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Worklife Model

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NURS 501: Theoretical Foundations in Advanced Practice Nursing

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Background

Healthcare providers in all fields are entirely too familiar with long hours, physical and emotional distress, and the subsequent burnout. The phenomenon of burnout and the perceived expectation to endure poor treatment is so prevalent, that it is usually addressed while future providers are in school. Nurses in particular experience exceedingly high levels of burnout. (Browning, Ryan, Thomas, Greenberg & Rolniak, 2007). It is not uncommon for nurses to suffer physical and emotional distress related to work life, which leads to the decision to leave the nursing profession. Burnout has been frequently noted to affect nurses' health, emotional well-being, work performance, satisfaction, and contributes to high unit turnover (Browning et al., 2007). The most important tragedy to note when discussing burnout, is the lasting effects of the damage nursing work life inflicts upon both the lives of nurses and patient outcomes.

Keywords: Nursing burnout, burnout, Conservation of Resources, Nursing Worklife, theory, framework

Methods

Databases searched through UNM HSLIC were CINAHL, PUBMED, and PsycINFO. Selected qualitative and quantitative cross-sectional studies ($n=10$) were published in English, and examined the links between burnout, selected theories, and patient outcome studies.

Critical Issue

Nurses in the direct patient care setting often feel the effects of the everyday 'normal' stresses that must be navigated every shift. It is all too common to experience burnout, physical and mental exhaustion, and feelings of guilt and inadequacy (Browning, 2007). This guilt may be related to the fear of not providing the most proficient and emotionally connected care that an individual can provide. The purpose of this theory application is to explore the toxicity of the

idea of nurses as ‘heroes’, who are put on a pedestal and regarded as limitless and invulnerable fonts of compassion. Working in the inpatient setting can give the sense of not being allowed the space to show weakness or humanity, at the risk of criticism from management, patients, families, and peers. Patients in the state of New Mexico are often admitted for chronic, preventable conditions. Interdisciplinary teams of nurses, physicians, and other skilled staff work within scopes of practice to provide patients with the tools for success and health maintenance. However, there appears to be a seemingly unending cycle of readmissions for the same hospital problems and overwhelming noncompliance with care plans. This cycle of noncompliance and apparent disregard for nurses’ time, effort and emotional expenditure could promote a damaging effect to a nurse’s self-esteem and sense of purpose (Browning, 2007). Inversely, the question can be posed: is staff burnout and disengagement a causal factor in the high prevalence of patient non-compliance and readmission?

The concepts that will be surveyed in the theory application process will include models catalogued by Nabizadeh-Gharghozar et al. (2021). These concepts were developed utilizing the hybrid model of concept development by Schwartz-Barcott and Kim (McEwen and Wills, 2019). Nabizadeh-Gharghozar et al. (2020) conducted a concept analysis to understand the contributing factors and consequences of nurse burnout. The theories that will be applied to these developed concepts are the Conservation of Resources Theory and the Nursing Worklife Model. These selected models will be introduced in depth later in this study.

Beginning with depersonalization and emotional exhaustion, which is a common self-preservation response which is described as pessimism, objectification, and negative feelings toward clients and colleagues (Nabizadeh-Gharghozar et al.,2020). Lack of participation in leadership, which is both perceived and actual negative self-evaluation in job performance

(Nabizadeh-Gharghozar et al.,2020). Organizational factors, which is decidedly the most important concept to discuss (Nabizadeh-Gharghozar et al.,2020). Organizational policies, structure, centralized decision-making, role conflicts and impractical expectations are not beneficial to nurses and can lead to staff shortages, unsafe patient ratios and physical symptoms of stress that is intrusive in personal lives. Finally, patient-related consequences related to burnout are the reduction in quality of care, increased risk of non-compliance at discharge and complications, long hospital stay, high costs of care and low patient satisfaction (Nabizadeh-Gharghozar et al.,2020). These concepts should be explored because the issue of burnout is not new and has had few meaningful interventions to slow its effects on nurses in the field. In addition to this point, explore patient perceptions and consequences of nurse burnout with respect to perception of the necessity to remain compliant with suggested treatment and perception of what nursing care means.

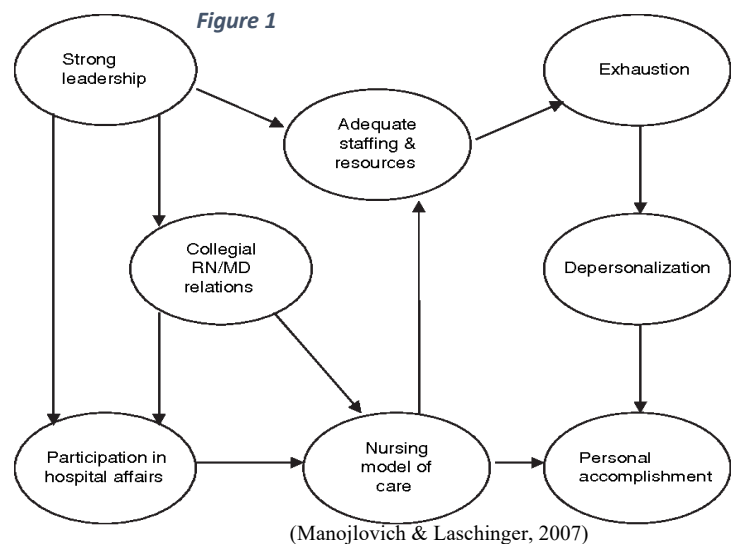
Selected Theories

The objective is to explore nurse burnout as it applies to the Conservation of Resources Theory by Hobfoll, and Leiter and Laschinger's Nursing Worklife Model. These theories were chosen in hopes that a focus on nurses as people in a stressful environment and the causal relationship to patient outcomes could be investigated. Betty Neuman's Systems Theory and other grand theories were not an entirely appropriate fit for this purpose because the concepts are too broad, and don't cover or concern themselves with the phenomena of stress and compassion fatigue from the perspective of the working nurse. The Nursing Worklife Model is an appropriate theory to apply because few studies have utilized a theoretical framework to analyze nursing work environment in relation to patient outcomes.

Nurse Worklife Model

The Nurse Worklife Model emerged as a study that was descriptive of nursing and work life, burnout, and the subsequent effects on patient outcomes (Spence Laschinger & Leiter, 2006). Developed by Dr. Heather Spence Laschinger, a nurse researcher in Canada and Dr. Michael Leiter, an organizational researcher (Spence Laschinger & Leiter, 2006). It has been noted in prior studies that inadequate nurse staffing directly influences safe patient care and unsafe work practices that are driven by institutions or nurse management is a threat to patient safety (Spence Laschinger & Leiter, 2006). As seen in Figure 1., this model contends that

‘burnout’ is the disruption between what people are and what they are asked to do. It is described as a gradual destruction of dignity, values, and willpower that is difficult to recover from (Spence Laschinger & Leiter, 2006). The symptoms are chronic emotional exhaustion, depersonalization, feelings of ineffectiveness (p.260). The theoretical



framework for the Nurse Worklife Model was developed with E.T. Lake’s (2002) five worklife factors in mind. (1) effective and visible nursing leadership, (2) staff participation in the organization, (3) adequate staffing, (4) support for a nursing model of patient care, (5) effective nurse/physician relationships. (p.260). These factors were identified by Laschinger and Leiter to be interactive and predictive of nurse burnout and meaningful engagement with their work. The hypothesized model expanded on the five factors of nursing work environments (Lake, 2002).

Leadership is the first point in the system, and it is directly linked to adequate staffing, nurse and physician collaboration, and participation and involvement in hospital policy. The idea is to draw RN/MD relationships in with policy involvement to develop a nursing model of care as opposed to a purely medical model (Spence Laschinger & Leiter, 2006). Nursing-centric models of care are proposed as a means of attaining personal accomplishment and predicting adequate staffing (p.261). Adequate staffing has a direct link to exhaustion when there is imbalance between nurse/ patient ratios. Exhaustion is linked as a direct contributing factor in depersonalization. The three paths to burnout: exhaustion, depersonalization and loss of perceived personal accomplishment are the channels through which adverse events can occur (Spence Laschinger & Leiter, 2006).

Conservation of Resources Theory

The second theory to be applied to the problem of nursing burnout originates in the field of psychiatry. This theory is suitable because burnout is a perceived loss of resources and energy to a system that is not in turn rewarding to the provider. Steven Hobfoll's Conservation of Resources Theory was developed in 1989. Hobfoll was a professor of psychology at Rush medical college in Chicago (Prapanjaroensin, 2017). The theory aims to explain the phenomenon of stress and how the social and physical demands of individuals can be met while value is obtained during the work experience (Hobfoll & Freedy, 2017). A breakdown of the Conservation of Resources Theory (figure 2) asserts, stress is an individual's reaction to the environment under threat of (1) resource loss, (2) actual resource loss, (3) when the ability to obtain necessary resources is lacking following investment of time, skill, and knowledge (Hobfoll, 1989) (Prapanjaroensin, 2017). Resources are further described as four possible types in this theory.

Figure 2

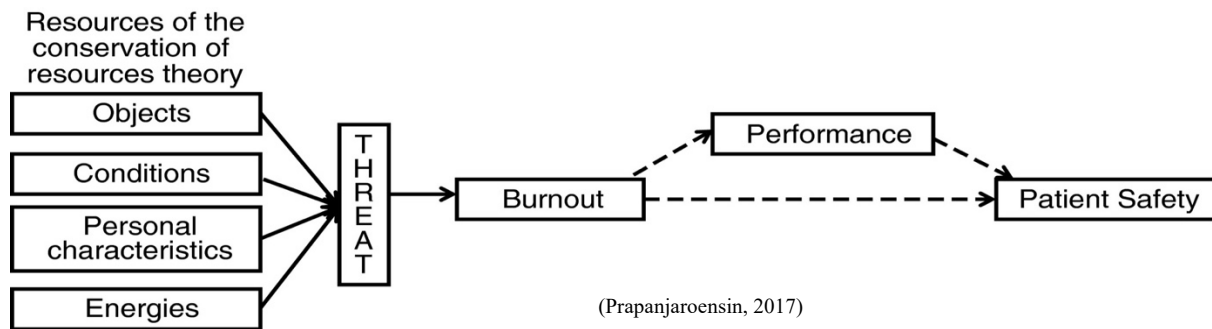


Table 1

Types of resources	Examples
Object	Food, home, clothing
Condition	Marital status, social relationship, health condition
Personal characteristics	Stress coping skills, social support
Energy	Time pressure

(Prapanjaroensin, 2017)

As seen in table 1, resources are listed as objects, conditions, personal characteristics, and energy (Prapanjaroensin, 2017). The real or perceived threat to any one or combination of the identified resources has the potential to lead to chronic stress and burnout. Conservation of Resources Theory asserts that there is a causal relationship between burnout, work performance and the results of this chronic stress can affect patient outcomes in the form of medication errors, treatment mistakes, or failure to identify decompensation.

According to the Conservation of Resources Theory, a perceived or actual threat to an individual’s essential resources, can result in burnout and reduced efficacy of job performance (Hobfoll, 1989). This is the exact point where patient safety and the perception of loss of resources in nurses and providers comes together. Stress related to the threat of loss oof essential resources is a human response. Thus, the contribution of the psychology-derived Conservation of

Resources theory in alignment with the nurse-centric Nursing Worklife Model will be meaningfully applied to the pervasive matter of nursing burnout and patient outcomes.

Application of Theories

The purpose of combining and applying both the Nursing Worklife Model and The Conservation of Resources model is to introduce a mediating factor between the relationship of nursing burnout and patient safety outcomes.

To conceptualize stress and burnout in a new way, The Conservation of Resources (COR) Theory seeks to clarify the contributory factors of emotional exhaustion and depersonalization. Hobfoll and Freedy (2017) emphasizes the causes of exhaustion and depersonalization are likely a workload or assignment that is unreasonably difficult. This ultimately leads to feelings of being overwhelmed, and unable to meet personal and professional goals. The energy resource is expended by individuals in the form of time and knowledge expenditure to gain object, and condition resources, such as money, housing and interprofessional relationships (Prapanjaroensin et al., 2017). Time pressure as an energy resource is noted by Browning et al., (2007) to be linked to reports of low sense of personal control and autonomy and elevated reports of burnout.

When the tremendous workload and inability to meet goals occurs, the personal characteristics resource (stress coping skills and social support) is threatened and burnout begins. When the four resources identified by Hobfoll and Freedy (2017) are under threat and out of balance, burnout is theorized to be the ensuing step that results in stress and loss in the integrity of job performance, (both actual and perceived). Once both burnout and negative effects on performance occurs, the aforementioned patient-related consequences are a potentially negative impact to patient safety, and an unnecessarily high cost of care related to errors or failure to recognize deterioration. (Prapanjaroensin et al., 2017). When nurses' patient ratios and acuity are

too high, and the energy resource is under pressure, patient safety may be impacted since nurse alertness and ability to recognize errors can arise with more frequency, despite department safety protocols (Wakefield et al., 2005).

The Nurse Worklife Model (NWM) intersects seamlessly with Hobfoll's theory since it details the effects of variances (threat of lost resources) in the attainment of leadership, participation, and a sense of personal accomplishment. These concepts can be placed in the category of "personal characteristics" in the COR model. The NWM implies without the core elements of strong leadership, participation in institutional affairs, appropriate RN/MD relations, and safe adequate staffing, the consequences are exhaustion and depersonalization (Manojlovich & Laschinger, 2007). By recognizing the benefit of utilizing the NWM (derived from nursing theory) and the COR (derived from psychology), it is easier to shape a more adapted approach to addressing burnout in hospital staff by teaching recognition of stress using these combined frameworks. Lack of Participation in institutional decision-making can chronically contribute to the feeling of a loss of autonomy and personal power (Manojlovich & Laschinger, 2007). Nursing-centric models of care and safety for patients and staff is proposed to be the safest means of attaining self-accomplishment and predicting staffing needs to protect the interests of core patient care staff (Spence Laschinger & Leiter, 2006).

The Nurse Worklife Model is intended to be used as a template for nursing leadership. The goal is to reduce burnout and potential sentinel events by promoting empowerment and participation in facility affairs, healthy RN/MD collaboration, and staffing and relief resource capability (Manojlovich & Laschinger, 2007). This model, however, can also be applied to additional aspects of nursing worklife. Nurse empowerment will result in the successful demonstration of the characteristics the NWM claims are necessary for a healthy work life

(Manojlovich & Laschinger, 2007). Nursing-centric models of care that are a result of strong nursing leadership and participation in hospital-wide operations are anticipated to ensure adequate staffing and stress-reduction to better meet the needs of patients. Manojlovich and Laschinger (2007) explain that this nurse-driven enhancement to patient care will result in improved feelings of accomplishment, reduction in exhaustion and depersonalization, and could translate to better patient care outcomes.

Limitations

Limitations to these theories are the lack of extensive and statistically conclusive research of the relationship between either of these models and poor patient outcomes (Prapanjaroensin, 2017). The majority of the studies selected for this theory application proposal are cross-sectional studies, therefore making cause and effect statements is not feasible. Manojlovich and Laschinger (2007) suggests that a valid model exploration for these selected theories should be longitudinal studies which use causal modelling techniques to measure worklife perceptions with ongoing testing and analysis. The theories require more research and larger sample populations to decide if the pillars of the Conservation of Resources Theory and Nursing Worklife Model are indeed the primary causative factors of exhaustion. There should also be further testing on how they may be related to increased incidence of poor patient outcomes related to nurse burnout.

The organizational factors that are involved in nursing burnout may also be part of the solution. Facility and nursing leadership can have a direct and positive impact on high turnover, burnout, patient outcomes, and overhead costs (Chen et al., 2019). The simplest solution is to advocate for direct patient care staff by adhering to the safe staffing ratios that are deemed appropriate by nurses when they are involved in facility affairs. Some of these safe staffing ratios are enumerated by law in some states (Wakefield et al., 2005). Facility leadership would likely

be more successful in this endeavor by learning to provide safe staffing from empowered nursing staff that are involved in policy change. Seminars and continuous education programs concerning the theory and findings about nurse burnout should be encouraged to provide awareness of risk management. Also, continuous communication opportunities and open-door policies between hospital management, nursing leadership and staff nurses should be implemented to optimize coordination. It would likely be beneficial to healthcare facilities to take the time to run a cost and risk analysis of overloading patient care staff and present it to legislators and policy makers to ensure adequate staffing and patient ratios are enforced by all facilities (Chen et al., 2019).

Summary

The intersection of these two theoretical frameworks has potential to be valuable in the current and future prevention of nurse burnout and negative or suboptimal patient outcomes. The Conservation of Resources Theory framework defines and identifies four primary resources that may influence nurse burnout. The Nursing Worklife Model teaches the importance of attaining job satisfaction through continuous empowerment, participation, and formation of strong and representative leadership. Overall, there appears to be a true need to protect nurses and direct patient care providers from the threat of lost resources and reduction in personal control. Nursing leadership should be encouraged to take a stand develop a louder voice against non-clinical administrative decisions that do not benefit nurses or patients. Nurse-driven seminars and education opportunities should be highly encouraged at all levels of care. The purpose is to promote education on the importance of identification of burnout and the benefits of risk management. This intervention should occur in each separate department because each unit has different needs and processes. Active engagement of nurses and nurse leadership in decision-

making must be encouraged at all levels for the purpose of transparency and encouragement. Staffing ratios should be decided by nursing leadership involved in direct patient care to avoid the threat of resource loss and ensuing burnout. It is highly likely that hospital administration in the current healthcare model will deliver a significant amount of resistance to these ideas proposed by both models. Healthcare organizations may cite cost and lack of resources as a reason for refusing to adopt these proposed models. However, by taking the time to conduct a thorough cost analysis and risk analysis that takes into account the variables of staff turnover and outcome-related costs, there may be convincing data to support implementation. Today's post-COVID-19 economic climate has seen a marked increase in the demand for better pay and better treatment. The realization of the power to unionize against organizations that persist in the failure to treat individuals with dignity and respect is becoming more influential. Currently, most health systems do not allow nursing staff to unionize, otherwise they may be faced with negative consequences and potential loss of essential resources. This institutional self-protective strategy does not serve the staff, the clients and patients, or the interests of the community the health system serves. Human beings are subject to human responses under certain conditions. Therefore, it can be concluded that the human condition that all healthcare workers are governed by, guarantees the institution cannot consider staff an invulnerable, blindly reliable resource. Rather than having a labor dispute, hospitals must instead attempt to live by these models to promote healthy growth and functionality within its own walls.

Nursing staff and leadership should continuously affirm their power and influence in the hospital system by remaining involved in facility operations and policy. Making time and space to remain involved with institutional policymaking and role expectations will hopefully serve to inoculate healthcare professionals from anxiety and burnout. This consistent maintenance of

personal power in the nursing and patient care departments will allow stability in staffing, critical thinking, nurse-driven problem-solving, and growth of effective leadership.

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