Letters to the Editor

Resources Needed to Build Resiliency

As a nurse for over 5 years, the article “The Impact of Resiliency on Nurse Burnout: An Integrative Literature Review” (Brown, Whichello, & Price, 2018) spoke to me about the problem of burnout in the nursing field. Many of us are burning out because we do not have the proper resources, including the tools and skills to cope with ever-increasing stressful work environments. I truly believe many new nurses are not being taught coping mechanisms, and therefore are not gaining resiliency fast enough; as a result, many are leaving the field.

Brown and colleagues believe nurses can become more resilient. I too conceive they can, but we must start preparing our nurses at the student level. According to Bauer (2014), “Educators are ethically responsible for supporting students in managing their stressors and identifying coping mechanisms. If students are not taught to manage stress in healthy ways, their growth in self-awareness and caring capabilities may be impaired which could adversely affect the care they provide for their patients” (p. 2). If we can teach these mechanisms during the education process, we can help reduce nurse burnout and drop out from the field. Bauer also stated, “One approach for retaining nurses and other healthcare professionals in the workforce is to teach health care students effective stress management techniques and health behaviors during their education period prior to entering the workforce” (p. 2).

I cannot stress enough how important it is to begin teaching coping mechanisms early in a nurse’s career. With the looming nursing shortage, we must fight to keep the nurses we have and work to gain new ones. We can accomplish this by helping to provide skills earlier to increase nurse resiliency faster.

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Interventions to Prevent Burnout

In the article, “The Impact of Resiliency on Nurse Burnout: An Integrative Literature Review,” the authors discussed the issue of nurse burnout and how resiliency helps with managing stressful work environments (Brown, Whichello, & Price, 2018). They also wrote about the reasons why nurse burnout occurs. While having a positive outlook on challenging situations is helpful with managing stress, nurses need advocacy to encourage them to use their resources and reinforce self-care as a primary care measure to prevent or address burnout.

As a former licensed practical nurse, I noticed the signs of burnout before it affected my overall nursing performance. I worked at a nursing home that was usually short of nursing staff. The workload was tremendous and in-service training was limited. I would arrive early and leave late. I experienced chronic fatigue because I would only take 15-20 minutes breaks per shift with so much work to be completed. I also felt anxious because I did not want to get in trouble or make a mistake. After I gained several months of full-time experience in the nursing home, I moved into homecare. I worked in homecare for 10 years and decided to become an RN. I was fortunate to notice that changes were needed to prevent burnout and possibly leaving the profession.

Waddill-Goad (2018) discussed how burnout can be seen in different departments of nursing. The author cited examples for preventing burnout, such as using periods of rest to recover both mentally and physically and listening to one’s body to prevent injury to self or others. Waddill-Goad concluded it is the responsibility of organizations or employers and nurses to identify and address the causes of burnout. Organizations such as the American Nurses Association make great efforts to lobby for nurses to practice with acceptable nurse-to-patient ratios to promote patient safety and reduce nurse work strain (Pearce et al., 2018).

Thanks again for this very informative article. Healthcare organizations in general, and nurses in particular practicing in all specialties, will find needed help for decreasing nurse burnout by employing the suggested interventions at the primary, secondary, and tertiary levels of prevention.

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Improving End-of-Life Care

“The Medical-Surgical Nurse’s Guide to Understanding Palliative Care and Hospice” (Croson, Keim-Malpass, Bohnenkamp, & LeBaron, 2018), published by MEDSURG Nursing, was an aptly named, comprehensive discussion of the definition and relevance of in-hospital hospice and palliative care implementation, end-of-life (EOL) symptom management, and patient advocacy within nursing. The authors did an excellent job of explaining hospice and palliative care within the hospital setting. However, not discussed was the underutilization of these important services or the importance of having these conversations in the outpatient setting with primary care providers while patients are still well enough and cognizant enough to participate meaningfully in the discussion.

Many terminally ill patients prefer supportive care, but often the care received reflects a curative rather than palliative goal (Teno, Fisher, Hamel, Coppola, & Dawson, 2002). Although hospice is a Medicare benefit available throughout the final 6 months of life (Croson et al., 2018), admission data strongly suggest the service is underused, with median enrollment lasting 17 days and 25% of beneficiaries only using the service during the last 5 days of life (Kaufman et al., 2018). Dying at home is a frequently endorsed wish (Gomes, Calanzani, GyseI, Hall, & Higginson, 2013) that only about 40% of people attain (Teno et al., 2018).

Croson and co-authors (2018) effectively addressed the process of having difficult but vital EOL conversations during hospitalization. However, patient care can be improved further when these conversations are held before the onset of acute health crisis to allow information exchange that is uncompromised by debility, haste, and distress (Smith-Howell, Hickman, Meghani, Perkins, & Rawl, 2016). Multiple barriers deter having EOL conversations in the outpatient setting, including patient and physician disinclination, prognostic uncertainty (Walczak et al., 2015), and wish to facilitate both hope and continued physician-patient rapport (Tulsky, 2002; Walczak et al., 2015).

Conversational facilitators include having the discussion within the context of fidelity within a well-established physician-patient relationship (Keary & Moorman, 2015). Patients who have achieved greater acceptance of their diagnosis and have assimilated the disease process into their cognitive schema may be more willing to discuss the inevitable (Walczak et al., 2015). Broaching EOL conversations gradually over time within the more emotionally neutral confines of the primary physician’s office allows time for the evolution of emotion and thought, reducing the urgency of decision making under duress and increasing the likelihood EOL decision making will reflect patients’ well-articulated wishes (Smith-Howell et al., 2016).

The process of accurately ascertaining patients’ final wishes in the outpatient setting can be improved. This is relevant to the care given to dying patients who are admitted to medical-surgical units. By reducing uncertainty, previous assertion of wishes can improve the timeliness of EOL nursing care.

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Building Resiliency Among Nurses

I am writing in response to the recent MEDSURG Nursing article “The Impact of Resiliency on Nurse Burnout: An Integrative Literature Review” (Brown, Whichello, & Price, 2018). As an oncology nurse on a busy inpatient unit, I see burnout as an ongoing concern with staff faced with the ever-increasing demands of patient care. Nurses try to balance the difficult assignment of caring for patients in different stages of their health journeys. It is not unusual for nurses to be caring for postoperative patients, those admitted for symptom management, and distress (Smith-Howell et al., 2015). Patients who have achieved greater acceptance of their diagnosis and have assimilated the disease process into their cognitive schema may be more willing to discuss the inevitable (Walczak et al., 2015). Broaching EOL conversations gradually over time within the more emotionally neutral confines of the primary physician’s office allows time for the evolution of emotion and thought, reducing the urgency of decision making under duress and increasing the likelihood that decision making will reflect patients’ well-articulated wishes (Smith-Howell et al., 2016).

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Nurse leaders need to put methods in place to help build resiliency, which has been shown to decrease nurse burnout and improve nurse retention (Brown et al., 2018). As Brown and co-authors found, strategies such as resiliency workshops and mindfulness training are effective ways to support and build resiliency. However, nurses may not see this as necessary and not participate. Schmidt and Haglund (2017) described

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using personal reflective debriefing, in which nurses can talk about a stressful event, what went well, and what could be done differently.

For leaders, using a regular scheduled personal reflective debriefing on a monthly or bi-monthly basis is a proactive way to help staff recognize feelings of burnout and allow others to share and support their team members. The personal reflective debriefing also would be appropriate to hold at the end of a stressful shift so staff can debrief immediately and not carry home the emotional burden of the day. Because building resiliency in ourselves and our staff is of the utmost importance, it is a worthwhile endeavor to advocate for regularly programmed and as-needed debriefing sessions.

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