Strengthening workplace wellbeing: Perceptions of intensive care nurses

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Abstract

Background: Intensive care nursing is a professionally challenging role, elucidated in the body of research focusing on nurses' illbeing, including burnout, stress, moral distress, and compassion fatigue. Although scant, research is growing in relation to the elements contributing to critical care nurses' workplace wellbeing. Little is currently known about how intensive care nurse wellbeing is strengthened in the workplace, particularly from the intensive care nurse perspective.

Aims and objectives: Identify intensive care nurses' perspectives of strategies that strengthen their workplace wellbeing.

Design: An inductive descriptive qualitative approach was used to explore intensive care nurses' perspectives of strengthening work wellbeing.

Method: New Zealand intensive care nurses were asked to report strategies strengthening their workplace wellbeing in two free text response items within a larger online survey of wellbeing.

Findings: Sixty-five intensive care nurses identified 69 unique strengtheners of workplace wellbeing. Strengtheners included nurses drawing from personal resources, such as mindfulness, and yoga. Both relational and organisational systems strengtheners were also evident, including peer supervision, formal debriefing, and working as a team to support each other.

Conclusions: Strengtheners of intensive care nurses' workplace wellbeing extended across individual, relational and organisational resources. Actions such as simplifying their lives, giving and receiving team support, and accessing employee assistance programmes were just a few of the intensive care nurses' identified strengtheners. These findings inform future strategic workplace wellbeing programmes, creating opportunities for positive change.

Relevance to clinical practice: Intensive care nurses have a highly developed understanding of workplace wellbeing strengtheners. These strengtheners extend from the personal to inter-

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professional to organisational. The extensive range of strengtheners the nurses have identified provide a rich source for the development of future workplace wellbeing programmes for critical care.

Key words: workplace wellbeing, ICU nursing, critical care nursing, positive psychology intervention.

Background

Research about intensive care unit (ICU) nurses has largely focused on illbeing (or the 'negative side' of wellbeing) and recovery from illbeing rather than on preventing illbeing or promoting wellbeing (Jarden et al., Under review-b, Jarden et al., Under review-a). The research base is strongly skewed towards nurses' experiences of burnout (Zarei et al., 2016, Vévoda et al., 2016, Pereira et al., 2016, Weigl et al., 2016), compassion fatigue (Sacco et al., 2015), moral distress (De Villers and DeVon, 2013, Choe et al., 2015, O'Connell, 2014), and stress (Borteyrou et al., 2014, Dewe, 1987, Burgess et al., 2010). Until 2018, primary research of ICU nurse wellbeing was limited to four studies on spiritual wellbeing (Azarsa et al., 2015), team commitment (Galletta et al., 2016), effects of a mindfulness programme (Hee Kim et al., 2014), and emotional wellbeing (Siffleet et al., 2015). These four studies lacked a common definition of wellbeing and had limited generalisability (Jarden et al., Under review-b). More recently, ICU nurse conceptions of workplace wellbeing were explored in a prototype analysis, which is a study that investigates the key features of a concept (Jarden et al., In-press). Workload and work-life balance were identified as central characteristics of their wellbeing, alongside feeling valued, and experiencing respect and having workplace support. The current study extends the knowledge base of ICU nurse workplace wellbeing, exploring strength-building opportunities as identified by ICU nurses.

Identifying strength-building opportunities aligns with the developing area of research called positive organisational scholarship (Cameron et al., 2003b). Positive organisational scholarship (POS) studies what is positive, flourishing, and life-giving in organisations (Cameron et al., 2003b). Drawing from the heliotropic effect in which living systems have a tendency towards positive and life-giving forces, POS seeks out these in the organisational context (Cameron and McNaughtan, 2014). Positive organisational scholarship moves from the problem-focused and deficit-based inquiry towards new ways of understanding positive outcomes in organisations (Cameron et al., 2003b), for example, appreciative inquiry (Cooperrider and McQuaid, 2012). Although negative events strongly overshadow positive events (e.g., see Baumeister et al., 2001), creating positive change is thought to require both (Cameron, 2008). Given the strength of the negative, Cameron (2008) proposes more emphasis on the positive is required for positive change to occur. Whilst adversities and difficulties still occur, the challenges and obstacles are reframed as opportunities and strength-building experiences. Gittell et al. (2006) give the example of "accepting the short-term costs of excess staffing levels to maintain positive human relationships in the face of adversity" (p. 324), as opposed to redundancies and cost-savings in response to a financial crisis.

Work wellbeing interventions in nursing are largely focused towards recovery from illbeing, rather than preventing illbeing or promoting wellbeing. For example, quiet time to reduce stress levels (Rierner et al., 2015), yoga for stress and anxiety management (Bernstein et al., 2015), and mindfulness for stress management (Pipe et al., 2009). An exception is the investigation by Hee Kim et al. (2014) into the effects of mindfulness training on mindfulness and subjective happiness. Adopting this positive lens allows for exploration and an emphasis on resourcefulness in creating

positive change (Cameron and McNaughtan, 2014), potentially for ICU nurses.

Context

The ICU registered nurse provides specialised expertise managing complex and challenging situations with patients, patients' families, and inter-professional teams. In New Zealand, 2,245 registered nurses (4.5% of the local nursing workforce) identify as working in one of 30 ICUs (Nursing Council of New Zealand, 2015, Australian and New Zealand Intensive Care Society Centre for Outcome and Resource Evaluation, 2015). These nurses are exposed to various psychological risks whilst working with patients experiencing life-threatening situations. These risks include personal or family health concerns or crises, high patient acuity, changes in technology, and working rotating night shifts or extended shift hours. Given such stressors, nurses may be vulnerable to significant psychological harms such as burnout (Epp, 2012, Pereira et al., 2016), compassion fatigue (Jenkins and Warren, 2012), moral distress (Choe et al., 2015) and bullying (Ganz et al., 2015). These stressors provide significant opportunity to draw from psychological capital, and the strengthening evidence base of positive psychology and positive psychological interventions (Hone et al., 2014, Bolier et al., 2013, Sin and Lyubomirsky, 2009, Weiss et al., 2016). Realising this opportunity could draw from the strengths of other initiatives where the "positive" has been added to organisations. Examples include the Brilliance Project (Dadich et al., 2015) which has strong foundations in positive organisational scholarship (Cameron et al., 2003a) and appreciative inquiry (Cooperrider and Whitney, 2005); Magnet hospitals (Laschinger et al., 2001, Scott et al., 1999); using the positive organisational scholarship lens and a foundation of the humanistic work ideology, the Big Hospital study examined an organization driven by humanitarian principles (Wooten and Crane, 2004). Examples of further "positive" interventions include the Reflected Best-Self Instrument (Spreitzer et al., 2009), Appreciative Inquiry Summits (Cooperrider and Whitney, 2005); Job Crafting (Berg et al., 2010), and Everest goals (Cameron and Pews, 2012).

Applied positive psychology provides new opportunities to develop initiatives aligned with key national strategies. For example, the working vision of the New Zealand Ministry of Health (2015) seeks to achieve a health and disability system that focuses on wellbeing and prevention (p. 2). With this aspirational policy in mind, and given the diversity in the ICU nursing workforce, innovative ways of working are necessary to meet the challenges of ICU nursing. Individuals involved in building these new ways of working in organisations have the potential to draw from the positive experiences of others in relation to principles, structures, practices and cultures (Laloux, 2014). Previous research has identified characteristics of ICU nurse workplace wellbeing (Jarden et al., In-press), this study seeks to identify strategies to foster workplace wellbeing.

Research objectives

Research questions investigated:

- 1) *What do ICU nurses think may enhance their workplace wellbeing (potential strengtheners)?*
- 2) *What strategies do ICU nurses currently use to enhance their workplace wellbeing (actual strengtheners)?*

This research will identify New Zealand ICU RN's perspectives of strengtheners of workplace

wellbeing in their context. These perspectives will inform individuals, teams, organisations and policy makers of the potential strengtheners of workplace wellbeing. As such, the opportunities for improved ICU nurse performance, engagement, retention, and patient satisfaction may be enabled and realised.

Methods

This qualitative descriptive study (e.g., see Sandelowski, 2000) reports the findings from a dataset of two online free-text open-ended questions. Participants also took part in a prototype analysis (see Jarden et al., In-press). The questionnaire asked participants to list actual and potential strengtheners of their workplace wellbeing in two questions:

Question One: *“What do you think would promote/enable/facilitate work wellbeing”*

Question Two: *“What strategies, tools, initiatives, and/or programmes are currently used in your workplace to promote/enable/facilitate your work wellbeing. Please list things you do (individual level), things your team does (team level), and things your organisation does (organisation level).”*

Participant selection

Purposeful sampling of registered nurses working in a New Zealand ICU (Nursing Council of New Zealand, 2015) was conducted through national professional bodies (e.g., New Zealand College of Critical Care Nurses and New Zealand Nurses' Organisation), New Zealand ICU research nurses, and social media networks (e.g., FacebookTM groups, TwitterTM, and LinkedInTM). All New Zealand RNs presently employed in an ICU were eligible for selection.

Ethical considerations

This research was conducted in accordance with Auckland University of Technology Ethics Committee approval (17/180). Advertisements provided potential participants with a URL to the study information webpage. The study information webpage requested participants to indicate their informed consent by entering their name and e-mail address for the study URL to then be emailed to them.

Data analysis

Using applied thematic analysis (Guest et al., 2012, Braun and Clarke, 2006, Braun and Clarke, 2013), the free-responses in this exploratory study were analysed using a six-phase content-driven, inductive approach to coding. After reviewing and becoming familiar with the data, initial codes were identified (RJ), drawing from explicit written statements by the participants. Two researchers (RJ & MS) categorised codes into three levels, consistent with the initial probe questions. The framework of 'me', 'we', and 'us' (Jarden and Jarden, 2016) was identified as an adaptable, user-friendly, flexible and highly applicable conceptual scheme to support the identification of levels for the strengtheners of ICU nurse workplace wellbeing. The framework was adapted for this study (with permission from the authors), applying the term 'me' to the personal or individual resources nurses bring to ICU, 'we' to the relational experiences of working in the ICU, and

‘us’ to the organisational systems the ICU nurses work within. For rigour in this process, researchers categorised the codes first independently, then compared and contrasted together. A third researcher (JKM) reviewed and resolved any uncertainty in relation to the categorising.

Findings

Eighty-Two New Zealand ICU nurses opted in to the study. Of these 82 nurses, 65 participated in the study by responding to the online questions. Three of the 65 provided incomplete data, their partial data were used in the analysis. Participants ($n = 65$) were primarily married ($n = 40$; 62%) women ($n = 57$; 88%), aged between 25 and 63 years, and identified as New Zealand European ($n = 45$; 69%). This was a largely representative sample of the New Zealand ICU nurse population.

Firstly, monolexemic linguistic items (i.e., meaningful individual words) were identified, for example, “support”, “supervision”, and “respect”. Items with modifiers were coded as single items, for example, “more support” was coded as “support”. Where a phrase was used, a coding decision was made. For example, “feeling supported when things don't go as planned”, was coded as “support”. A conservative approach to the coding preserved the integrity and richness of the data. For example, “regular feedback” was left as two items rather than coding to a single item, e.g., “feedback”. A total of 153 words and phrases were reported for potential strengtheners of workplace wellbeing, and 213 for actual strengtheners of workplace wellbeing. Of these words and phrases, 69 unique linguistic items were identified (see strengtheners in Appendix A).

Secondly, codes were categorised, 22 were applied to the ‘me’ level, 14 to ‘we’, and 33 to ‘us’. The participants’ explicit words were retrieved from the data to provide a richer description of each of the three categories in relation to either the actual or potential strengtheners of ICU nurse workplace wellbeing.

Me (personal or individual resources nurses bring to ICU)

For potential strengtheners, participants suggested they would like the “ability to take sick leave without feeling guilty”, and they would like to see an “ongoing attitudinal change that taking care of yourself - the clinician - is a priority before you are able to care for others”. Other participants suggested they’d like to see better work-life balance and have the ability to reflect on stressful events “in a positive manner for learning”.

For actual strengtheners, participants highlighted the importance of work-life balance, for example, “I set boundaries for how many shifts I do each week, i.e., depending on how tired I feel as to whether I do extras”. Others stated the benefits of engaging in activities outside of work time, for example, “sports outside work (swimming, snowboarding), leaving work behind completely after hrs or during my days off and I do not do on call”. Spirituality was also identified as an actual strengthener, for example, “prayer for the workplace - both for my colleagues and patients”. Reducing work hours was mentioned in a variety of ways, for example, “I work part time to suit the tiredness associated with shift work and aging”.

We (relational experiences of working in the ICU)

For potential strengtheners, one participant captured the complexity of the relational experiences by suggesting

I'm not a hundy [hundred] percent on if there is one main solution - I'm not sure, but I think it might take a long time of continuous positive interventions and collaboration between all of the team...giving time to listen to one another, feeling confident in our work and our teammates (continued education and opportunities to develop), safe staffing levels, maybe having a 'diffuse room' where you could go to take some time out....

Another participant felt the key could be

a supportive team environment. To me, the most important aspect of this is team. If I show up to work knowing that I'm not going to have to struggle to find someone to help me mobilise my patient or bounce ideas off of then I know that I will work hard but not leave a shift feeling like I did my best for the patient. Being isolated in a nursing role is a recipe for disaster not only for the patient but for the wellbeing of the nurse

and another suggested

regular encouragement and appreciation I find boosts confidence and morale in all staff, not just new staff. Respecting those we work with and taking time to listen and make people feel wanted and part of the team. Extra resources do help but I think if we are working with good people then even the busiest days are good

For actual strengtheners, participants stated a “mindfulness week, some peer supervision (not often enough yet), and formal debriefing when required”. Others focused on working as a team to support each other and communicate effectively, for example, “the team ensure breaks are taken at appropriate times. Good support is given during crisis situations - work and home...regular team meetings occur when anyone can raise issues”.

Us (the organisational systems nurses work within)

For potential strengtheners, participants suggested activities to promote their work-life balance, such as “not being hassled via texts to work extra shifts”, and “rosters to acknowledge some people do not do nights well and some do not do day shifts well”. Clinical supervision was also identified, as one participant stated

allied health must have clinical supervision to retain their practicing certificate yet we at the front-line have no resource for clinical supervision. We see a lot with no resource for debriefing or clinical supervision. More formal debriefing would allow a better understanding of medical decision making and allow a more multi-disciplinary approach to patient care. It also means staff do not end up taking things home with them or feeling perhaps they could have done better

The perceptions of “good staffing” was perceived as a potential strengthener, such as “100% staffing at all times”. However, another participant suggested that in times of “good staffing”, protection from redeployment was seen as important, for example, “not being redeployed the moment there is a second of downtime especially when all study leave is cancelled for 6 months of the year during the ‘busy’ period”. Others highlighted the importance of “better pay - feeling valued in a monetary

sense” and “adequate training and individualised plans for professional growth (that are followed through)”.

For actual strengtheners, participants identified both internal and external psychological support structures such as both formal and informal debriefing, trained counsellors and a psychologist, and employee assistance programmes. Other participants stated their organisations arranged group activities such as “pilates, yoga, boot-camp and spinning classes” alongside subsidised gym memberships and meditation classes. One participant identified a strengthener was their roster which “takes into account preferences and requests, and also sticks to the MECA [*Multi-Employer Collective Agreement*]”.

Intensive care nurse multi-level workplace wellbeing intervention programme

The socio-ecological framework (Bronfenbrenner, 1977b) is purported to inspire multi-level interventions, yet frequently public health interventions have single-level targets and are focused on intrapersonal change (Schölmerich and Kawachi, 2016). Drawing from the ecological framework (Bronfenbrenner, 1977a), the eco-social approach (Krieger, 1994), the health promotion adaption of the socio-ecological framework (McLeroy et al., 1988), and the “Me, We, Us” framework (Jarden and Jarden, 2016), an example of what a multi-level workplace wellbeing intervention programme might look like is depicted in Figure 1. This figure integrates examples of the ICU nurses’ strengtheners, potential interventions from the literature (Roberts et al., 2005, Wrzesniewski and Dutton, 2001, Page and Vella-Brodrick, 2013) and the “Me, We, Us” framework.

Discussion

The ICU nurses identified strengtheners at the individual, team and organisational levels. These findings are misaligned with many organisational initiatives to enhance workplace wellbeing which are largely focussed towards strengthening an individual’s personal resources (Day and Penney, 2017). In fact, this large list of individual strengtheners would suggest that ICU nurses have a highly developed understanding of personal workplace wellbeing strengtheners. The words “less” and “reduce” were evident throughout the data in relation to key terms such as “overtime” and “on-call” and “nights” and “extras”. These words are consistent with the concept of simplicity and simplifying your life, which is an area gaining more attention in the literature in relation to personal wellbeing (Rich et al., 2017a, Rich et al., 2017b). Most of the personal workplace wellbeing strengtheners were also actual, rather than potential, strengtheners. Thus, most are strengtheners currently being used by the ICU nurses. In contrast, the organisational strengtheners were predominantly reported as potential strengtheners of wellbeing, meaning they are not being currently used. This suggests an opportunity to capitalise on these potential strengtheners identified by the ICU nurses, such as “courses to promote wellbeing”, “appreciation”, and “fair pay”.

Job and workplace design are proposed in the literature as key areas where workplace wellbeing may be enhanced (Munir and McDermott, 2013). Firstly, at a primary-organisational intervention level, strategies include job redesign (see Carlgren et al., 2014, Nielsen and Christensen, 2014, Sangiorgi and Junginger, 2015, Roberts et al., 2016), job crafting (Kulik et al., 1987, Berg et al., 2010, van den Heuvel et al., 2015, Ghitulescu, 2015, Bipp and Demerouti, 2015, Tims et al., 2015) and structural changes to organisational processes and policies (see Guenole and Biggs, 2013). Examples of strengtheners identified by the ICU nurses in relation to this primary-organisational intervention level included preventative workplace wellbeing programmes to promote wellbeing and supporting

safe staffing levels. Secondly, at a secondary individual intervention level strategies include stress management, CBT or mindfulness education (see Houdmont et al., 2013, Tan et al., 2014, Hyland et al., 2015, Malik et al., 2014, Furlan et al., 2012, Rongen et al., 2013, Geaney et al., 2013). Examples of strengtheners identified by the ICU nurses at this secondary individual intervention level included mindfulness and yoga. Mindfulness as a strengthener resonates with previous literature such as (Hee Kim et al., 2014). Thirdly, at a tertiary individual intervention level strategies include counselling, employee assistance programmes, rehabilitation and organisationally supported wellness programmes to support those with identified problems (e.g., Robbins and Judge, 2013, Colquitt et al., 2013). Examples of strengtheners identified by the ICU nurses at this tertiary individual intervention level included “counsellors” and “employee assistance programmes”. Alternative ICU nurse identified strengtheners such as “pilates, yoga, boot-camp and spinning classes”, “courses to promote wellbeing”, subsidised gym memberships and meditation classes are opportunities yet to be empirically tested in the ICU nurse workplace.

There is strong evidence to support the important place of negative events in generating positive outcomes (e.g., see Baumeister et al., 2001). However, positive practices such as compassionate support for employees and expressions of gratitude predict organisational performance (Cameron et al., 2011). Since positive psychology began in 1998 (Seligman and Csikszentmihalyi, 2000), key research areas that have developed in relation to workplace wellbeing include Positive Organisational Behaviour (Luthans, 2002a), Positive Organisational Scholarship (Cameron et al., 2003a), and Positive Organisational Change (Cameron and McNaughtan, 2014). Within these research areas is a focus towards strengths and psychological capacities (Luthans, 2002b), examining the best of the human condition (Cameron et al., 2003a, Spreitzer and Sonenshein, 2003), and tapping into collective intelligence (or the knowledge gained through collaboration; Lewis, 2016). The potential strengtheners reported by the ICU nurses demonstrates the benefits of seeking out the collective intelligence. This study has drawn from the strengths and psychological capabilities of the ICU nurses, and now, disseminating this intelligence supports the co-creation of change in relation to ICU nurse wellbeing.

Strengths and Limitations

This dataset was obtained during the online collection of data for a prototype analysis exploring ICU nurse conceptions of workplace wellbeing. Strengths of the study include the strong contribution of the ICU nurses who shared their knowledge and experiences to support this exploration. Use of the participants’ quotes throughout the findings demonstrates the authors’ appreciation of the value of their voice. Support of the professional nursing organisations of New Zealand, alongside the social media networks to recruit participants was invaluable, and enabled a ‘bottom-up’ approach in the recruitment processes, preventing potential workplace and organisational barriers influencing participation. Given the findings are based on a single New Zealand sample, generalisability to other nations is limited. Greater depth and insight into the strengtheners of workplace wellbeing may have been obtained had we used a triangulated approach to data collection by incorporating both focus groups and interview data, however these additional data collection methods were outside the scope of this research and provide strong foundations for future research opportunities.

Implications for practice

Unique strengtheners of workplace wellbeing were identified by the New Zealand intensive care nurses. Actions such as simplifying lives, mindfulness, yoga, peer supervision, and working as a team to support each other were just a few of the intensive care nurses' identified strengtheners. This collective intelligence provides a robust foundation to inspire future multi-level workplace wellbeing programmes.

Conclusions

This study has identified that New Zealand ICU nurses have a robust complement of personal resources they draw from to strengthen their workplace wellbeing, including actions to simplify their lives. Nurses are also cognisant of a wide range of both relational and organisational systems strengtheners, including peer supervision, formal debriefing, and working as a team to support each other. These actions may be incorporated in strategic and theoretically informed workplace wellbeing programmes, drawing from these ICU nurses' collective intelligence to co-create change.

Impacts

What is known about the subject:

- The research base is strongly skewed towards nurses' experiences of burnout, compassion fatigue, moral distress, and stress.
- Adopting a positive lens allows for exploration and an emphasis on resourcefulness in creating positive change.
- The various psychological risks intensive care nurses face in their workplace provide significant opportunity to draw from psychological capital.

What this paper contributes:

- A rich foundation of workplace wellbeing strengtheners was identified by New Zealand intensive care nurses.
- Personal, inter-professional, and organisational systems level opportunities to strengthen workplace wellbeing are explored in relation to the literature.
- An example of a multi-level workplace wellbeing intervention programme which demonstrates how the intensive care nurses' collective intelligence may inspire the co-creation of positive change.

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Figure 1. Intensive care nurse multi-level workplace wellbeing intervention programme.

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