part of this commitment, the WCN is interested in exploring interventions to support the nursing workforce in building resilience. This toolkit was created in partnership with the WCN in an effort towards achieving this goal and is available for use to those interested in furthering this work.

Implementation

This resilience toolkit aims to provide nurse leaders with a resource that can be used with frontline nursing teams as a resilience building intervention. A range of different tools have been included to make the toolkit adaptable for varying departments and clinical settings. These tools may be used independently or in combination with one another, requiring no specific order of use, dependent on the needs of the individual or the team. Also included in this toolkit is the Brief Resilience Scale (BRS), which nurse leaders can provide to their teams as a reflective exercise for staff to obtain a baseline measurement and understanding of their personal state of resilience.

Nurse Leader Utilization

As previously noted, the intent of this toolkit is to provide nurse leaders with an adaptable set of resources that they may use to meet the needs of their teams. This section provides further considerations and recommendations for the utilization of the individual tools.

The toolkit provided first offers a resilience measuring tool, the BRS. The BRS is an evidence-based and validated tool for measuring the baseline resilience of an individual. The BRS is included so that nurse leaders can provide their team the opportunity to think about and identify their personal resilience level. Completing the BRS allows an individual to reflect on why their score does or does not align with their personal perception of themselves and begin the process of better understanding their own resilience. The intended use is for nurse leaders to encourage their team members to use the BRS as a tool for reflection rather than a means of collecting data.

The interventions in this toolkit can be divided into two main categories. The first of these categories are tools that staff can utilize independently and include the REST mnemonic and mindfulness interventions. The REST mnemonic is comprised of four strategies that focus on building resilience. This four-letter pneumonic may be provided to staff via a variety of platforms. A nurse leader may choose to present the mnemonic at a staff meeting or via email, as well as provide supplemental reminders such as buttons, strategically placed signage, or email signature. Additionally, nurse leaders may include suggested interventions for each strategy. This low-cost intervention allows for staff to practice these strategies during downtime, both in and outside of the workplace. The other individual focused toolkit item provides mindfulness practices that may be utilized. Included is a mindfulness book that can be purchased for approximately $25.00 per copy and provides a variety of mindfulness practices that include journaling, breathing and body exercises, and mindfulness techniques for everyday life. The other mindfulness resource provided is a free website or phone application through UCLA Health that has three-to-twenty-minute audio or text guided meditations in a variety of languages. When selecting an intervention nurse leaders may consider such factors as whether the intervention needs to be cost neutral, or if their teams are in need of tangible tools for practice and the accessibility needs associated with these tools.

The second category of tools are those that are partner or group focused. Nurse leaders may consider using these tools when there is a need or desire to foster community and collaboration amongst their teams. The partners in crisis resource aims to create supportive relationships between two peers, where the paired individuals provide support and a safe space to process during stressful times. This can take place in the workplace with an informal or structured approach, dependent on the capacity of a unit to carve out dedicated time and ability or resources to pay staff for their time specifically for this. The implementation of partners in crisis allows flexibility for leaders and can be implemented with little to no monetary cost as needed. Also provided is a guide that nurse leaders can use for leading debriefs with their teams. Debriefs are useful tools for nurse leaders to employ when assisting their teams in navigating critical events or even stressful times. The tool provided outlines important considerations for leaders when navigating these conversations based on the topic of the debrief, including who should be

involved, how to approach the topic of concern, and how to guide the conversation. Debriefs are low cost, as they do not require extensive training and they can be done real-time as needed.
Finally, the Community Resilience Model is the additional tool provided and it is focused on creating and fostering a community of resilience, valuing diverse perspectives and communities. This program does have an associated cost and two potential different approaches. A nurse leader may choose to send one or more staff to become trainers to a five-day training with a cost of $1,900.00 per person. Alternatively, leaders may choose a team training approach which the cost will vary dependent on the size of the group. Nurse leaders should consider such factors as the need for immediate and or long-term interventions and the monetary implications when determining which of the tools above to implement.

Additional Resources

This resource toolkit aims to provide nurse leaders with a functional means of supporting their teams in building resilience. It is however not suited for emergency or crisis support for mental health emergencies. Nurse leaders should be prepared to offer their teams crisis support resources; a few suggested resources provided below. Access to the below resources should be made available to staff regularly, and nurse leaders may consider posting them in break spaces and offices as visual reminders.

- **Crisis Text Line**
  - Text HOME to 741741
  - https://www.crisistextline.org

- **National Suicide Prevention Lifeline**
  - Call 1-800-273-8255
  - https://suicidepreventionlifeline.org

The Brief Resilience Scale

Introduction: The Brief Resilience Scale (BRS) is an evidence-based tool that may be utilized to measure an individual's resilience level. The BRS specifically aims to measure one's ability to bounce back from stress (Smith et al., 2008).

How to use: The BRS should be administered to staff before the tool kit interventions are implemented to gain a baseline resilience level. This tool should be used as an opportunity for an individual to measure and reflect on the current state of their personal resilience.

Evidence to support its use: The BRS has proven to be a reliable resource for measuring individual resilience (Smith et al., 2008).

	Please select 1 box per row.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 2	I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 3	It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 4	It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 5	I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 6	I tend to take a long time to get over setbacks in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Scoring: Divide the total sum of scores by 6 to get a total average score. **My score:** _____

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The Brief Resilience Scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200. DOI: 1080/10705500802222972

Interpretation

Sum	Man	Level
30	5.00	Very High
29	4.83	Very High
28	4.67	Very High
27	4.50	High
26	4.33	High
25	4.17	High
24	4.00	High

Sum	Mean	Level
23	3.83	Medium
22	3.67	Medium
21	3.50	Medium
20	3.33	Medium
19	3.17	Medium
18	3.00	Medium
17	2.83	Low

Sum	Mean	Level
16	2.67	Low
15	2.50	Low
14	2.33	Low
13	2.17	Low
12	2.00	Very Low
11	1.83	Very Low
10	1.67	Very Low

Sum	Mean	Level
9	1.50	Very Low
8	1.33	Very Low
7	1.17	Very Low
6	1.00	Very Low

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Smith, B. W. (n.d.). *User guide for the stress adaptation scale.* Unpublished manuscript.

Partners In Crisis

Introduction: Partners in crisis is an adaptation of a peer support system utilized by the United States military. This program works by pairing staff who are experiencing similar stressors and serves as a partnership through which both individuals can connect and provide a safe supportive environment for anticipating, processing, and planning for coping with emotions, stressors, and challenges.

How to use: Partners in crisis can be used during times of crisis or organizational strain when frontline staff are faced with increased stressors, burden, or uncertainty in their work. Nurse leaders may pair staff based on factors such as seniority, specialties, or pair people randomly (Albott et al., 2020). Partners may meet 2-3 times per week or more as needed. Meetings may be structured with sample questions or be open dialogue. Partners can meet for formal meetings, or the check ins may be via text, phone, or video chat. Ultimately meetings should occur in the forum most conducive for participants. Further guidance can be found via the provided resource.

Evidence to support its use: Social supports have been identified as important factors for in mitigating workplace stress (Tam et al., 2004), and in building resilience (Öksüz, 2018). During the COVID-19 pandemic the Washington State Department of Health recommended resilience building programs including those involving the anticipate, plan, deter model, on which the adapted partners in crisis program is based (Washington State Department of Health, 2020).

Resources:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7199769/

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REST

Introduction: The REST mnemonic is a tool that can help build individual resilience. REST stands for: Relationships, Exercise, Soul, and Transformative thinking. Because it is an easy to remember four letter sequence, it is a useful tool that frontline staff can use as a reminder throughout their workday.

How to use: The REST mnemonic as outlined by Rajaman et al. (2020), involves four strategical prompts for individuals to remind themselves of. The first of these is fostering healthy **relationships** with both self and others. The second is **exercising** the body, mind, and spirit, which may include physical exercise or mindful meditation. The third is **soul** or practicing self-compassion towards oneself through self-kindness. The fourth is **transformative thinking,** which requires an individual to reflect on situations and consider what may have gone wrong or gone well, identifying barriers, and thinking about how better or differently things can be done moving forward.

This tool can be shared proactively with staff, either via electronic or in person forums. The mnemonic makes it easy to remind staff of this tool via signs, buttons, messages, or other workplace reminders.

Evidence to support its use:
The REST mnemonic has been specifically developed for nurses and nursing students and incorporates evidence-based practices that focus on building an individual's protective factors (Stephens, 2013) in their ability to navigate stressful events and adversity and help to foster resilience.

Resources:
http://www.qgdigitalpublishing.com/publication/?i=667049&article_id=3719704&view=articleBrowser&ver=html5

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Debrief

Introduction: The utilization of debriefs after traumatic, critical, or difficult events has been found to help foster resilience. Debrief sessions allow a safe space for those involved to review an incident and discuss the impact it had on them while also helping to identify what did and did not go well in an effort to better prepare for future occurrences.

How to use: Debriefs may be held after such events as difficult patient care experiences, traumatic events, prolonged periods of high stress, or other severe stress inducing occurrences. These may vary in both the number of participants involved as well as duration. Typically, a debrief may be led by a team leader with some or all of those involved in a critical incident. Factors leaders should consider in preparation for a debrief include the purpose of the conversation and who to include. Leaders should allow staff to share initial reflections, feelings and should validate these experiences. When leading the debrief it is important that leaders set clear expectations about the purpose, length, and structure of the conversation.

Evidence to support its use: Debriefing has been identified as a tool to promote resiliency (Schmidt, & Haglund, 2017) by providing an opportunity to practice both self-reflection and one's involvement in a critical incident. Additionally, debriefs are recommended by The Joint Commission (Salas et al., 2008).

Resources:

*See attached document

Mindfulness Practices

Introduction: Mindfulness practices allow individuals to exercise being present in the moment, paying thoughtful attention to one's feelings, thoughts, and the surrounding environment. Mindfulness exercises can vary, which means they can be easily adapted for personal needs.

How to use: Nurse leaders can share mindfulness practices and techniques with their teams, allowing for individual practice to be either formal or informal. These practices may be further facilitated by nurse leaders by providing quiet space or dedicated time for their teams to practice.

Of note, for staff who have experienced trauma, particular care should be used when suggesting mindfulness practices. Trauma-informed practices and approaches may be most appropriate.

Evidence to support its use: Mindfulness has been identified as a strategy that nurse leaders can employ to help foster resilience amongst their teams (Wei et al., 2018). Additionally, mindfulness trainings have been found to positively influence resilience in medical professionals (Krogh et al., 2019).

Resources:
https://www.newharbinger.com/9781684033553/a-mindfulness-based-stress-reduction-workbook/
https://www.uclahealth.org/marc/body.cfm?id=22&iirf_redirect=1
https://apps.apple.com/us/app/ucla-mindful/id1459128935?ls=1

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Community Resilience Model

Introduction: The Community Resilience Model is a program that provides a trauma-informed approach to training individuals in wellness skills and helping to build resiliency (Trauma Resource Institute, 2022).

How to use: The Community Resilience Model teaches skills to participants that include noticing and tracking one's own sensations, building resources that help them to feel better, grounding to bring one's attention to the present moment, gestures that are self-soothing, and "shift and stay," which involves shifting your attention from a distressing to a more comfortable state (Trauma Resource Institute, 2022). These skills can also be accessed through the iChill app (Trauma Resource Institute, 2021). This program can be employed in one of two ways. Nurse leaders may choose to either to provide training for their entire team, or have selected individuals receive teacher training, who then may provide trainings at the local unit level.

Evidence to support its use: The Community Resilience Model has been shown to increase both resilience and well-being amongst frontline nurses and has proven effective in supporting staff in self-stabilization at work during stressful times (Grabbe et al., 2019). It has also been identified as a useful intervention to help increase nurses stress tolerance and capacity for self-compassion (Grabbe et al., 2019).

Resources:
https://www.traumaresourceinstitute.com/crm
http://www.ichillapp.com

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Debrief Document Attachment

EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2021) **33**, 925–927 doi: 10.1111/1742-6723.13856

TRAINEE FOCUS

How to lead a hot debrief in the emergency department

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Effective team communication is a critical element of ED performance. Trainees are encouraged to develop skills in leading resuscitation and trauma teams through effective prebriefing, recaps and handovers.

Recently, attention has turned to 'debriefs' – conversations that support team reflection on clinical practice. These may occur after discrete clinical events, after a shift or at other times. The impact of clinical debriefing can be powerful – by improving performance, encouraging learning and mitigating psychological distress.

As with many powerful communication techniques, there are risks. Conversations that are badly executed may fail to identify points of improvement, magnify team conflicts, exacerbate feelings of distress or simply waste time when there is work to be done. Emergency physicians and trainees may hesitate to lead clinical debriefings when they have had poor prior experiences or lack confidence in their own skills. They will find it harder to lead clinical debriefings if there is no local departmental strategy.

There are many useful resources available. Some focus on designing and implementing departmental clinical debriefing strategies,[1] encouraging reflection on important questions such as purpose,[2] timing, location, triggers, who leads debriefs and processes for following up outcomes of these conversations. While there is heterogeneity in successful programmes – some are designed purely for quality improvement impact, some are led by senior nurses,[3] while others are focused on a narrow performance indicator such as paediatric intubation[4] – all share strong leadership and clarity on these issues, underlining the need for consistency and intentionality in departmental programmes.

Other published resources focus on the structure and use of language in leading debriefing conversations and include helpful tools to support these conversations, for example STOP,[5] TALK,[6] INFO,[3] and DISCERN.[7] These give confidence to those leading a hot debrief and consistency for participants. However, any generic tool is a blunt instrument when applied to the diverse clinical situations where debriefing may help. For example, insistence on finding 'points to improve' after an unsuccessful paediatric resuscitation may be inappropriate if the team is merely seeking defusal of strong emotions, appreciation and 'sense-making'.

We offer an approach for trainees when asked "Can we do a debrief?" after a clinical event in the ED.

Principles

1. Consider the *purpose of the conversation*. Does the team need a chance to review performance, defuse high emotion, or take an opportunity for a teaching moment? Are the needs within the team similar or heterogeneous? Are those needs urgent?
2. Consider the *departmental strategy* (or lack thereof) for clinical debriefing. Align your debrief plan with the strategy, adapt to current purpose and tailor expectations of team members' participation accordingly.
3. *Ask one or two other senior team members* if they think a hot debrief is appropriate right now, and what they think the needs of the team are and the purpose of the conversation. Listen to what they say.
4. Consider *who needs to be part of this conversation* and where it should happen. Is this just ED doctors and nurses? Or should the conversation involve other specialities, social work, porterage staff or others integral to the team. Reflect on the balance of feasibility and the 'ideal' conversation.
5. *Be clear and set expectations*. Gather the team, thank them for their work and give them a clear idea of the length, purpose and structure of the conversation you are going to lead. Encourage but do not mandate participation. Promise respect but not confidentiality (unless you truly can promise it).
6. *Open the conversation* to initial reflections, thoughts and feelings – acknowledge, normalise and validate feelings. Actively listen. Resist temptations to immediately 'rebut' negative thoughts or perceptions. Encourage appreciation of efforts, irrespective of performance. These strategies will support psychological safety, akin to those familiar in simulation debriefing.[8]

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Accepted 21 August 2021

7. Provide a *detailed, objective description of events* from you or another staff member with sufficient overview of the clinical event. 'Sense-making' is probably one of the most important outcomes for team members – whether to mitigate psychological distress, or for individual or team learning. Seek questions for clarification of the event.
8. Decide whether the team is ok to move from emotional defusal to *cognitive analysis*. If appropriate, *use a departmental tool or personal structure* to discuss things that went well, opportunities for improvement, and any outstanding issues that require follow up. Listen. Allocate responsibility if there are important next steps.
9. *Watch and listen for signs that individual team members require more than the immediate team-based conversation*. Know your resources for supporting more significant psychological distress – psychological first aid, secondary 'cold' debriefings, conversations with more senior staff and employee assistance schemes. Teaching points or performance feedback relevant only to individuals should be shifted to a different conversation.
10. *Reflect on your experience* leading the conversation and discuss with colleagues – peers, senior nurses and consultant supervisors. Provide feedback to leaders of your local clinical debriefing strategy.

Practice

We offer a series of hypothetical case vignettes to illustrate the application of these principles to clinical situations in the ED.

Scenario 1: Debriefing with a quality improvement focus

Britt is leading the ED team who have just intubated a young woman with an altered level of consciousness secondary to a quetiapine overdose. The ED has a strategy to debrief after every intubation as a quality improvement initiative. Britt gathers the team who are familiar with the process and structure of these conversations. There is a 5-min discussion. Britt runs through the details of the case, the team agrees that the intubation went well with clear roles, appropriate induction agents and first-pass success without pre-oxygenation. The airway nurse lets the team know that there are no more sterile video laryngoscope blades, and the nursing shift coordinator agrees to follow up after the debrief. A medical student is interested in how ketamine works, and Britt arranges to chat with him after the team debrief.

Scenario 2: Debriefing when there is psychological distress

Jack is leading the ED team who have just ceased resuscitation efforts on a 75-year-old man who arrived in ED with breathlessness and severe pleuritic chest pain, and then went into a PEA arrest. The resuscitation was a bit messy and there was a lack of clarity about whether the patient would be put on ECMO. The team are 'keen for a debrief', and Jack perceives this is a combination of frustration with ICU and some distress about the death. It is 06:30 and Jack does not feel confident to lead the debrief. After discussion with the nursing team leader, they decide to delay the conversation and ask the morning ED consultant to run an initial debrief and help decide on any next steps.

Scenario 3: Debriefing for learning at end of shift

Mei is working a day shift in the ambulatory care area of the department with three residents and four nurses. At their start-of-shift team huddle, Mei flags to the doctors that she plans to have a short debrief with them at the end of the shift and has invited the nurses to join if their workloads allow. Just prior to nursing handover at 3 pm, Mei pulls the team together and thanks them for their work during the day, and asks the team to reflect on their learning points from the day. They spend 10 min briefly discussing antibiotics for cellulitis (are they necessary?), imaging in back pain and the best ways to remove a fish hook.

Scenario 4: Debriefing dilemmas

Roger is leading a team who have just looked after a major trauma patient on night shift. He thought it went well – they got to CT quickly and delineated the injuries needing urgent treatment. As part of the departmental debriefing strategy, Roger gathers the team for a STOP debrief.[5] The nursing team leader is reluctant to spend much time on this chat given the workload at present. Roger quickly summarises the case, and then invites discussion. No one has much to say, except for one of his registrar colleagues who is fuming about what she perceived as dismissive comments made by the anaesthetic registrar. She makes several generalisations about bad behaviour of anaesthetics registrars (who are not present for the debrief). Roger acknowledges the frustration, but gently closes the team discussion after thanking everyone for their efforts. He later checks in with the other registrar and realises there are stressors at home, but is reassured she has support to manage them.

Conclusion

We encourage trainees to embrace clinical debriefing as leadership practice, and as part of a repertoire of skills in leading conversations with teams. We emphasise these conversations should be guided by principles, rather than over-reliance on simple formats. We suggest developing skills through observation, practice in simulation, seeking feedback and through reflection on others' experiences.

Competing interests

None declared.

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