How nurses can cope with stress and avoid burnout

Stephanie Wilkinson offers a literature review on the workplace stressors experienced by emergency and trauma nurses

Abstract

This article draws on a systematic literature review to identify stressors in emergency and trauma nursing settings, and their potential effects on staff. After a search of relevant databases, six articles were chosen and analysed, and the main causes of stress in the workplace for emergency and trauma nurses were identified. These stressors include work demands and lack of time, lack of managerial support, patient aggression and violence, and staff exposure to traumatic events. Their effects on nurses include burnout, compassion fatigue, somatic complaints, mental health problems and difficulties in life outside work. The article goes on to discuss the implications of the findings on practice.

Keywords

Aggression, job satisfaction, post-traumatic stress disorders, security measures, workplace

ONE OF THE main causes of absenteeism in nurses in the NHS is high levels of stress and burnout (Jones-Berry 2013), yet the prevalence and causes of occupational stress among nurses are rarely researched. As the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) shows, a good work environment is important to employers, while poor management and insufficient support for staff can affect the care given to patients.

Staff experience occupational stress when they perceive a discrepancy between environmental demands made of them and their capability to meet them (Beheshtifar and Nazarian 2013). According to Brooker and Nicol (2011), stress can lead to a variety of physical and psychological health problems, including altered bowel function, anxiety, depression, fatigue, headaches, insomnia and poor concentration. Continued occupational stress may also result in burnout, which Maslach and Jackson (1986) describe as a syndrome characterised by emotional exhaustion, reduced personal accomplishment and depersonalisation, or lack of empathy with patients. Staff experience burnout when they are at the end stage of chronic stress (Brooker and Nicol 2011) or exposed continually to psychological risk factors linked to the work environment (Escribá-Agüir et al 2006), such as staffing problems. Some members of staff are more vulnerable to the effects of burnout than others (Gillespie and Melby 2003).

In examining nursing workplace stressors, it is logical to investigate the experiences of nurses in emergency departments (EDs) and trauma centres because staff in these settings are often exposed to life-or-death situations (Adriaenssens et al 2010), and have intense and occasionally violent interactions with the public (Gerberich et al 2004), and so must be able to demonstrate high degrees of empathy and compassion (Hooper et al 2010).

To determine the work environment stressors for, and potential results of stress on, emergency and trauma nurses, the authors conducted a literature review. This involved a comprehensive literature search of the EBSCOhost and Ovid databases using combinations of the keywords ‘accident and emergency’, ‘anxiety’, ‘burnout’, ‘compassion fatigue’, ‘depression’, ‘emergency’, ‘fatigue’, ‘nurse’, ‘post-traumatic stress disorder (PTSD)’, ‘stress’ and ‘trauma’, as well as combinations of ‘PTSD’ with Boolean operators.

Inclusion criteria were peer-reviewed articles based on original research that had been published
in English since 2002. Fifty two articles were identified but, after duplicates, literature reviews and unavailable articles had been removed, the total was reduced to 29. After further reading, articles that focused on healthcare professionals other than emergency nurses, PTSD but not other forms of stress, or workplace stressors but not their effects were removed to leave six articles. This account of the literature review draws mainly on these six articles (Gillespie and Melby 2003, Crabbe et al 2004, Escribá-Agüir et al 2006, Hooper et al 2010, Adriaenssens et al 2010, 2012), but also refers to some of the other 23 relevant or available articles identified in the search.

The authors of the six chosen articles based their studies on findings from questionnaires, although one pair of authors (Gillespie and Melby 2003) also conducted focus group interviews. Participants in all of the questionnaires identified four main stressors, namely:

- Work demands and lack of time.
- Lack of managerial support.
- Patient aggression and violence.
- Staff exposure to traumatic events.

They also identified three main effects of stress, namely:

- Burnout and compassion fatigue.
- Somatic complaints and mental health problems.
- Personal problems and an inability to cope.

Stressors

Work demands and lack of time A major cause of stress for nurses, demanding work with too little time to complete it, can lead to emotional exhaustion (Gillespie and Melby 2003), fatigue and psychosomatic stress (Adriaenssens et al 2010). Emergency nurses report that higher demands are made of them than are made of the average nurse due to the unpredictable nature of emergency nursing and because conditions in EDs are less controllable than in wards (Adriaenssens et al 2010).

Due to staff shortages, 66% of emergency nurses in the NHS work more than their contracted hours and 51% work extra hours without extra pay (Brown 2010). Use of agency staff is a stressor for nurses, who must spend time inducting new staff to the work environment but still carry out their usual duties (Gillespie and Melby 2003). In recent years, many NHS trusts have attempted to reduce the use of agency staff by asking existing staff to cover extra shifts, manage additional patients or take on extra responsibilities (Scott 2010). These strategies can result in junior nurses taking over senior roles, leading to decreased patient care quality and satisfaction, and increased workload and stress for all multidisciplinary team members (Dubois and Singh 2009).

Staff shortages also result in staff regularly skipping breaks to keep up with increased workloads. Nurses are relieved of responsibility for patients long enough to take adequate breaks during only about half of their shifts, which puts nurses under more stress and, if it gives them too little time to eat well, affects their health (Rogers et al 2004).

Care Quality Commission (2014) guidance on staffing levels and skill mix recommends that staff use evidence-based tools as well as their professional judgement when assessing staffing requirements and using e-rostering systems, and to raise concerns about the issue when necessary. The guidance also recommends that staff are given the time and training to develop their skills, and that managers should try to hire new staff while retaining the staff they already have. While the Royal College of Nursing (RCN) (2012) has called for stricter standards on staffing levels, cuts to NHS funds and staff training budgets are likely to lead to further reductions in staffing levels over the coming years (Buchan and Seccombe 2012).

According to the RCN (2012), most nurses prefer to work three or four 12-hour shifts a week rather than five seven and-a-half-hour shifts a week because, by working fewer but longer shifts, they have more full days off work and more time to restore their ‘work-life balance’. In this context, the RCN (2012) advises nurses to spend their days off recuperating rather than working overtime.

Although some nurses can adapt to shift work more easily than others, shift length has no apparent effect on job satisfaction or stress levels among nurses with similar lengths of service. However, less experienced nurses tend to feel more stressed by working 12-hour shifts than experienced nurses (Hoffman and Scott 2003). Similarly, Admi et al (2008) found no differences in health or propensity to make errors between shift workers and daytime workers.

Nurses report that they spend too much time on paperwork, much of which they regard as a distraction from patient care (Gillespie and Melby 2003). The amount of paperwork required of nurses is a long-standing yet poorly researched issue although, in a report on non-essential paperwork, the RCN (2013) states that staff should spend less time on paperwork and more time with patients.

Lack of managerial support Good managerial support is an important predictor of high levels of staff engagement, and low levels of
emotional exhaustion, fatigue, psychological distress, PTSD symptoms and somatic complaints (Escribà-Agüir 2006, Adriaenssens et al 2012), yet almost 42% of nurses have reported low levels of such support (Escribà-Agüir 2006).

Nurses welcome having more time with, and more recognition and rewards for their work from, their supervisors (Adriaenssens et al 2010). Forty years ago, McCloskey (1974) found that nurses like to be rewarded with greater responsibility and control over their rota, and more educational opportunities and group-reflection sessions. Four years ago, Adriaenssens et al (2010) found that nurses want the same things with one addition: greater financial rewards.

If staff nurses and senior staff are to work together as proficient and motivated teams, group-reflection and team-building exercises are essential (Gillespie and Melby 2003, Amos et al 2005). Such exercises allow staff to break down barriers between them, such as those due to past disagreements, and improve communication so that they can work together more efficiently. This in turn increases job satisfaction and reduces sick leave absence (Adriaenssens et al 2010). It is important that junior and senior staff participate in team-building activities because both groups of staff expect evidence that their concerns are understood and acted on, and all team members must be able to communicate and accept criticism (DiMeglio et al 2005).

Patient aggression and violence Nearly all nurses have encountered verbal abuse from patients, more than three quarters have been threatened with assault and more than one quarter have experienced violence. Many nurses experience these events repeatedly, which makes trauma nursing a 'high-risk healthcare job' (Crabbe et al 2004), and there are significant correlation between heightened levels of aggression from patients and their families, and burnout among staff (Crabbe et al 2004). Nurses have reported that aggression and violence are more prevalent in EDs than in wards, and that they are heightened due to the high expectations of patients and families, and issues such as bed shortages, long waiting times and poor facilities. Nurses also say they cannot spend as much time as they would like with each patient, which can lead to further aggression and violence from patients and families (Gillespie and Melby 2003).

The causes of aggression and violence include the effects of alcohol and substance abuse, and mental health problems. It can also be a continuation of domestic violence, and may be exacerbated by overcrowding and long waiting times (NHS Security Management Service (SMS) 2010a).

Most EDs have introduced security measures, such as panic buttons and closed-circuit TV. Many also employ security personnel, although the benefits of this are uncertain because security personnel have limited powers (NHS SMS 2009). Such security measures are recommended by the Emergency Nurses Association (ENA) (2010), which states that nurses have a responsibility to report violence, and should be trained to recognise and diffuse potentially violent situations. Reports of violence inform the NHS SMS (2010b) marker system for patients' records, which reveals whether patients have histories of violence. The system does not violate patient confidentiality or affect patients' rights to non-discriminatory care, but acts as an early warning system for healthcare staff. The NHS SMS also provides a one-day training session in conflict resolution and positive communication for nurses.

Staff exposure to traumatic events According to Adriaenssens et al (2012), 87% of emergency nurses had been involved in one or more traumatic events over the previous six months, while 17% had experienced at least one traumatic event every month. The most distressing of these incidents involve young children or are of a sexual nature (Crabbe et al 2004, Adriaenssens et al 2012). Repeated exposure to traumatic events strongly correlates with poor health outcomes and many nurses expect psychological support after such incidents occur. Such support is not always available, however, and Crabbe et al (2004) found that, in one case, only one member of staff had been offered it.

Although nurses cannot reduce their exposure to serious trauma, they can prepare for it better and can be given more support after traumatic events occur. The RCN recommends the recording of traumatic events so that nurses’ exposure to them can be measured and risk assessments made. This is because staff are sometimes reluctant to ask for help, either because they do not think they need it or do not want to be characterised as unable to cope. For these reasons, managers and nurses should be trained in assessing the risks and recognising the signs of PTSD, and psychological support should be available to all members of staff (Bannister and Mclnnes 2007).

Effects of stress

Burnout and compassion fatigue According to Hooper et al (2010), 59% of emergency and trauma nurses are at moderate risk, and 24% at high risk,
of burnout, while 86% are in the moderate-to-high-risk category of compassion fatigue. Signs of these conditions include depression, disengagement, frustration, hopelessness, impatience and loss of empathy with patients (Hooper et al 2010). Crabbe et al (2004) found that 82% of nurses under stress become less sympathetic towards patients.

Somatic complaints and mental health problems

Adriaenssens et al (2012) sent emergency nurses questionnaires to investigate their exposure to traumatic events, and the correlation between these events and reported symptoms of anxiety, depression, fatigue, PTSD and somatic complaints. In an assessment of the proportions of nurses who have the symptoms of undiagnosed depressive disorders, they found that 32% of nurses exceeded the score for anxiety, 37% exceeded the score for somatic complaints, almost 29% exceeded the score for depression and fatigue, and almost 25% exceeded the score for PTSD symptoms. Compared with normative results, these are extremely high, and show that nurses experience much higher levels of anxiety and depression than the general population.

Personal problems and an inability to cope

Nurses often find relaxation at home difficult, particularly after working long shifts, and report directing irritable outbursts at loved ones (Gillespie and Melby 2003). They also report unhealthy coping mechanisms, such as smoking and alcohol consumption (Gillespie and Melby 2003), avoidance coping associated with somatic complaints, and emotional coping associated with higher levels of PTSD symptoms, fatigue, psychosocial distress, sleep problems and somatic complaints (Adriaenssens et al 2012). The only positive coping strategy likely to be reliable is talking about these issues with colleagues (Maloney 2012) or with

References


Care Quality Commission (2014) How to Ensure the Right People, with the Right Skills, Are in the Right Place at the Right Time. tinyurl.com/o7onije (Last accessed: October 13 2014.)


trained counsellors appointed by their occupational health departments.

Implications for practice

Measures to protect staff from occupational stress can be arranged easily by ward managers. Debriefing immediately after traumatic events, for example, allows the people concerned opportunities to reflect on events, facilitates recovery and reduces the risk of PTSD (Maloney 2012).

Occupational health departments should be involved in caring for the mental health of nurses, and offer confidential services for communication and counselling. They should also help to set up training and awareness programmes to teach staff to recognise the signs and symptoms of occupational stress, such as burnout and PTSD. Such programmes should include training for junior and senior staff in the use of risk-assessment tools to assess PTSD signs and symptoms, and positive coping strategies to deal with stress and traumatic situations (Hooper et al 2010). Such coping strategies should involve analysing, learning from and talking about traumatic events with counsellors or trusted colleagues, rather than avoiding dealing with them or adopting negative coping strategies, such as drinking or smoking.

Conclusion

The findings of this literature review describe the results of occupational stress on emergency and trauma nurses, and suggests that nurses in other specialities are subject to many of the same stressors (Hooper et al 2010). Changes to work environments are needed to reduce these stressors to protect nurses, and benefit patients and the NHS. Healthier, happier nurses means increased productivity and patient satisfaction, and decreased absences due to illness and staff turnover.


