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Research article

Burnout and resilience in critical care nurses: A grounded theory of Managing Exposure

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ABSTRACT

Background: Many critical care nurses experience burnout; however, resilience shows promise as a potential solution to burnout. This study was conducted to better understand nurse burnout and resilience in response to workplace adversity in critical care.
Design: A grounded theory investigation, using the Corbin and Strauss methodology. Participants engaged in qualitative, open-ended interviews about burnout and resilience.
Setting: A multi-site, urban, teaching hospital in Canada.
Participants: 11 female critical care nurses, with 1–30+ years of critical care experience.
Findings: Burnout and resilience can be understood as indicators in a process of responding to workplace adversity. Workplace adversity can take many forms and has a negative impact on nurses. Nurses must be aware of this impact to take action. The process of Managing Exposure is how nurses address workplace adversity, using variety of techniques: protecting, processing, decontaminating, and distancing. The indicators of this process for nurses are thriving, resilience, survival and burnout. Organisational policies can impact on this process.
Conclusions: Resilience and burnout are connected, as indicators of the same process for critical care nurses. Nurse leaders can intervene throughout this process to reduce workplace adversity and support resilience among nurses.

Implications for clinical practice

- Burnout and resilience are indicators of the same process of managing adversity and do not necessarily reflect an individual nurse's coping skills.
- Workplace adversity has a toxic impact upon critical care nurses and should be addressed through workplace policies and supports.
- This theoretical model of burnout and resilience provides evidence to guide a proactive approach to promoting resilience and preventing burnout.

Introduction

Burnout in nursing was first described by Shubin (1978) as disillusionment and emotional exhaustion. Since then, burnout in critical care nurses has received significant research attention (Adriaenssens et al., 2015; Epp, 2012; Poncet et al., 2007; Rushton et al., 2015). Burnout is characterised as emotional exhaustion, detachment and cynicism, and low levels of personal efficacy and accomplishment (Epp, 2012). Burnout has also been related to other psychological distressors including moral distress, compassion fatigue, and symptoms of Post-Traumatic Stress Disorder (Mason et al., 2014; McCarthy and Gastmans, 2015; McGibbon et al., 2010;

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Mealer et al., 2012a; Oh and Gastmans, 2015). Despite attempts to address burnout, it remains endemic in critical care nursing (Epp, 2012). In an effort to address burnout, nurse researchers have increasingly focused on promoting resilience. However, there has been minimal attention given to understanding resilience in relation to burnout in critical care nurses.

Although there is debate about the definition of resilience in nursing (Aburn et al., 2016), it can be understood as "*the ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment, and continue to move on in a positive manner*" (Jackson et al., 2007, p. 3) Researchers have demonstrated that resilience is not associated with demographic variables; thus, anyone can develop their resilience (Lee et al., 2013; Pines et al., 2012). A need for more resilience research in nursing has been identified (Aburn et al., 2016). Researchers have recognised that individuals have varying degrees of resilience and that fostering resilience is complex (Luthar et al., 2000).

Researchers examining resilience in nursing have explored and described the phenomenon (Burgess et al., 2010; Mealer et al., 2014, 2012b; Rushton et al., 2015). Workplace stress and nurse personality have been suggested as important factors in resilience (Burgess et al., 2010; Rushton et al., 2015) but how these factors are linked to resilience remains unclear. It is suggested that resilience could be an effective countermeasure to burnout for critical care nurses. However, the potential for resilience as a protective factor to prevent burnout has not been adequately addressed.

Research question

This study aimed to answer the question: *What is the process of resilience for critical care nurses in the face of workplace adversity*? The scope of the study was limited to addressing workplace adversity, which is defined by Jackson et al. (2007, p. 3) as "*any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the occupational environment*". It is known that critical care nurses can experience burnout or resilience and the goal was to learn more about how these processes occur. While the initial objective of the study was to focus on resilience, it became clear that the processes of burnout and resilience were inextricably linked and the study was broadened as a result.

Methods

Research approach

The research methodology in this study was grounded theory. This study was conducted using the Corbin and Strauss (2014) variant of grounded theory. The purpose of a grounded theory is to explain a process and its drivers (or causes) as experienced by research participants (Corbin and Strauss, 2014). In grounded theory, one identifies concepts by the presence of indicators. It is important to note that an indicator is a sign of a process and not a description. For example, decreasing blood pressure can be an indicator of sepsis. What separates grounded theory from a method like thematic analysis is that grounded theories aim to be predictive (Corbin and Strauss, 2014; Glaser and Holton, 2007), meaning it is possible to use the theory to anticipate outcomes. This happens because grounded theories explain social processes and behaviours, which transcend individuals (Glaser, 2002). Grounded theory was chosen as the research methodology because of its predictive capacity. Understanding the process of how nurses become burnt out or resilient would make it possible to influence this outcome and providing a framework for future interventions.

Recruitment

Participants were recruited through purposive, convenience and snowball sampling. The inclusion criteria were that participants were registered nurses working in a critical care setting, with a minimum of one year of critical care experience, and the ability to complete an interview in English. Posters and e-mails were distributed by nurse educators in the research setting who had access to the target population but did not have the authority to impact a participant's employment status (avoiding the risk of coercion).

All 11 nurses who expressed interest in the study participated, no one withdrew from the study. Nurses received a gift card token and parking fees were also compensated, where applicable. All participants were given the number to contact a free, confidential counselling service, external to both the researcher and the research setting, in case they felt distressed after completing the interview.

Ethical considerations

This study was approved by the Athabasca University research ethics committee (File No: 21554) and the hospital research ethics committee (Protocol #20140653-01H). The principal investigator conducting the interviews did not work on the unit where the participants were recruited. Potential participants were provided with an information sheet and invitation to participate in the study. When the participants met with the researcher, the information sheet was reviewed together. Participants provided written consent to participate in the study. Participants were informed that their data would be kept confidential and that no identifying information would be included in publications. Each participant was assigned a pseudonym for the study, which was used in research dissemination as applicable.

Setting and context

The critical care setting was a 32 bed medical-surgical intensive care unit (ICU) in a large, urban, teaching hospital in Canada. The unit also housed the regional trauma and neuroscience centres. The unit was staffed by approximately 200 nurses. Nurses complete a critical care course prior to working in this setting. Nurses work exclusively 12 hour shifts, on a two day- two night- five off rotational basis (if full time). The nurse: patient ratio is usually 1:1.

Data collection

Interviews were open-ended, and began with the question: *What does resilience mean for you as a nurse*? From this point, the researcher used theoretical sampling and responsiveness to participants to guide the interview. For example, it became clear that debriefing was an important component in nurse resilience and burnout. In subsequent interviews, participants were asked specifically about debriefing if they did not address the subject unprompted. Additionally, probes helped to encourage participants to share their ideas during the interview. Each participant was interviewed once, for 60 to 90 minutes. Participants were encouraged to contact the researcher if they wanted to include more information at a later date. One participant did e-mail the researcher with a follow-up comment. Interviews were audio-recorded and transcribed and the participants were aware of this. Recognising that it is probably not possible to achieve total data saturation (Corbin and Strauss, 2014), it was determined that theoretical saturation was adequate after 11 interviews. Theoretical saturation is present when clear linkages are established between theoretical concepts in a comprehensive way (Morse, 1995). After

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