The Defense of
# PROMOTING STAFF RESILIENCE THROUGH DISTRESS DEFUSING VIA CODE LAVENDER
by

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**Of the Requirements for the Degree**

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# "Ubuntu"- I am, because we are...

**(African Nguni Bantu term, meaning 'Humanity')**

**This project is dedicated to those that could not be here today, due losing the fight with their inner struggles, where their darkness never saw the light...**

**Let us show them our Ubuntu...**

**You are not alone;**

# Learning Outcomes

Background

Needs Assessment

Intervention

Methodology

Results

Analysis

Conclusion

Further Research

# Background

**A critical incident:** anything that disrupts the mindset and flow of the workspace or staff life.
**Code Lavender**:  Crisis Intervention Tool
**CISM:** Critical Incident Stress Management

*NHS noted that 300-400 nurses have died by suicide over the last 7 years. We have no official data in the USA. Physicians have similar numbers, but it is yearly for them. **The numbers are not decreasing.**

**1** Staff are working longer hours, patients are sicker, and staff are expected to do more with less and still meet austerity goals (Brennan, 2017; Wray, 2013)= Moral injury, burnout, compassion fatigue.
   • Recommendations=Build resilient workforces

**2** Arrogante and Aparicio-Zaldivar (2017) noted that "resilience buffers the negative effects of burnout syndrome, and this could involve an increase of the quality of care and patient satisfaction, and a decrease of the number of medical errors, the rates of health care-associated infections, and mortality rates" (p.114).

**3** Osta, King, Serwint, and Bostwick (2019; 2018) literature supports organizations using emotional debriefings to mitigate reactions such as sadness, anxiety, disturbed sleep, and hypervigilance.

# Needs Assessment

## The Challenges

- **Staff Turnover, sick calls, missed worked**
  National turnover rates sit at 19.1% (Nursing Solutions, 2019).

- **Nursing Shortage**

- **No history of a code lavender program**

- **Build up current CISM team to harvest organizational resilience**

- **Loss of staff life**

*These are common needs assessment across the nation.*

**Our patients are only receiving the care as good as their healthcare providers (Glasper, 2016).**

# Mental Health Continuum Model

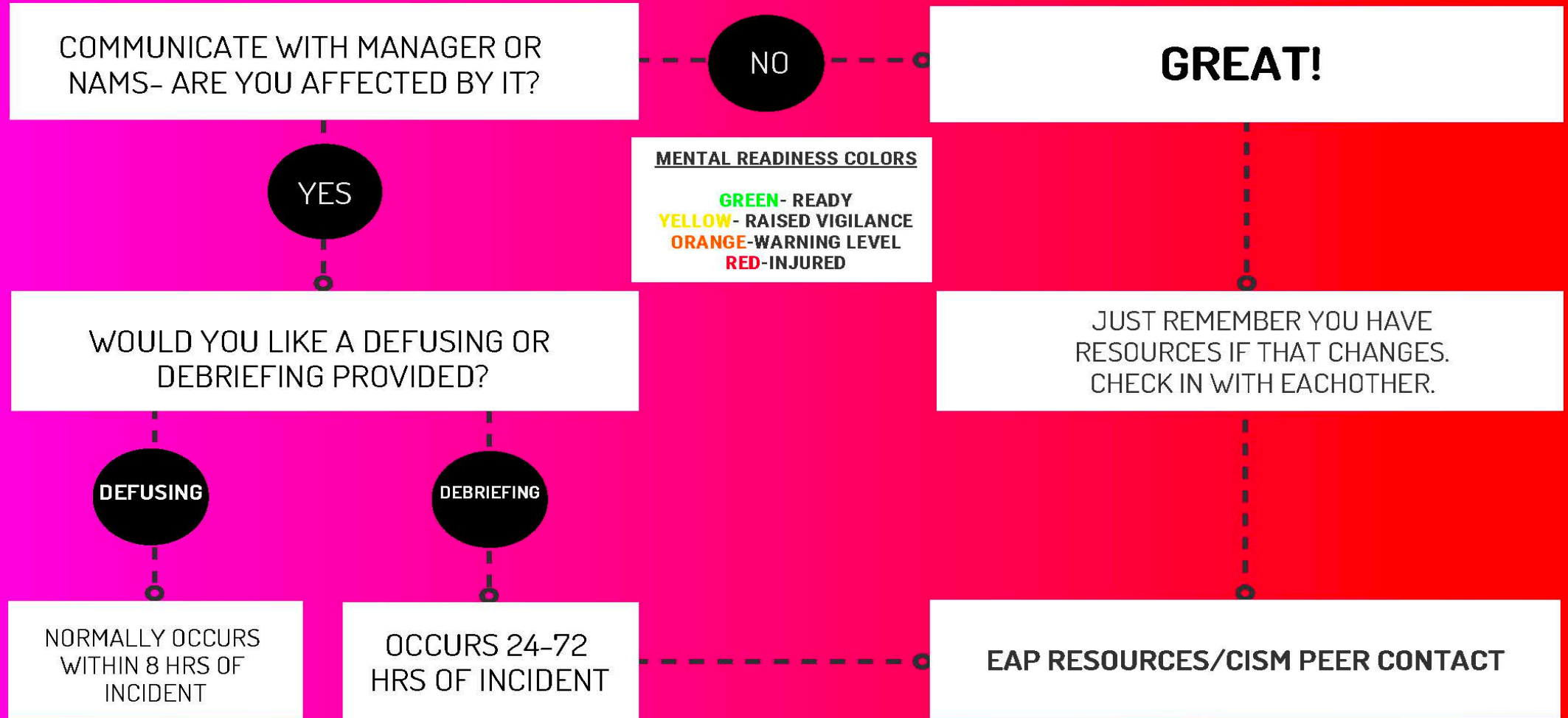| HEALTHY | REACTING | INJURED | ILL |
|---------|----------|---------|-----|
| **Changes in Mood** | | | |
| • Normal mood fluctuations<br>• Calm<br>• Confident | • Irritable<br>• Impatient<br>• Nervous<br>• Sadness | • Angry<br>• Anxious<br>• Pervasive sadness | • Easily enraged<br>• Excessive anxiety/panic<br>• Depressed mood, numb |
| **Changes in Thinking and Attitude** | | | |
| • Good sense of humor<br>• Takes things in stride<br>• Ability to concentrate and focus on tasks | • Displaced sarcasm<br>• Intrusive thoughts<br>• Sometimes distracted or lost focus on tasks | • Negative attitude<br>• Recurrent intrusive thoughts/images<br>• Constantly distracted or cannot focus on tasks | • Noncompliant<br>• Suicidal thoughts/intent<br>• Inability to concentrate, loss of memory or cognitive abilities |
| **Changes in Behaviour and Performance** | | | |
| • Physically and socially active<br>• Performing well | • Decreased social activity<br>• Procrastination | • Avoidance<br>• Skipping class or work<br>• Decreased performance, lower grades | • Withdrawal<br>• Dropping out of classes/work<br>• Cannot perform assignments |
| **Physical Changes** | | | |
| • Normal sleep patterns<br>• Good appetite<br>• Feeling energetic<br>• Maintaining a stable weight<br>• Good personal hygiene | • Trouble sleeping<br>• Changes in eating patterns<br>• Some lack of energy<br>• Some weight gain or loss<br>• Less attention to hygiene | • Restless sleep<br>• Loss/increase of appetite<br>• Some tiredness or fatigue<br>• Fluctuations or changes in weight<br>• Poor hygiene most of the time | • Cannot fall/stay asleep<br>• No appetite/over eating<br>• Constant and prolonged fatigue or exhaustion<br>• Extreme weight gain or loss<br>• Consistently poor hygiene |
| **Changes in SUBSTANCE USE** | | | |
| • Limited alcohol consumption, no binge drinking<br>• Limited/no addictive behaviours<br>• No trouble/impact (social, economic, legal, financial) due to substance use | • Regular to frequent alcohol use, binge drinking<br>• Some regular to addictive behaviours<br>• Limited to some trouble/impact (social, economic, legal, financial) due to substance use | • Regular to frequent alcohol use, including binge drinking<br>• Struggle to control addictive behaviours<br>• Increasing trouble/impact (social, economic, legal, financial) due to substance use | • Regular to frequent binge drinking<br>• Addiction<br>• Significant trouble/impact (social, economic, legal, financial) due to substance use |

Source: Canadian Department of National Defense



**Distress Defusings**



# Interventions

# CODE LAVENDER

## CRITICAL INCIDENT IDENTIFIED

COMMUNICATE WITH MANAGER OR NAMS– ARE YOU AFFECTED BY IT?

NO

GREAT!

YES

**MENTAL READINESS COLORS**

**GREEN**- READY
**YELLOW**- RAISED VIGILANCE
**ORANGE**-WARNING LEVEL
**RED**-INJURED

WOULD YOU LIKE A DEFUSING OR DEBRIEFING PROVIDED?

JUST REMEMBER YOU HAVE RESOURCES IF THAT CHANGES. CHECK IN WITH EACHOTHER.

DEFUSING

DEBRIEFING

NORMALLY OCCURS WITHIN 8 HRS OF INCIDENT

OCCURS 24-72 HRS OF INCIDENT

**EAP RESOURCES/CISM PEER CONTACT**

# Methodology

**Unitary Human Beings**

"Professional practice in nursing seeks to promote symphonic interaction between man and environment, to strengthen the coherence and integrity of the human field, and to direct and redirect patterning of the human and environmental fields for realization of maximum health potential" (Rogers, 1970, p. 122).

**Roger's theory proposes nursing burnout may contribute to the stress of the patients being served. Burnout has a cascading effect on patients as supported by Dall'Ora, Griffiths, and Ball (2015).**

Some attributes of Roger's theory uses approaches to patient care, but in fact this methodology can be applied to burnout occurring in health care staff.

**Martha Roger's Theory of Unitary Human beings takes holistic approach when working with people.**

The distress defusings or debriefings that occur with staff embrace the emotional components that happen post critical events.
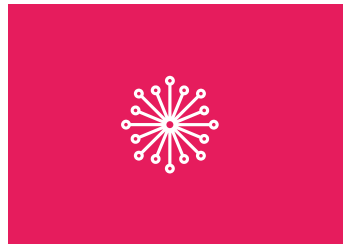
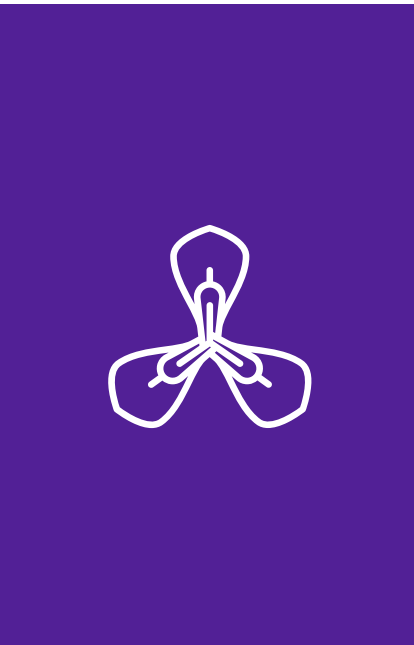## Indirect Qualitative Approach

### MEASURING TOOLS

✓ Workplace Resilience Instrument
✓ ProQOL (Professional Quality of Life) tool

# Results

**Pre and Post Survey Results**

| Section | Pre-Survey WRI N=18 | Pre-Survey PROQOL N=17 | Post Survey WRI N=18 | Post Survey PROQOL N=17 |
|---|---|---|---|---|
| **Active Problem Solving** | 4.01/5.0 | | 4.20/5 Increased | |
| **Team Efficacy** | 4.09/5.0 | | 3.90/5 Decreased | |
| **Team Confident Sense Making** | 4.03/5.0 | | 3.97/5 Decreased | |
| **Bricolage** | 3.77/5 | | 3.70/5 Decreased | |
| **Overall Score** | 3.98/5 | | | 3.95/5 Decreased |
| **Compassion Satisfaction** | | 42.54 (Low) | | 40.8 (low) Decreased |
| **Burnout Scale** | | 20.1 (low) | | 23.8 (low) Increased |
| **Secondary Traumatic Stress** | | 20.8 (low) | | 24.6 (low) Increased |

# Analysis

| Part 1 | Pre Pilot Project-WRI | Part 2 | Pre Pilot Project-ProQOL |
|---|---|---|---|
| 16% (18/110 staff members). 17 RNs 1 nursing aid. 8= 1-5 years of experience, 6= 6-10 years of experience, 3= 11-15 years of experience and1 = 16-20 years of experience. 16 female & 2 male | **WRI**<br><br>**Active problem-solving scale** 4.01/5 The lowest value was 2.66/5 and the highest was 5/5.<br>**Team efficacy** 4.09/5. The lowest score average was 3/5 and the highest was 5/5.<br>**Confident sense-making** 4.03/5. The lowest score noted was 3/5 and the highest was 5/5.<br>**Bricolage** 3.77/5 The lowest score result was 2.83/5 and the highest was 5/5. | 12% (n=13/110 ) 12 RNs and 1 nursing aid. 7 =1-5 years of experience,6= 6-10 years of experience. It appears as though the participants that had 11-15 years and 16-20 years of experience dropped out of the second part of the survey. 12 females and 1 male. | **Compassion satisfaction** average (42.54); The lowest score result was 35, indicating average compassion satisfaction. The highest score result was 50.<br>**Burnout levels** 20.1=low burnout rate. The highest result was 28, indicating an average burnout rate (between 23-41) on the unit. The lowest result was 13; anything below 22 indicates a low burnout rate.<br>**Secondary traumatic stress** =20.8 (low< 22). The highest result was 33 (23-41) which is on the higher end of average secondary traumatic stress. |

# Analysis

| Part 1 | Post Pilot Project-WRI | Part 2 | Post Pilot Project-ProQOL |
|--------|------------------------|--------|---------------------------|
| 16% voluntary engagement in the survey (n=18/110). **Added question** asked if they found the tool useful. With a 66% (n=12/18) participation rate with this question, the varying responses were as follows: 33% found the tool useful (n=4/12), 25% (n=3/12) did not find it useful, and 42% (n=5/12) stated they did not receive the tool or did not know what the tool was. **Q2**:Out of 18 participants, 2 wrote comments regarding the themes of ensuring work-life balance and checking in with one another. | **WRI** <br><br> **Active problem-solving scale** 4.2/5 (84%). The lowest score was 2.7/5 and the highest score was 4.7/5 on the scale. **Team efficacy** 3.9/5 (74%). Decrease from the initial pre-survey of 82%. The lowest score average was 3.25/5 and the highest was 4.75/5. **Confident sense-making** 3.97/5,(79%).The lowest score was 3.6/5 and the highest score was 4.4/5. **Bricolage** 3.7/5 (74%). The lowest score was 2.7/5 and the highest score was 4.5/5. | 15.4% (17/110) participation rate (one person did not complete part 2) | **Compassion satisfaction** average (40.8) **Burnout levels** 23.8= average burnout rate. **Secondary traumatic stress** =24.6 moderate. |

**p-value**

**T-test**

**KS Test**

**Correlation**
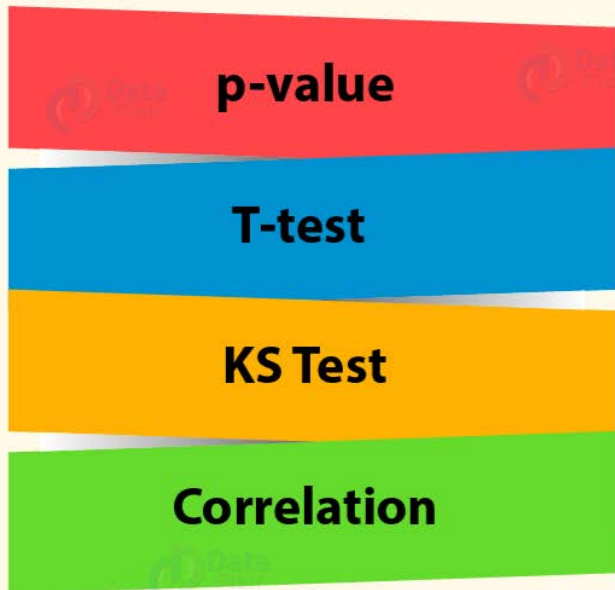
**Python Statistics**

**Significance?**

- Using a Python statistical analysis program, the statistician conducted a Kolmogorov-Smirnov test on the recommendation of the author from the WRI due to the nature of the samples being separate entities.
- This test is nonparametric.
- Even though this test is normally run with larger samples, it was chosen to see if there was any significance to the resulting data.
- Out of all the data tested, the only significant results that showed change were in the mean burnout results ($p=0.05$, t-test).
  - One can ask if there is an explanation for why that would be the area where the effect is more apparent.
  - Is this something that occurred during the eight weeks of the Code Lavender pilot project?
  - The researcher can also ask if burnout something that people can more consistently rate?
  - **At this time, the pre and post data is inconclusive.**

# Conclusion/Recommendations

- Have Excellent Peer Support Training

- Use Mitchell Model (Defusing/Debriefing Phases)

- Ensure leadership and stakeholders support

- Defusings=Patient assignment covered

- Team available 24/7

- Mental Readiness Tool

- Peer teams collaborate with other peer teams

- Educate staff organization-wide on CISM team

- Differentiate operational debriefing vs. critical incident stress debriefings.

- Ensure confidentiality

- Homogenous groups

- Stigma Reduction

- Reach In

- Be Proactive

- Provide vetted mental health clinicians trained in psychological trauma injury*

# Further Research

**Longer Pilot Testing-12 weeks vs 8 weeks**

**Compare CISD programs to other programs such as schwartz rounds or other mental wellness programs.**

**Control Groups that are the same pre and post program implementation**

**Further research on the mental readiness tool efficacy for gaging one's emotions.**

**Include multiple units since the CISM team serves the whole organization.**

**Provide questionaires prior to an actual defusing or debriefing, then follow up with questionnaire at a different time.**
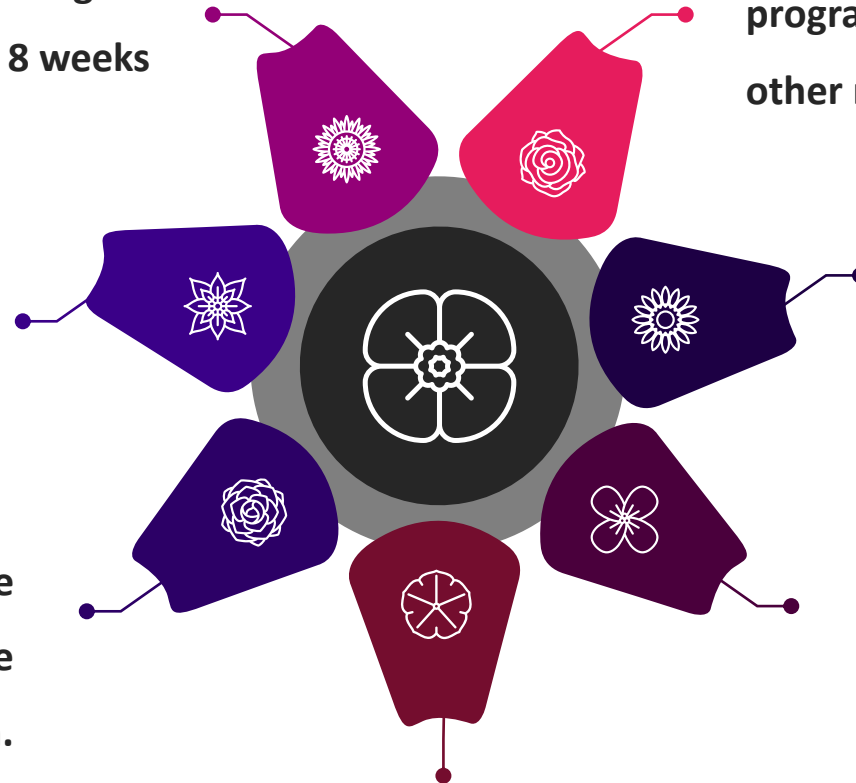
# Thank You All for Your Time, Support, Mentorship and Collaboration. 🍃

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