

8-1-2021

## New Nurse Reality Shock & Early Burnout: Can Role Transition Education Received During New Nurse Residency Positively Affect Satisfaction?

Bonnie L. Stolzman

Follow this and additional works at: <https://digitalscholarship.unlv.edu/thesesdissertations>



Part of the [Health and Medical Administration Commons](#), and the [Nursing Commons](#)

---

### Repository Citation

Stolzman, Bonnie L., "New Nurse Reality Shock & Early Burnout: Can Role Transition Education Received During New Nurse Residency Positively Affect Satisfaction?" (2021). *UNLV Theses, Dissertations, Professional Papers, and Capstones*. 4268.

<https://digitalscholarship.unlv.edu/thesesdissertations/4268>

This Dissertation is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Dissertation in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Dissertation has been accepted for inclusion in UNLV Theses, Dissertations, Professional Papers, and Capstones by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact [digitalscholarship@unlv.edu](mailto:digitalscholarship@unlv.edu).

NEW NURSE REALITY SHOCK & EARLY BURNOUT: CAN ROLE TRANSITION  
EDUCATION RECEIVED DURING NEW NURSE RESIDENCY  
POSITIVELY AFFECT SATISFACTION?

By

Bonnie L. Stolzman

Bachelor of Science - Nursing  
University of Wisconsin  
2013

Master of Science - Nursing  
Master of Business Administration  
Grand Canyon University  
2016

A doctoral project submitted in partial fulfillment  
of the requirements for the

Doctor of Nursing Practice

School of Nursing  
The Graduate College

University of Nevada, Las Vegas  
August 2021

July 6, 2021

This doctoral project prepared by

Bonnie L. Stolzman

entitled

New Nurse Reality Shock & Early Burnout: Can Role Transition  
Education Received During New Nurse Residency Positively Affect Satisfaction?

is approved in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice  
School of Nursing

Angela Silvesrti-Elmore, Ph.D.  
*Examination Committee Chair*

Kathryn Hausbeck Korgan, Ph.D.  
*Graduate College Interim Dean*

Roseann Colosimo, Ph.D.  
*Examination Committee Member*

Howard Gordon, Ed.D.  
*Graduate College Faculty Representative*

## **Abstract**

Newly licensed nurses are at incredibly high risk for reality shock leading to early burnout which results in many of them resigning their positions or leaving nursing altogether. Common feelings leading to reality shock often involve exhaustion, cynicism, depersonalization, decreased self-efficacy, and decreased job satisfaction. The result of early burnout presents significant financial strain and quality concerns for our already struggling healthcare systems. In the 1960s and early 1970s, Marlene Kramer brought her research regarding newly licensed nurses and their experience of “reality shock” to publication. Kramer felt strongly that reality shock was a key factor that led newly licensed nurses to leave the profession. More than 40 years later, newly licensed nurses continue to experience the same problems when trying to transition into their roles.

The purpose of this project was to examine whether participation in a nurse residency program that actively addressed reality shock and early burnout reduced the incidence of emotional exhaustion, cynicism, depersonalization, and increased newly licensed nurse’s sense of personal accomplishment and self-efficacy within the first year of practice. Kramer’s “Reality Shock” theory (1974) and Boychuk-Dunscher’s “Process of Becoming” theory (2008) was the theoretical framework used as a basis for the educational intervention content. The Maslach Burnout Inventory Human Services Survey for Medical Personnel was utilized to assess exhaustion, cynicism, depersonalization, and personal accomplishment among newly licensed nurses. Demographic questions were asked at the beginning of the survey.

Questions related to the COVID-19 pandemic were also included as it was recognized that participation in the care of patients during the COVID-19 crisis may have added stressors that would not have been otherwise present. The setting was an education and training center

located in Las Vegas, Nevada, that provides centralized education services and a nurse residency program for newly licensed nurses in a seven-hospital system. Forty-five newly licensed nurses completed the initial online demographic survey, COVID-19 survey, and MBI survey.

Descriptive statistics using frequency distributions were used to characterize sampled demographics and participant's perception of providing care to patients with COVID-19 during the pandemic. Twenty-six newly licensed nurses completed the educational intervention discussing reality shock and early burnout via a digital learning management system. The educational intervention and surveys were available for 4 months. Twenty-six participants completed the same online MBI survey following completion of the educational intervention. A paired samples *t*-test was used to analyze data obtained from the pre- and post-intervention surveys.

The educational intervention was successful in achieving its overall objectives, but the incidence of burnout did not improve as much as hoped, perhaps due to the unexpected added stress of a nationwide pandemic. Increasing organizational awareness of new nurse reality shock and early burnout through the project contributed positively to development of initiatives to assess and address burnout within the healthcare organization. A system wide retention committee was formed to address engagement and assess and address early burnout of newly licensed nurses within the first year of practice.

Raising the awareness of organizational leadership regarding reality shock and early burnout will help support ongoing retention efforts.

It is suggested that in the future, in person educational sessions be added to supplement the presentation which will enhance ongoing efforts to assist newly licensed nurses to feel

understood and supported through their transition to practice. When they feel they are well supported in their respective clinical work settings, retention occurs.

## **Acknowledgments**

I cannot express enough thanks to my committee, Dr. Angela Silvestri-Elmore, Dr. Roseann Colosimo, and Dr. Howard Gordon for their guidance and support. A special note of gratitude goes out to Dr. Angela Silvestri-Elmore, my committee chair, for her guidance and words of encouragement along the way which made a seemingly insurmountable journey achievable.

Completion of this project could not have been accomplished without the support of my dear friend and colleague Dr. Carol Rayfield. I cannot thank you enough for all the expressions of kindness, encouragement, and support during this challenging journey. I owe you a debt of gratitude that I will never be able to repay for the hours and hours personal time that you spent assisting me with the layers and layers of statistical data analysis. Thank you for your blind confidence even when I was unsure.

## **Dedication**

This project is dedicated to my loving husband Richard who encouraged me to pursue my dreams and finish my doctorate. I would like to recognize my family, friends, and colleagues who have supported me throughout this process. Their continued love, support, and encouragement were pivotal to the successful completion of this journey.

A special dedication goes out to Mary Krueger who saw something in me many years ago. Mary's encouragement set me on the path that helped build the solid leadership foundation that I stand on today. Her belief in my strengths never wavered. Mary believed in me before I knew how to believe in myself.

## Table of Contents

Abstract	iii
Acknowledgement	vi
Dedication	vii
Chapter I	1
Introduction	1
Background and Significance	1
Problem Statement	2
Statement of Purpose	3
Needs Assessment	3
Chapter II	5
Introduction	5
Literature Review	5
Reality Shock	5
Phases of Reality Shock	6
Early Burnout	7
Emotional Exhaustion	7
Cynicism	8
Self-Efficacy	8
Lack of Confidence	9
Cost of Turnover	10
Other Key Factors Leading to Early Turnover	11
History of NRPs	12
NRP Curriculum and Retention Rates	12
Summary	13
Chapter III	15
Change Theory	15
Introduction	15
Kramer's Reality Shock	15

Honeymoon Phase	16
Assault Phase	16
Recovery/Resolution Phase	17
Boychuk-Duchscher’s “Process of Becoming”	17
The Doing Stage	17
The Being Stage	18
The Knowing Stage	19
Application of Boychuk-Duchscher’s Theory	20
Conclusion	21
Chapter IV	22
Project Proposal	22
Setting	22
Sample	22
Inclusion Criteria	22
Exclusion Criteria	23
Project Design	23
Measures, Instruments, and Activities	23
Data Analysis and Outcomes Evaluation	25
Timeline	26
Definitions	26
Resources and Support Required	27
Risks, Limitations, and Threats	27
Conclusion	28
Chapter V	29
Summary of Intervention and Results	29
Precis of the Phenomenon of Interest, Problem, and Purpose of the Project	29
Threats and Barriers	29
Monitoring	30
Data Collection and Analysis	30
Demographics	31
COVID-19 Pandemic Care of Patients and Stress	33
COVID-19 Pandemic Care of Patients and Stress Assumptions	34

MBI Survey Results	34
Emotional Exhaustion (EE) Subscale	36
Depersonalization (DP) Subscale	38
Personal Accomplishment (PA) Subscale	40
Cynicism (CY) Subscale	42
Limitations	44
Discussion	47
Relation to Literature and Theory	50
Contribution and Potential for Sustainability	51
Utilization and Dissemination of Results	52
Conclusion	52
References	55
Appendix A	62
Appendix B	63
Appendix C	70
Appendix D	71
Appendix E	72
Appendix F	73
Curriculum Vitae	74

## List of Tables

Table 1: Demographics of Post Intervention Group.....	33
Table 2: Paired Samples <i>t</i> -Test MBI Survey Pre/Post Intervention ( <i>n</i> =26). .....	35
Table 3: Paired Samples <i>t</i> -Test Emotional Exhaustion Subscale Total Score Pre/Post Intervention ( <i>n</i> =26).....	37
Table 4: Paired Samples <i>t</i> -test Emotional Exhaustion Individual Items Pre/Post Intervention....	38
Table 5: Paired Samples <i>t</i> -Test Depersonalization Subscale Total Score Pre/Post Intervention ( <i>n</i> =26).....	39
Table 6: Paired Samples <i>t</i> -test Depersonalization Pre/Post Intervention Per Question.....	40
Table 7: Paired Samples <i>t</i> -Test Personal Accomplish. Subscale Total Score Pre/Post Intervention ( <i>n</i> =26).....	41
Table 8: Paired Samples <i>t</i> -test Personal Accomplishment Pre/Post Intervention Per Question...	42
Table 9: Paired Samples <i>t</i> -Test Cynicism Subscale Total Score Pre/Post Intervention ( <i>n</i> =26). ..	43
Table 10: Paired Samples <i>t</i> -test Cynicism Pre/Post Intervention Per Question.....	44

## **Chapter I**

### **Introduction**

This chapter provides background information on the prevalence of reality shock and early burnout that new nurses experience in the first year of practice. It also addresses potential contributing variables that result in reality shock and burnout within the first year of practice. This Doctor of Nursing Practice (DNP) project proposal examines whether participation in a nurse residency program (NRP) that actively addresses reality shock and early burnout reduces the incidence of exhaustion, cynicism, depersonalization and increases personal accomplishment of newly licensed nurses (NLNs) within the first year of practice.

### **Background and Significance**

The first year of practice can be very taxing and stressful for new nurses. NLNs report coming out of school with high expectations only to face a workforce that they perceive to be uninviting, overworked, and understaffed (Altier & Krsek, 2006). In 1974, Kramer published research on the topic of “reality shock” that is experienced by NLNs within their first year of practice (Kramer, 1974). Black’s Law Dictionary (2020) defines reality shock as a “jarring” experience that one experiences when there is a vast difference between what one anticipates or expects and what they really experience. Common feelings reported by NLNs leading to reality shock and decreased job satisfaction often involve exhaustion, cynicism, depersonalization, lack of personal accomplishment and decreased self-efficacy (Maslach & Jackson, 1981).

The Robert Wood Johnson Foundation performed a 10-year registered nurse (RN) work project that focused on the career path taken by NLNs (Foundation, 2012). The Foundation research found that as of 2012, within 13 months of beginning their first nursing job, 18.1% of NLNs had left to seek other employment both within and outside of the nursing field (Foundation, 2012). The 2017 National Health Care Retention and RN Staffing Report found

that five years later, average turnover rates for nurses that had practiced fewer than twelve months had risen to 25.6% (National Healthcare Retention and RN Staffing Report, 2017). High levels of NLN turnover poses a negative impact upon team members who must work extra hours or shifts to cover for the vacancy and experience increased stress and burnout from increased patient loads (Jones, 2008).

NLNs are at incredibly high risk for reality shock leading to early burnout which results in many of them resigning their positions or leaving nursing altogether (Boamah, Read, & Spence Laschinger, 2017). The end result of this early burnout poses significant financial strain and patient quality concerns to our healthcare systems. The average cost to replace a nurse can range from \$37,700 to \$58,400 (Jones, 2008). This can put a significant financial strain on already struggling healthcare systems (Van Camp & Chappy, 2017).

There are ways for healthcare organizations to assist NLNs in combating these intense feelings of stress and early burnout. NRPs have been recommended to guide new nurses in their transition to practice (Wolford, Hampton, Debra, Tharp-Barrie, & Goss, 2019). One specific goal of an NRP is to promote enhanced engagement which increases an employee's overall commitment and loyalty to the organization where they are employed (Wolford, et al, 2019).

### **Problem Statement**

Retention of NLNs is of significant importance to any healthcare organization due to its financial implications, the effect it has on workflow and strain on employees, as well as downstream effects on patient experience and the overall quality of care (Djukic, 2011). Finding effective ways to ease reality shock and curtail early burnout in NLNs will lead to increased satisfaction and overall retention in the first year of practice. Examining variables that contribute to reality shock in NLNs and determining how NRPs can support or enhance the transition into practice will identify interventions to help support a more stable workforce. With the nation

facing a potentially critical nursing shortage, immediate efforts must be made to study and understand the impact that reality shock and early burnout has on NLN turnover and whether NRPs can address these issues to positively impact satisfaction and retention (Zinn, Guglielmi, Davis, & Moses, 2012).

### **Statement of Purpose**

The purpose of this DNP project was to examine whether participation in an NRP that actively addressed reality shock and early burnout reduced the incidence of exhaustion, cynicism, depersonalization and increased personal accomplishment of NLNs within the first year of practice. Many NLNs experience extreme performance anxiety and self-doubt during their first year of practice that for some, leads to intention to leave the practice of nursing. Actively addressing reality shock with NLNs, and providing a deeper understanding of this phenomenon, will significantly help to support their transition from student to professional in the first year of practice.

### **Needs Assessment**

To understand the effect that curricula addressing reality shock has on early burnout and job satisfaction of new nurses in their first year of practice, an organized NRP in an acute care hospital system in southern Nevada conducted a needs assessment. The hospital system has an organized NRP in place that does not offer specific curricula that addresses reality shock. The assessment analysis indicated that the overall RN turnover rate due to early burnout within the first year of practice was above the 15% target range for the NLNs that participated in the NRP.

The Patient/Population, Intervention/Indicator, Outcome, Time (PICOT) framework was utilized to highlight the elements of the project purpose. A randomized sample of newly hired NLNs in their first year of practice enrolled in a seven-hospital health system's NRP were the intended population of interest (P). The group will take part in answering survey questions

regarding exhaustion, cynicism, depersonalization, personal accomplishment, and early burnout 6 to 8 months post-graduation. The group of NLNs received online education that addressed reality shock. The group took part in answering the same survey questions again 12 months post-graduation after completion of the reality shock education (I). The first survey results were compared to post education survey results as it pertained to reported levels of exhaustion, cynicism, depersonalization, and personal accomplishment. The assumption (C) was that the group at the 12-month post-graduation timeframe would report less reality shock symptoms relating to exhaustion, cynicism, depersonalization, and burnout along with improved sense of personal accomplishment and self-efficacy because of the enhanced curricula offered in their NRP (O). The intervention was an enhanced education module within an established NRP lasting a period of 12 months in total (T). The NRP and its participants were essential to the design of this project.

## **Chapter II**

### **Introduction**

This chapter will present a review of the literature, providing a critical assessment of current literature on the benefits of NRPs. It also illustrates a review of literature related to reality shock and early burnout which leads to reduced job satisfaction and new nurse turnover within the first year of practice.

### **Literature Review**

An integrated review of literature was performed using CINAHL, MEDLINE-EBSCOhost, Sage, and Wiley Online databases to examine peer reviewed articles that were published within the past five years. The search was performed using keywords: new nurse residency, burnout, reality shock, retention, exhaustion, cynicism, depersonalization, personal accomplishment, self-efficacy, and turnover, which produced 30 relevant published studies.

### **Reality Shock**

NLNs are coming out of school with high expectations only to face complex healthcare work environments with limited resources (Anderson, Linden, Allen, & Gibbs, 2009; Rudman & Gustavsson, 2011). As early as the 1970s, there was recognition of a high incidence of turnover in NLNs and published research on “reality shock” in the first year of nursing practice was completed (Boychuk-Duchscher & Windey, 2018; Kramer, 1974). According to the 2019 National Healthcare Retention and RN Staffing Report, 27.2% of new nurses leave their employment within the first year of service because of the perceived stress they feel when transitioning from student to professional (Asber, 2019; Anderson, Hair, & Todero, 2012; NSI Nursing Solutions, 2019). Within their first year of practice, NLNs struggle with general lack of confidence, organizing and managing their respective workload, fears related to giving medications, lack of ability to perform timely and accurate assessments, difficulty

communicating with doctors and ultimately a fear of harming patients (Anderson, et. al, 2012). NLNs experience reality shock in varying intensity often having symptoms that affect them emotionally, intellectually, and physically (Boychuk-Duchscher & Windey, 2018; Kramer, 1974).

### **Phases of Reality Shock**

Most academic nursing programs do not adequately prepare students with the coping mechanisms to effectively address and manage each phase of reality shock (Boamah et al., 2016). The primary challenge for NLNs is that they must recreate a professional sense of self that blends their education together with the often-harsh realities that their new profession presents (Boychuk-Duchscher & Windey, 2018). Boychuk-Duchscher (2018) reports that the first 12 months post-graduation for new nurses is considered a process of “becoming.” In order to complete the process of becoming, new nurses must move through the stages of doing, being, and knowing (Boychuk-Duchscher & Windey, 2018).

**Stage of doing.** The stage of “doing” usually occurs during the first 3 to 4 months after an NLN graduates (Boychuk-Duchscher & Windey, 2018). During this phase, NLNs feel that their work is exciting. Because so much about being a “real nurse” is new to them, NLNs often are unaware of what they do not know. They often are developmentally unable to set appropriate limits and take on the proverbial world without setting up a good organizational workflow foundation. During this phase, NLNs can feel stressed about literally everything (Boychuk-Duchscher & Windey, 2018).

**Stage of being.** The stage of “being” sets in during the next 4 to 5 months and can peak at 7 months (Boychuk-Duchscher & Windey, 2018). During the first half of this second stage, NLNs become increasingly comfortable with their roles but are often faced with perceived inconsistencies and inadequacies within their healthcare environment (Boychuk-Duchscher &

Windey, 2018). NLNs often become disenchanted during this phase with the whole concept of nursing. Some will question why they left the comforts of nursing school only to expose themselves to the harsh reality of daily responsibilities that leave them feeling “incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless” (Boychuk-Duchscher & Windey, 2018 p. 230).

**Stage of knowing.** The final stage that NLNs must experience is the stage of “knowing” (Boychuk-Duchscher & Windey, 2018, p. 231). NLNs that make it to this stage are often still feeling the hangover symptoms from the prior stages (Boychuk-Duchscher & Windey, 2018). Often the NLNs are still struggling to find their identity. Employers may hear complaints about shift work or work life balance. NLNs may express critical comments about their workloads and the condition of their working environment (Boychuk-Duchscher & Windey, 2018). They may express feelings that no one is listening to them and that their concerns are falling on deaf ears. They often feel powerless to effect change (Boychuk-Duchscher & Windey, 2018).

### **Early Burnout**

Reality shock often leads to subsequent early burnout of NLNs during their first 12 – 24 months of practice (Rudman & Gustavsson, 2011). Longitudinal studies performed on a national cohort of 1153 nurses in Sweden in 2010 identified that early burnout is often accompanied by signs and symptoms of depression and intentions to leave the profession of nursing (Rudman & Gustavsson, 2011). Depression in NLNs is linked to increased absenteeism, decreased productivity, and an increase in errors, which puts patients at risk (Brandford & Reed, 2016).

### **Emotional Exhaustion**

Nurses are at high risk for suicide and substance abuse because of job stressors that lead to emotional exhaustion (Havaei, Macphee, & Dahinten, 2016). Some researchers report that

when new nurses are experiencing reality shock and perceive that they are not supported by their work environment, they suffer emotional exhaustion early on in their career and leave both their current jobs and the nursing profession (Havaei et al., 2016). Health care researchers view nurses' relationship to their work as a sort of continuum from positive and actively engaged to negative disengagement which leads to burnout (Havaei et al., 2016; Maslach et al., 1981). In nursing research, the commonly used Maslach Burnout Inventory (MBI) scale often uses the emotional exhaustion scale as a proxy for overall nurse burnout (Havaei et al., 2016; Maslach et al., 1981). Health care organizations are under pressure to preserve the health and wellbeing of their nursing staff. Employee engagement improves when emotional exhaustion is reduced and nurses feel cared for (Havaei et al., 2016).

### **Cynicism**

Cynicism in the healthcare industry can occur when employees believe that organizational leaders lack integrity and don't care about their employees (Mantler, Godin, Cameron, & Horsburgh, 2015). Experiencing cynicism early in one's career can be especially destructive to a new nurse. NLNs who are experiencing cynicism due to perceived job demands will often show signs and symptoms of frustration, pessimism, and overall distrust towards their leaders, coworkers, and organization (Mantler et al., 2015). Cynicism is strongly correlated with reduced commitment, reduced work effort, and poorer job performance (Mantler et al., 2015). When NLNs begin to experience reality shock, signs and symptoms of cynicism often become exaggerated (Boychuk-Duchscher & Windey, 2018; Mantler et al., 2015). Cynicism has been found to be higher in nursing than in any other occupation (Mantler et al., 2015).

### **Self-Efficacy**

Self-efficacy is the belief in one's ability to take action and manage future actions and situations (Masoudi Alavi, 2014). Educators believe that positive self-efficacy is a good indicator

to predict how a nursing student will transition into clinical practice (Masoudi Alavi, 2014). High levels of self-efficacy lead to increased independence and confidence (Masoudi Alavi, 2014). New nurses come out of school on a proverbial high with the feeling of “I can do” which gives them a sense of mastery over their environment (Anderson, et al., 2009; Masoudi Alavi, 2014). Reality shock can lead to a decline in an NLNs self-efficacy (Boychuk-Duchscher & Windey, 2018; Masoudi Alavi, 2014). NLNs that begin to feel a decline in their sense of self-efficacy and tend to avoid situations which they perceive led to failure in their performance or patient care (Masoudi Alavi, 2014). This can lead to a significant lack of confidence and grave errors in patient care.

### **Lack of Confidence**

Professional confidence is a key trait that nurses must possess to provide quality care in complex hospital settings (Mun et al., 2016; Ortiz, 2016). After graduation, many NLNs report feeling they lack the clinical competence, comfort, and confidence to perform the multitude of tasks required at the bedside due to a disconnect between clinical knowledge attained in school and the reality of how this knowledge should be applied in actual nursing practice (Gardiner & Sheen, 2016; Mun et al., 2016; Ortiz, 2016).

According to Ortiz (2016), NLNs feel that perceived lack of skill in communicating with other team members, physicians, patients, and preceptors erodes their professional confidence. NLNs report that receiving both constructive and destructive criticism from peers, physicians, patients, and leaders, leads to an overall decrease in confidence levels (Mun, et al., 2016; Ortiz, 2016). NLNs report that receiving positive feedback from their mentors, preceptors and leaders during their orientation period led to an increase in confidence, but negative comments had a negative effect on their overall professional confidence. To increase overall confidence in communication techniques, it is important for facilities to implement curricula that can enhance

skills in communication for NLNs during their orientation period (Anderson et al., 2012; Ortiz, 2016; Rush et al., 2019; Walsh, 2018).

Another area that leads to overall decreased confidence for NLNs is fear of making errors in day-to-day patient care (Ortiz, 2016). Some NLNs feel that they are so focused on perfection and prevention of errors that they forget key patient care tasks which makes them look and feel incompetent (Mun et al., 2016; Ortiz, 2016). Some NLNs fear making errors because it will lead to being humiliated or bullied by their peers (Mun et al., 2016). Mandatory training to discuss daily workflow and organization as well as open discussion regarding how constructive criticism differs from bullying behaviors is crucial to provide a smooth transition for NLNs (Mun et al., 2016).

Development of professional confidence occurs throughout the first year of nursing practice (Ortiz, 2016, p. 23). It is important for NLNs to understand that sometimes both positive and negative experiences are necessary for them to grow even if it is uncomfortable (Ortiz, 2016). Working through some of these issues in a variety of curricula and formats can help NLN transition to professional practice (Ortiz, 2016).

### **Cost of Turnover**

First-year turnover rates for NLNs have been documented as high as 55% – 61% (Anderson, Linden, Allen, & Gibbs, 2009). According to the 2019 National Health Care Retention & RN Staffing Report, the cost of turnover for a bedside RN ranges from \$40,000 to 64,000, which leads to an average hospital losing \$5.7 million per year on turnover alone (NSI Nursing Solutions, 2019; Schmitt & Schiffman, 2019). The cost of replacing newly graduated nurses is exponentially higher due to the extra time, cost, and resources necessary to orient and transition them to professional practice (Djukic, 2011; Schmitt & Schiffman, 2019). Another key factor employers consider is that new nurse productivity is lower than that of an experienced

nurse. According to Schmitt and Schiffman (2019), it takes at least a full year for a new nurse to feel “relaxed” and “self-assured ” practicing in the acute care setting (p.1).

Secondary to shrinking operational budgets, the requirement to “do more with less,” and the cost of new nurse turnover, many hospitals are requiring nurses to have a minimum of one year of experience before getting hired (Djukic, 2011). The American Nurses Association (ANA) predicts that the US will require more than one million new nurses by 2022 to replace those retiring as well as to care for our aging Americans (Haddad & Toney-Butler, 2019). Because we are facing a global nursing shortage, limiting the hiring scope to experienced nurses will only add to the problem (Salt, Cummings, & Profetto-McGrath, 2008). The key to reducing the high incidence of new nurse turnover is identifying and addressing causative factors for early turnover, and intervention of NRPs that will support NLNs and ease their transition to practice (Anderson et al., 2009; Rush, Janke, Duchscher, Phillips, & Satvir, 2019; Salt et al., 2008; Walker & Campbell, 2013; Wildermuth, Weltin, & Simmons, 2019; Williams et al., 2018).

### **Other Key Factors Leading to Early Turnover**

Evidence indicates that multiple different factors lead to burnout and the early turnover of NLNs (Boamah, Read, & Spence Laschinger, 2017; Eun-Young, Jung Hee, Hyunjeong, Kyung Mi, & Jones 2018; Gardiner & Sheen, 2016; Mun et al., 2016; Schmitt & Schiffman, 2019). Across the span of literature reviewed, some of the biggest dissatisfiers identified by NLNs that led to early burnout was poor scheduling, lack of adequate staffing, work-life balance, poor physician relations, and a perceived theory-practice gap (Anderson et al., 2009; Boamah et al., 2016; Gardiner & Sheen, 2016). Cleary et al. (2013) surveyed 147 new nurse graduates in Singapore. The survey results indicated that although nurses reported feeling overall “satisfied” with their new career, they felt that lack of support in the workplace, insufficient career development opportunities including further education, excessive working hours, and high

patient ratios were key dissatisfiers that may lead them to change jobs (Cleary et al., 2013). Boamah et al. (2016) performed a study of 3,743 NLNs between 2013 and 2014 to determine if there was a direct correlation between nurse manager authentic leadership style and reduction in overall job dissatisfaction. The results of the study indicated that short-staffing and work-life balance are important factors in predicting early turnover in NLNs and that nurse manager leadership behaviors were key in reducing turnover; there were no results related to participation in an NRP (Boamah et al. 2016).

### **History of NRPs**

NRPs, first researched in the 1980s, have been identified as a critical measure to successfully prepare new nurses for their transition from student to practicing professional and helps to decrease overall turnover in their first year (Altier & Krsek, 2006; Eckerson, 2018; Wolford, Hampton, Tharp-Barrie, & Goss, 2019). In an integrated review of 16 studies between 2010 and 2016, Asber found that 13 of the 16 studies supported NRPs and reported a one-year retention rate of 90-100% post-intervention of an NRP (Asber, 2019).

NRPs were designed to contain detailed orientation curricula for graduate nurses that are transitioning into professional practice as a newly licensed RN (Asber, 2019). NRPs typically last from 6 to 12 months and serve as an opportunity for new nurses to hone critical-thinking and evidence-based decision-making skills (Anderson, et al., 2012, Asber, 2019, Eckerson, 2016). NRPs promote professional socialization opportunities and clinical competency, which improves overall quality outcomes (Williams, Scott, Tyndall, & Swanson, 2018).

### **NRP Curriculum and Retention Rates**

Based on the literature reviewed, it is evident that not all NRPs are created equal, and therefore, produce varying results in turnover. Local organizational-based residency programs can have variable curricula and vary in length based on available resources. Retention rates

among hospitals that have organizationally created NRP curricula are lower than those that utilize national programs created by the American Association of Colleges of Nursing (AACN) and Vizient (Asber, 2019). The AACN/Vizient is a 12-month NRP that offers a standardized curriculum and is designed to allow NLNs to expand upon their critical thinking and evidence-based decision-making skills (Vizient/AACN, 2019). In 2019, Brook et al. (2019) performed a systematic review of literature published between 2001 & 2018 to review characteristics of successful interventions to reduce turnover of NLNs. A total of 53 studies proved to be eligible and offer promising interventions that supported new nurse retention. NRPs lasted between 27 and 52 weeks and included a preceptor and mentor component (Brook et al., 2019). In 2019, Rush et al. (2019) performed an integrative review of nursing research literature from 2000-2018 to identify best practices of NRPs. Seventy-six studies were included in the Rush et al. (2019) review; however, the results were inconclusive because of the variability and quality of the evidence.

### **Summary**

Research has provided evidence that NRPs can be an effective strategy to support NLN transition into practice (Wildermuth et al., 2019). Literature indicates that when NLNs feel they are well supported in their respective clinical work settings, retention occurs (Leong & Crossman, 2016). While each NLN experiences the transition into practice in a very personal and unique way, there are common themes that are prevalent in the literature that must be identified and addressed during the first year (Wildermuth et al., 2019). One weakness noted during this review is that none of the literature specifically identifies if or how an NRP addresses or ties into the key issues of reality shock and early burnout that leads to turnover.

The AACN purports that standardized residency curriculum helps cover the perceived theory-practice gap, which then helps to build confidence (Vizient/AACN Nurse Residency Program, 2019).

**Chapter III**  
**Change Theory**  
**Introduction**

NLNs are entering the workforce with high hopes and aspirations of making a difference in the lives of the patients they care for. They instead are faced with the hard truth that they have neither the expertise nor the confidence to tackle the high patient acuities and the burdensome workloads that nurses carry every day. This chapter will focus on Kramer's "Reality Shock" theory (1974) and the "Process of Becoming" theory of Boychuk-Duchscher (2008). New nurses experience multiple challenges trying to transition from student nurse to practicing nurse. In her theory of transition, Boychuk -Duchscher (2008) illustrates a journey of becoming whereby new nurses personally and professionally progress through sometimes difficult stages of "doing, being, and knowing" (Boychuk-Duchscher, 2008, p. 444).

**Kramer's Reality Shock**

In the 1960s' and early 1970s', Marlene Kramer brought her research regarding NLNs and their experience of "reality shock" to publication (Kramer, 1974; Boychuk-Duchscher & Windey, 2018, July/August). Kramer felt strongly that it was reality shock that was causing NLNs to leave the profession. Kramer's theory focused on NLNs becoming socialized in their new work environments and describes three stages NLNs experience as they transition from student nurse to practicing nurse. In her works, Kramer described a transition process for NLNs that moved from excitement (honeymoon phase) to disillusionment (the assault phase) and finally, to balance (recovery and resolution phase) (Kramer, 1974). More than 40 years later, NLNs continue to experience the same problems when trying to transition into their roles.

## **Honeymoon Phase**

NLNs that are in the honeymoon phase are excited and exhilarated with the concept of starting their career (Kramer, 1974) (Boychuk-Duchscher, 2008). They begin their new nursing positions in a seemingly euphoric state of mind with idealistic visions. They chose this honorable and humble career to help people. It is their intent to make a difference in the lives of the patients they care so tenderly for. The honeymoon stage is short lived as new nurses begin to notice there is a stark difference between what they learned in school, what they envisioned their career to be, and what they are experiencing in their day-to-day jobs. They often begin to question whether they should follow the values that they were taught in school or the ones that every other nurse on their unit seems to be following (Boychuk-Duchscher, 2008).

## **Assault Phase**

In the assault phase, Kramer reports that NLNs feel as if they are in a perpetual state of shock (1974). NLNs report feeling an “assault on their professional values...that left them disoriented and disillusioned” (Boychuk-Duchscher, 2008 pg. 442). It is in this phase that NLNs question why they spent so many years in nursing only to find out that the professional reality is not what they wanted. NLNs are often heard using words such as “drowning,” “terrified,” and “exhausted” when describing their experience (Wakefield, 2018). New graduates fear rejection from their more experienced counterparts. They fear being accused of being incompetent and providing unsafe care (Wakefield, 2018). It is during this high burnout phase that new nurse job satisfaction is often at its lowest point which causes them to seek other employment or leave the nursing profession completely (Wakefield, 2018). NLNs that are supported through the assault phase and are provided tools to successfully navigate through this phase will transition to the recovery/resolution phase (Wakefield, 2018).

## **Recovery/Resolution Phase**

In the recovery/resolution phase, NLNs report feeling less anxiety and improved coping capabilities (Wakefield, 2018). They reach a realistic perspective of what their nursing career entails, and they become more organized (Kramer, 1974). According to Kramer, this final phase can be either positive or negative (1974). Nurses who reach this phase are at a turning point. They will either continue to cycle through the process of socialization and repeat earlier phases or they may transition confidently and become a competent nurse (Kramer, 1974; Boychuk-Duchscher, 2008). It is during this pivotal phase that new nurses could continue to experience similar burnout to the assault phase and potentially leave the profession altogether (Kramer, 1974; Wakefield, 2018).

### **Boychuk-Duchscher's "Process of Becoming"**

Boychuk-Duchscher based her theory on the work that Kramer published in 1974. Boychuk-Duchscher's (2008) research illustrates that the initial 12 months after a new nurse graduates are a "process of becoming" (p. 444) (Appendix A). Boychuck-Duchscher (2008) considers this process a journey that is a rite of passage for new nurses. The "process of becoming" journey is transformative for those that experience it (Boychuk-Duchscher, 2008).

### **The Doing Stage**

The first stage a new nurse goes through is considered the "doing" stage. This stage can last for the first 3 to 4 months of practice. New nurses move from a controlled environment in school to an environment that feels foreign and frightening. Their perception of what a nursing career was supposed to look like was more "idealistic" than "realistic" (Boychuk-Duchscher, 2008). According to Boychuck-Duchscher (2008), this first stage is very intense and produces a myriad of emotions for new nurses related to "discovering, learning, performing, concealing, adjusting, and accommodating" (p.444). Because so much of what the new nurses were

experiencing was alarming to them, Boychuk-Duchscher (2008) found that many new nurses fractured under the weight of self-doubt and anxiety. New nurses reported feeling like they were missing something or constantly on the precipice of causing a patient unintentional harm because of their perceived ignorance (Boychuk-Duchscher, 2008). In the doing stage, new nurses become expert taskmasters. They are consumed with completing tasks associated with their patient assignments and are seemingly unaware of the bigger picture of what is happening around them. In this stage of development, new nurses are exceptionally hard on themselves when they feel that they let down their patients due to their perceived ignorance (Boychuk-Duchscher, 2008).

### **The Being Stage**

The “being” stage occurs from months 4 to 8 whereby NLNs experience less self-doubt and begin to gain confidence (Boychuk-Duchscher, 2008). Although there is a rapid advancement in their level of knowledge, skills, and competency, new nurses continue to experience a high degree of exhaustion and frustration with their overall career at a slower pace (Boychuk-Duchscher, 2008). Many new nurses begin to view their choice to enter the healthcare field as an error in judgment. Boychuck-Duchscher (2008) purports that during the being stage, new nurses begin to voice frustration with perceived lack of work-life balance. Many questioned why they left the comforts of a well-organized and protected school setting to face the harsh realities of “real” nursing which left them feeling “incompetent, inadequate, exhausted, disappointed, devalued, frustrated, and powerless” (Boychuk-Duchscher, 2008, p. 446). It is at this stage when some show signs of clinical depression (Boychuk-Duchscher, 2008; Brandford & Reed, 2016). Feelings of uselessness and futility shade every thought which causes these nurses to sometimes pull away from their colleagues and even trusted family members (Boychuk-Duchscher, 2008). As preceptors and mentors sense the increasing emotional distancing and disengagement of the new nurses they attempt to step in and assist. Boychuck-Duchscher (2008)

posits that it is during this phase that some new nurses viewed the proverbial olive branch put out by mentors as “overly vigilant supervision” due to their incompetence. In the instances where mentors and preceptors did not reach out, new nurses report feeling abandoned by those that are supposed to be there to support them. It is during the latter part of this stage that new nurses seemingly begin to adjust to their new career. They are more apt to be able to recognize a more positive work-life balance while seemingly adjusting to “what is” in their new career versus what they thought “it should be.”

### **The Knowing Stage**

Boychuk-Duchscher’s (2008) “knowing” stage occurs between months 8 to 12. It is during this time that new nurses finally achieve stability and confidence in their professional abilities. Many new nurses at this stage share their apprehension about moving from the role of “learner” or “orientee” to independent practitioner. In order to secure their more comfortable position as “orientee” some new nurses will seek to transfer to a new department or new facility at this stage in order to lengthen their orientee status and postpone the transition to completely independent practitioner.

Nurses that journey through this stage report less stress than felt in earlier stages. Interestingly nurses in this stage report their stress focus changed from fear of personal failure to disenchantment with the institution of healthcare (Boychuk-Duchscher, 2008). According to Boychuk-Duchscher (2008), most new nurses that she encountered in the knowing stage reported feeling like nurses in general were at the proverbial bottom of the healthcare feeding chain. They report feeling professionally devalued and felt they had no authority or power to effect change (Boychuk-Duchscher, 2008). Nurses that previously felt generalized stress over work-life balance now will often inspire dissatisfaction with shift work as a whole.

By the end of their first year of practice, all new nurses that Boychuk-Duchscher (2008) encountered had reached a relatively stable level of self-assurance and confidence in their role as nurse. Several new nurses made the realization that they had achieved a level balance of reality when looking back at their journey. Some new nurses even spent time “comparing” their newly realized skill level to that of other new graduate nurses just entering the profession (Boychuk-Duchscher, 2008).

### **Application of Boychuk-Duchscher’s Theory**

Many new nurses feel that once they graduate nursing school and pass their respective state board exams, they automatically become competent professional nurses. They hold in their hand a license to practice and are on a type of euphoric high whereby they feel that they have crossed a rite of passage and can conquer the proverbial world. NLNs are seemingly unaware that their journey is far from over.

Boychuk-Duchscher (2008) recognized that it is important for members of academia and employers in health care to understand the often-difficult phases of “becoming” that NLNs need to navigate in order for them to reach professional role transition. It should be considered a natural part of their professional development (Boychuk-Duchscher, 2008). This knowledge should not only be understood by instructors and employers; it also should be understood by NLNs themselves. It is only fair to new nurses that they possess the knowledge that they are facing a journey of “highs” and “lows.” It is imperative that they understand that the transitional phases of doing, being, and knowing are not only normal, but to be expected. Understanding the details of Boychuk-Duchscher’s (2008) phases of transition will aid NLNs in recognizing that they are going through a “phase” rather than feeling like they are having a mental health breakdown and thinking that their world is crumbling beneath them. In this project, curricula

regarding the “process of becoming” will be introduced to NLNs at an established NRP. The inclusion of this education will aim to ease NLNs' experience of reality shock and help them to feel more comfortable in their various stages of transition which will ultimately reduce emotional exhaustion, cynicism, depersonalization, and improve their overall sense of personal accomplishment and self-efficacy which will reduce turnover rates in the first year of practice.

### **Conclusion**

A key concept to keep in mind is that the journey that new nurses make through either Kramer’s “reality shock” or Boychuk-Duchscher’s “process of becoming” is not linear (Boychuk-Duchscher & Windey, 2018). Occasionally new nurses will experience transient regressions moving between stages (Boychuk-Duchscher & Windey, 2018). The overall changes in roles and responsibilities that a new nurse experiences in their first year of practice will have lasting impact on their sense of self confidence, and perception of acceptance into their new career (Boychuk-Duchscher & Windey, 2018).

Interventions to improve job satisfaction and increase retention of new nurses in their first year of practice have been implemented in many facilities across the nation. Unfortunately, there is a lack of overall understanding of the theoretical underpinnings of what is causing high turnover in this population which negatively affects retention efforts. Pairing the knowledge and understanding of the phenomenon of “reality shock” and “process of becoming” with researched retention tools will move towards positively supporting the experiences of new nurses and support positive retention outcomes. Boychuk-Duchscher (2008) purports that having an institutional approach to addressing NLN transition will “determine the recruitment and retention capacity of all future health human resource institutions” (p. 449).

## **Chapter IV**

### **Project Proposal**

The purpose of this project was to examine whether participation in an NRP that actively addressed reality shock and early burnout reduced the incidence of exhaustion, cynicism, depersonalization, and increased personal accomplishment of NLN's within the first year of practice. The setting, sample, procedure, project tasks and team, outcomes and instrumentation, and a timeline were reviewed. Additionally, resources, support, risks, and threats were presented.

#### **Setting**

The setting for this project was an education and training center located in Las Vegas, Nevada. The education center provided centralized education services to seven hospitals including six urban and one rural hospital in the Las Vegas Nevada area. The education center offers an organized NRP for NLNs within the system. The core curriculum includes didactic classroom content, online learning, and simulation laboratory experiences.

#### **Sample**

The sample was 50 nurses who were enrolled in the NRP at the education and training center in the year 2020.

#### **Inclusion Criteria**

NLNs enrolled in the seven-hospital system's NRP in the Las Vegas Nevada area were included in this project. NLNs invited to participate had 6 to 8 months of experience working on various acute care inpatient units within the system. Rosters were obtained from the system educator who currently manages the established NRP.

## **Exclusion Criteria**

Nurses that were greater than twelve months from their graduation date and had previous nursing job experience were excluded from the NRP and from this project.

Nurses enrolled in the education center's gap program or deemed not eligible for the NRP were excluded from this project.

## **Project Design**

The design for this project was a descriptive correlational approach in which a group of 50 NLNs hired by the health system in Las Vegas, Nevada was asked to complete a survey before and after the educational intervention via the system's online learning management system (LMS).

## **Measures, Instruments, and Activities**

The Maslach Burnout Inventory (MBI) (Appendix B) is an introspective psychological survey that consists of 22 items relating to occupational burnout (Maslach et al., 1981). Following the publication of the MBI in 1981, new versions of the MBI were gradually developed to fit different groups and different settings (Wheeler, et al., 2011). For this project, the Maslach Burnout Inventory (MBI) Human Services Survey for Medical Personnel was utilized to assess exhaustion, cynicism, depersonalization, and personal accomplishment among the NLNs participating in this project (Beckstead, 2002; Maslach & Jackson, 1981). The MBI assesses burnout on the dimensions of emotional exhaustion (EE), depersonalization (DP), cynicism (CY), and a reduced sense of personal accomplishment (PA) using a 7-point Likert scale (Beckstead, 2002; Maslach & Jackson, 1981). The EE scale describes feelings of emotional lability and exhaustion with regards to one's work (Beckstead, 2002; Maslach & Jackson, 1981). The DP scale contains five questions that address a flat or indifferent feeling towards patients

and patient care (Beckstead, 2002; Maslach & Jackson, 1981 2002). The CY scale consists of five questions and, like the DP scale, measures levels of indifference towards one's work. People experiencing high levels of stress and burnout tend to score higher on this subscale (Beckstead, 2002; Maslach & Jackson, 1981 2002). The PA scale helps identify NLN feelings of competence and achievement in their new career (Beckstead, 2002; Maslach & Jackson, 1981).

### **Validity**

Validity of the MBI survey is demonstrated by data that confirmed hypotheses about the relationships between job characteristics and burnout (Maslach & Jackson, 1981). It was predicted and proven that the more patients a healthcare provider has, the higher burnout scores appeared on the MBI (Maslach & Jackson, 1981). A study of 43 healthcare personnel in California found that those who spent all or most of their time performing direct patient care scored high on the emotional exhaustion scale ( $r = 0.30, p = <0.03$ ).

Additional validation of the MBI is confirmed with the prediction that people experiencing burnout are dissatisfied with opportunities for personal growth on the job, or lack thereof. In a study of 180 nurses, scores on the Job Diagnostic Survey (JDS) measure of "growth satisfaction" were negatively correlated with Emotional Exhaustion ( $r = -0.26, p < 0.001$ ) and Depersonalization ( $r = -0.39, p < 0.001$ ) and positively correlated with Personal Accomplishment ( $r = 0.29, p < 0.001$ ) (Maslach & Jackson, 1981).

### **Reliability**

Studies carried out by Iwanicki & Schwab (1981) support reliability such as the three-factor structure and internal reliability. Internal consistency was estimated by Cronbach's coefficient alpha (Maslach & Jackson, 1981; Iwanicki & Schwab 1981). The MBI shows internal consistency "estimates of reliability at 0.90, 0.79, and 0.71 for the EE, DP, and PA subscales

respectively (Beckstead, 2002, p. 786).” A reliability generalization meta-analysis of coefficient alpha for the MBI was performed by Wheeler et al. in 2011. The purpose of the study was to synthesize internal consistency reliability for each of the subscale scores on the MBI (Wheeler, Vassar, Worley, & Barnes, 2011). Of the 221 studies reviewed, 84 provided alpha coefficients and were used in their analysis (Wheeler et al., 2011). Results suggested that mean alpha estimates across subscales generally fell within the .70 to .80 range (Wheeler et al., 2011).

### **Data Analysis and Outcomes Evaluation**

Gathering demographics information allowed for a better understanding of certain background characteristics of the NLNs being surveyed. Demographics questions were asked at the beginning of the survey (see Appendix C). Questions related to the COVID-19 pandemic were also included as it is recognized that participation in the care of patients during the COVID-19 crisis may have added additional stressors that would not have been otherwise present.

Pre- and post-intervention responses from the MBI survey results were analyzed as outcomes. Ordinal level (ranked) items on the MBI questionnaire were converted to interval level data and reported as scores. Based upon previous analysis of the MBI survey tool, a common approach utilized the three subscales to determine participant’s level of burnout (Havaei et al., 2016; Maslach et al., 1981). Participants who score greater than 27 on the EE subscale or a score higher than 9 on the DP subscale are suffering from severe burnout (Havaei et al., 2016; Maslach et al., 1981). Descriptive statistics were used to report results as a mean and described sample characteristics. The independent variable was the change to NRP which included the enhanced curricula. The dependent variable was the scores on the MBI subscales; EE, DP, CY, & PA. A paired samples *t*-test was used to determine whether there were differences in the means between the same group ( $n=26$ ) at two points in time (pre-intervention, post-intervention).

Questions relating to COVID-19 were analyzed for any extreme or unexpected responses. The responses were analyzed to determine whether this may have been a factor in the way the participants were responding to the MBI survey.

### **Timeline**

The randomized group of NLNs in the NRP were assigned the MBI survey via the hospital's computerized LMS. Part I of the survey included a consent to participate in the survey along with demographic questions. Part II of the survey included 22 of the standard questions on the MBI Human Services Survey for Medical Personnel. Participants were given 30 days to complete the survey. After completing the initial survey, the same group of NLNs in the NRP were assigned enhanced curricula via LMS computerized training module that specifically addressed professional role transition and reality shock. They were given 30 days to complete the education module. Two weeks after completion of the training module regarding professional role transition and reality shock, the same group of NLN's in the NRP were re-assigned the MBI survey via the LMS. Again, they were given 30 days to complete the MBI post education survey. A comprehensive task list may be viewed in Appendix D.

### **Definitions**

The following definitions were used in understanding the variables addressed in the research question.

Newly Licensed Nurse (NLN) – The NLN is a newly graduated registered nurse who is placed in a structured NRP to assist their transition to practice.

Nurse Residency Program (NRP) – The 8-month structured program for NLNs at the seven-hospital system in Las Vegas, NV. The program offers established curricula that covers both didactic classroom and onsite clinical settings. The program is designed to support the transition of NLN from student to professional practice.

## **Resources and Support Required**

Financial resources required for this project were nominal. They included costs associated with purchasing the copyright to the MBI survey. Resources included the proposed use of a Statistical Package for the Social Sciences (SPSS) package and the time required to enter and analyze data.

A statement of mutual agreement was obtained from the hospital system. Institutional Review Board (IRB) approval was obtained from UNLV (Appendix E). Each participating NLN was advised of their rights, the project's details, and what was expected to be accomplished by participating in the survey(s). Implied consent was achieved by participants advancing electronically to the online survey.

## **Risks, Limitations, and Threats**

Risks, limitations, and threats were anticipated. First, the sample was limited to only 50 random NLNs located in the southern Nevada area. Therefore, the findings are not representative of the entire United States. Second, the data was obtained from nurses' self-reports and may have reflected bias in reporting certain feelings. Lastly, during the timeframe that this project was implemented, our nation was in the midst of a serious COVID-19 pandemic. As healthcare providers, the NLN participants may have had altered perceptions of exhaustion, cynicism, depersonalization, and personal accomplishment than they normally would have during times of more stability. Their altered perception may have negatively impacted the scores on the MBI. To address perceptions related to the COVID-19 pandemic, there were two additional questions included after the MBI survey (see Appendix F).

## **Conclusion**

This DNP project was designed to achieve the stated purpose which was to examine whether participation in an NRP that actively addressed reality shock and early burnout reduced the incidence of exhaustion, cynicism, depersonalization, and increased personal accomplishment for NLNs within the first year of practice. A group of NLNs that were enrolled in an NRP in a seven-hospital health system in the Las Vegas area took a survey before and after an educational intervention discussing reality shock and early burnout via the system's LMS. The MBI was utilized to assess exhaustion, cynicism, depersonalization, and personal accomplishment among the NLNs participating in this project.

Pre- and post-intervention responses from the MBI survey results were analyzed as outcomes. A paired samples *t*-test was used to determine whether there were differences in the means between the groups at two points in time. Financial resources required for this project were nominal. A statement of mutual agreement was obtained from the hospital system and IRB approval obtained from UNLV (Appendix E). Risks, limitations, and threats were anticipated. Due to the COVID-19 pandemic, NLN participants were suspected to have altered perceptions of exhaustion, cynicism, depersonalization and reduced sense of personal accomplishment and self-efficacy than they normally would have during times of more stability. Their altered perception potentially negatively impacted the scores on the MBI. To address these potential altered perceptions, additional questions were included after the MBI survey. Inclusion of education regarding NLNs' experience of reality shock may have helped them to feel more comfortable in their various stages of transition. It was anticipated that this would ultimately reduce emotional exhaustion, cynicism, depersonalization and improve their overall personal accomplishment and self-efficacy, which can reduce turnover rates in the first year of practice.

## **Chapter V**

### **Summary of Intervention and Results**

#### **Precis of the Phenomenon of Interest, Problem, and Purpose of the Project**

Most new nurses celebrate once they complete their rigorous educational programs, graduate, and secure their first nursing job. They enter the job force with joy and hope only to be faced with perceived negativity and adversity. Newly licensed nurses are at incredibly high risk for reality shock leading to early burnout which results in many of them resigning their positions or leaving nursing altogether within their first year of practice. Common feelings leading to reality shock often involve exhaustion, cynicism, depersonalization, decreased self-efficacy, and decreased personal accomplishment (Maslach & Jackson, 1981).

The high percentage of new nurse burnout and turnover poses significant financial strain and patient quality concerns to our already struggling healthcare systems (Brook et al., 2019). The purpose of this project was to examine whether participation in an NRP that actively addressed reality shock and early burnout reduced the incidence of exhaustion, cynicism, depersonalization, and increased personal accomplishment and self-efficacy of NLNs within their first year of practice.

#### **Threats and Barriers**

Threats and barriers were encountered during the data collection process as it relates to the COVID-19 pandemic and staffing issues at the healthcare system's education center. Because of the pandemic, many central staff educators were reallocated to system hospitals to assist during times of high census in addition to experiencing personal illness issues. In-person nurse residency classes were also cancelled due to the pandemic. This significantly delayed the deployment of the initial MBI survey and educational intervention into the LMS as well as in-person follow up by system educators. When the demographics and MBI survey data were

returned by the Director of the education center, it was realized that there were no post intervention surveys completed by participants. The threat was overcome by asking the Director to assist by tracking the participants completed LMS modules and contacting the respective leaders of the participants to encourage them to complete the post-intervention survey. This task delayed the data collection period by 6 to 8 weeks. As participation was voluntary and no financial incentive provided, fewer participants than expected were recruited for the project. Fewer participants completed the post-intervention surveys than the pre-intervention surveys. While there were some dropouts anticipated, the low number of completions potentially impacted certain data outcomes of the project as it relates to measurement of emotional exhaustion, depersonalization, cynicism, and personal accomplishment.

### **Monitoring**

The project was monitored from inception to conclusion by the project facilitator and project chair. Monitoring of the data collection also occurred at an organizational level by the Director of the education center.

### **Data Collection and Analysis**

Prior to viewing the electronic educational module in the LMS, the participants ( $n=45$ ) completed the MBI pre-survey, which also included a demographic questionnaire and two questions specifically related to the care of COVID-19 patients (Appendices A, B, and E). Only 26 participants ( $n=26$ ) completed the pre-intervention survey, educational module, and post-intervention survey; therefore, the full data set is represented by 26 total participants. The survey data were exported electronically into an Excel<sup>®</sup> spreadsheet and then exported into Statistical Package for the Social Sciences<sup>®</sup> (SPSS) version 25 for analysis.

## Demographics

Descriptive statistics using frequency distributions were used to characterize sampled demographics and participant's perception of providing care to patients with COVID-19 during the pandemic. The independent variables of age, gender, ethnicity, highest nursing degree, and nursing as a first career were explored for violations of normality. The Shapiro-Wilk test for normality indicates that the demographic variables of the participant group do not violate a normal distribution ( $n = 45, p = 0.31$ ).

Only a portion of the sample completed both the pre- and post-intervention surveys. There were 45 participants that completed the pre-intervention instruments and 26 participants completed post-intervention requirements. Normality violations were explored for the 26 participants that completed the entire project. The Shapiro-Wilk test for normality indicates that the demographic variables of the post-intervention group ( $n = 26, p = 0.18$ ) did not violate normality. Table 1 provides an overview of the demographic characteristics of the sample for both pre- and post- intervention groups. The demographic characteristics of the pre-intervention sample ( $n=45$ ) revealed that 86.7% were female and 13.3% were male. Data were further subdivided into several age groups: 4.4% ranged in age from 18-22, 51.1% between 23-26, 15.6% 27-30 and 28.9% 31+. As for ethnicity, 48.9% identified as Caucasian, 26.7% Hispanic, 4.4% were Black/African American, 17.8% Native American/American Indian, and 2.2% Asian/Pacific Islander. The highest degree attained by the participants was 22.2% with Associate Degree in Nursing (ADN) and 77.8% with a Bachelor of Science in Nursing (BSN). The participants indicated that 64.4% selected nursing as their first career while 35.6% identified nursing as a second career choice.

The demographic characteristics of the post-intervention sample ( $n=26$ ) (Table 1) revealed that 84.6% of the participants were female and 15.4% were male. Data were further

subdivided into several age groups: 7.7% ranged in age from 18-22, 46.2% between 23-26, 15.4% 27-30 and 30.8% 31+. As for ethnicity, 46.2% identified as Caucasian, 26.9% Hispanic, 7.7% were Black/African American, 15.4% Native American/American Indian and 3.8% Asian/Pacific Islander. The highest degree attained by the participants was 26.9% with ADNs and 73.1% with BSNs. The participants indicated that 65.4% selected nursing as their first career while 34.6% identified nursing as a second career choice.

Table 1: Demographics of Post Intervention Group.

		Post (n=26)
Gender	Male	4 (15.4%)
	Female	22 (84.6%)
Age	18-22	2 (7.7%)
	23-26	12 (46.2%)
	27-30	4 (15.4%)
	31+	8 (30.8%)
Ethnicity	Caucasian	12 (46.2%)
	Hispanic	7 (26.9%)
	Black/African American	2 (7.7%)
	Native American/American	
	Indian	4 (15.4%)
	Asian/Pacific Islander	1 (3.8%)
Highest Nursing Degree	Associate	7 (26.9%)
	BSN	19 (73.1%)
First Career	Yes	17 (65.4)
	No	9 (34.6%)

### COVID-19 Pandemic Care of Patients and Stress

Because the world was in the throes of the COVID-19 pandemic, healthcare workers across the nation were experiencing abnormally high levels of stress. New nurses experience multiple challenges trying to transition from student nurse to practicing nurse during “normal” circumstances. It was anticipated that participants would also be experiencing increased levels of

stress related to the provision of care to COVID-19 patients in addition to stress that NLNs would normally experience in their new roles.

### **COVID-19 Pandemic Care of Patients and Stress Assumptions**

The participants that completed pre- and post-intervention surveys ( $n = 26$ ) were queried regarding the frequency of providing care to COVID-19 patients and their perceived stress level specifically related to COVID-19. The dependent variables of direct care of COVID-19 patients and perceived stress level connected to the care of COVID-19 patients were explored for violations of normality. The Shapiro-Wilks test demonstrated there were violations of normality ( $p = 0.00$ ). Two outliers were detected that were two box-lengths from the edge of the box in a boxplot. Inspection of their values did not follow the expected value as they were participants who did not provide direct daily care to COVID-19 patients but indicated that they perceived extreme stress being exposed to COVID-19 daily. The decision was made for the outliers to remain in the analysis.

Of the group surveyed ( $n=26$ ), 65.4% ( $n = 17$ ) participants reported providing direct care to patients with COVID-19 every shift, 15.4% ( $n = 4$ ) reported providing care occasionally, 11.5% ( $n = 3$ ), reported indirect or rare care of COVID-19 patients, and 7.7% ( $n = 2$ ) reported not caring for COVID-19 patients. All 100% of the group ( $n=26$ ) reported feeling varying symptoms of stress regardless of whether they were directly involved in providing care to COVID-19 patients.

### **MBI Survey Results**

The pre- and post-intervention group ( $n = 26$ ) was queried utilizing the MBI survey which consisted of 22 items relating to the perception of occupational burnout (Havaei et al., 2016; Maslach et al., 1981) (Appendix B). The survey further stratified the participants by breaking down questions into several subgroups: Emotional Exhaustion (EE), Depersonalization (DP),

Personal Accomplishment (PA), and Cynicism (CY) (Havaei et al., 2016; Maslach et al., 1981). Each participant ranked their responses on a 7-point Likert scale: Never, A few times a year or less, Once a month or less, A few times a month, Once a week, A few times a week, or Every day (Havaei et al., 2016; Maslach et al., 1981).

The dependent variable (NLN burnout) was measured on a continuous scale. Each participant that completed the pre-intervention survey, education module, and post-intervention survey ( $n = 26$ ) contributed one score on two separate occasions. The data points were explored to determine if there were outliers. There was one outlier detected upon analysis that was more than 1.5 box-lengths from the edge of the box in a boxplot. Inspection of the value did not reveal it to be extreme and it was kept in the analysis. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test ( $p = .619$  pre-intervention,  $p = .732$  post intervention).

A paired samples  $t$ -test was used to determine whether there was a statistically significant mean difference between the pre-intervention MBI survey total score and the post-intervention MBI total score (Table 2). There was no statistically significant difference identified between the total score on the pre-intervention MBI and the post-intervention MBI scores ( $M = 1.80$ ,  $SD 12.48$ );  $t(25) = 0.739$ ;  $p = 0.467$ ,  $d = 0.14$ ).

Table 2: Paired Samples  $t$ -Test MBI Survey Pre/Post Intervention ( $n=26$ ).

Mean	Std. Dev.	Std. Err	95% Confidence Interval of the Difference		$t$	$df$	Sig. (2-tailed)
			Lower	Upper			
1.807	12.48	2.44	-3.23	6.84	0.739	25	0.467

### **Emotional Exhaustion (EE) Subscale**

A paired samples *t*-test was used to determine whether there was a statistically significant mean difference between the pre-intervention EE subscale scores and the post-intervention EE subscale scores. The EE subscale consisted of nine items ranging from feeling emotionally drained to feeling like one is at the end of their rope. The data points were explored to determine if there were outliers within the responses. There was one outlier detected upon analysis in the post intervention score that was more than 1 box-length from the edge of the box in a boxplot. Inspection of the value did not reveal it to be extreme and it was kept in the analysis. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test ( $p = .462$  pre-intervention,  $p = .437$  post intervention). Analysis of the Emotional Exhaustion total score ( $n = 26$ ) was approaching statistical significance related to participants feeling like they were drained and at the end of their rope after educational intervention ( $M = 2.73$ ,  $SD = 7.19$ );  $t(25) = 1.935$ ;  $p = 0.064$  (Table 3).

Each item was analyzed individually to determine the differences in the mean scores between the pre-intervention time point and post-intervention time point. Six of the items on the EE subscale did not reach statistical significance (Table 4).

The six items were related to: feeling emotionally drained from work, working with people all day, feeling burned out from work, feeling frustrated, and feeling like one is at the end of their rope.

Three items on the EE subscale revealed statistically significant change pre-intervention versus post-intervention. The first item on the subscale that showed significance related to feeling used up at the end of the workday. A paired samples *t*-test was performed to assess the differences in the means pre-intervention ( $M = 4.54$ ,  $SD = 1.77$ ) and post-intervention ( $M = 3.69$ ,  $SD = 1.54$ );  $t(25) = 2.59$ ;  $p = .016$ . The second significant change identified after the educational

intervention was related to perceived feelings of fatigue, with pre-intervention results ( $M = 3.88$ ,  $SD = 1.63$ ) compared to post-intervention ( $M = 3.23$ ,  $SD = 1.56$ );  $t(25) = 2.19$ ;  $p = .038$ .

The final component to show significant change related to participants feeling as if working with people directly caused “stress.” Pre-intervention responses indicated ( $M = 1.42$ ,  $SD = .757$ ) and post-intervention ( $M = 1.92$ ,  $SD = .109$ );  $t(25) = -2.23$ ;  $p = .035$ .

Table 3: Paired Samples t-Test Emotional Exhaustion Subscale Total Score Pre/Post Intervention (n=26).

		95% Confidence Interval of the Difference					
Mean	Std. Dev.	Std. Err	Lower	Upper	<i>t</i>	<i>df</i>	Sig. (2-tailed)
2.73	7.19	1.41	-.176	5.64	1.934	25	.064

Table 4: Paired Samples t-test Emotional Exhaustion Individual Items Pre/Post Intervention.

	95% Confidence Interval of the Difference							
	Mean	Std. Dev.	Std. Err Mean	Lower	Upper	<i>t</i>	<i>df</i>	Sig. (2-tailed)
I feel emotionally drained from my work.	0.54	1.50	0.29	-0.07	1.14	1.82	25	0.080
I feel used up at the end of the workday.	0.85	1.66	0.33	0.17	1.51	2.59	25	0.016
I feel fatigued when I get up in the morning and have to face another day on the job.	0.65	1.52	0.30	0.04	1.26	2.19	25	0.038
Working with people all day is really a strain for me.	-0.04	1.50	0.30	-0.65	0.57	-0.13	25	0.898
I feel burned out from my work.	0.42	1.52	0.30	-0.19	1.04	1.41	25	0.170
I feel frustrated by my job.	0.42	1.20	0.24	-0.06	0.91	1.78	25	0.086
I feel I am working too hard on my job.	0.23	2.04	0.40	-0.60	1.05	0.58	25	0.570
Working with people directly puts too much stress on me	-0.50	1.14	0.22	-0.96	-0.04	-2.23	25	0.035
I feel like I am at the end of my rope.	0.00	0.85	0.17	-0.34	0.34	0.00	25	1.000

### Depersonalization (DP) Subscale

A paired samples *t*-test was used to determine whether there was a statistically significant mean difference between the pre-intervention DP subscale scores and the post-intervention DP subscale scores. The DP subscale consisted of six items ranging from treating patients as

impersonal objects to feeling that patients blame participants for their personal problems. The data points were explored to determine if there were outliers within the responses. There were no outliers identified. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test ( $p = .106$  pre-intervention,  $p = .186$  post intervention). It was determined that there was no statistically significant mean difference between the pre-intervention and post-intervention total scores (Table 5).

Each DP survey question was analyzed individually to determine if there were differences in the mean scores between the pre-intervention time point and post-intervention time point. There were no areas within the five items that demonstrated a statistically significant difference in the means from pre-intervention to post-intervention (Table 6).

Table 5: Paired Samples t-Test Depersonalization Subscale Total Score Pre/Post Intervention (n=26).

Mean	Std. Dev.	Std. Err	95% Confidence Interval of the Difference		<i>t</i>	<i>df</i>	Sig. (2-tailed)
			Lower	Upper			
.006	.235	.046	-.088	.101	.142	25	0.888

Table 6: Paired Samples t-test Depersonalization Pre/Post Intervention Per Question.

	95% Confidence Interval of the Difference							
	Mean	Std. Dev.	Std. Err Mean	Lower	Upper	<i>t</i>	<i>df</i>	Sig. (2-tailed)
I feel I treat some patients as if they were impersonal objects.	0.15	1.49	0.29	-0.45	0.76	0.53	25	0.603
I have become more calloused towards people since I took this job.	0.00	1.47	0.29	-0.59	0.59	0.00	25	1.000
I worry that this job is hardening me emotionally.	0.42	1.98	0.39	-0.38	1.22	1.09	25	0.287
I don't care what happens to some patients.	0.08	0.63	0.12	-0.18	0.33	0.63	25	0.538
I feel that some patients blame me for some of their problems.	0.42	1.20	0.24	-0.06	0.91	1.78	25	0.086

### Personal Accomplishment (PA) Subscale

The PA subscale analyzed NLN feelings of competence and personal achievement in their new career. A paired samples *t*-test was used to determine whether there was a statistically significant mean difference between the pre-intervention PA subscale scores and the post-intervention PA subscale scores. The data points were explored to determine if there were outliers within the responses.

There were no outliers identified. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test ( $p = .159$  pre-intervention,  $p = .159$  post intervention).

Analysis revealed there was a statistically significant change related to participants having increased self-efficacy and sense of personal accomplishment after the educational intervention ( $M = -55.5, SD = 14.47$ );  $t(25) = -19.57; p = 0.000$  (Table 7).

Each of the 8 questions from the PA subscale were analyzed individually to determine the differences in the mean scores between the pre-intervention time point and post-intervention time point. Analysis revealed no statistical significance related to pre- and post- intervention impact on specific questions in the personal accomplishment subscales (Table 8).

Table 7: Paired Samples t-Test Personal Accomplish. Subscale Total Score Pre/Post Intervention (n=26).

Mean	Std. Dev.	Std. Err	95% Confidence Interval of the Difference		<i>t</i>	<i>df</i>	Sig. (2-tailed)
			Lower	Upper			
-55.5	14.4	2.83	-61.4	-49.7	-19.57	25	0.000

Table 8: Paired Samples t-test Personal Accomplishment Pre/Post Intervention Per Question.

		95% Confidence Interval of the Difference						
	Mean	Std. Dev.	Std. Err Mean	Lower	Upper	<i>t</i>	<i>df</i>	Sig.(2-tailed)
I can easily understand how my patients feel about things.	-0.38	1.31	0.26	-.568	0.49	-.150	25	.882
I deal very effectively with the problems of my patients.	.000	0.85	0.166	-.343	0.34	0.00	25	1.00
I feel I am positively influencing other people's lives through my work..	0.15	0.92	0.18	-.220	0.53	0.84	25	.400
I feel very energetic.	-0.16	1.16	0.23	-.620	0.31	-.679	25	.503
I can easily create a relaxed atmosphere with my patients.	-0.15	.967	0.19	-.544	0.23	-.811	25	.425
I feel exhilarated after working closely with my patients.	-.615	1.92	0.38	-1.39	0.16	-1.63	25	0.12
I have accomplished many worthwhile things in this job.	-.192	1.52	0.29	-.807	0.42	-.644	25	0.53
In my work, I deal with emotional problems very calmly.	-.153	.880	0.17	-.509	0.20	-.891	25	0.38

### Cynicism (CY) Subscale

The CY subscale analyzed the perception that participants are experiencing a more hardened and calloused view of patient care and believing that patients are directly blaming them

for their problems. A paired samples *t*-test was used to determine whether there was a statistically significant mean difference between the pre-intervention CY subscale scores and the post-intervention CY subscale scores. The data points were explored to determine if there were outliers within the responses. There were no outliers identified. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test ( $p = .810$  pre-intervention,  $p = .187$  post intervention). Analysis revealed there was a statistically significant change to means related to participants experiencing an overall easing of their hardened and calloused view of patient care after educational intervention ( $M = .625$ ,  $SD = .135$ );  $t(25) = 2.35$ ;  $p = 0.027$  (Table 9).

Each of the five items on the CY subscale were analyzed individually to determine the differences in the mean scores between the pre-intervention time point and post-intervention time point. There was not a statistically significant difference in the means on any of the specific cynicism subscale questions from pre-intervention to post-intervention (Table 10).

Table 9: Paired Samples t-Test Cynicism Subscale Total Score Pre/Post Intervention (n=26).

Mean	Std. Dev.	Std. Err	95% Confidence Interval of the Difference		<i>t</i>	<i>df</i>	Sig. (2-tailed)
			Lower	Upper			
.625	.135	.026	.007	.117	2.35	25	.027

Table 10: Paired Samples t-test Cynicism Pre/Post Intervention Per Question.

	95% Confidence Interval of the Difference							
	Mean	Std. Dev.	Std. Err Mean	Lower	Upper	<i>t</i>	<i>df</i>	Sig.(2-tailed)
I feel burned out from my work.	0.38	1.47	0.29	-0.21	0.98	1.33	25	0.195
I feel I am positively influencing people’s lives through my work.	0.19	0.97	0.18	-0.19	0.57	1.04	25	0.306
I feel frustrated by my job.	0.42	1.21	0.24	-0.06	0.91	1.79	25	0.086
I feel that I am working too hard on my job.	0.23	2.05	0.40	-0.60	0.11	0.58	25	0.570
I don’t really care what happens to some patients.	0.08	0.63	0.12	-0.18	0.33	0.63	25	0.538

### Limitations

The intervention of the education module within the electronic LMS was limited to a relatively small number of NLNs in a single health system in southern Nevada. Forty-five NLNs completed the initial demographic information and pre-education MBI survey. Only 26 participants completed the education module and the post-intervention survey which further limited the sample size and reduced confidence in applicability to the NLN population.

Because of the pandemic, the in-person NRP was shuttered. Several of the education staff were off with personal illness, and the others were deployed to the front lines to provide direct care for COVID-19 patients. This caused a 6 – 8 week delay in the data collection period. The

delay along with lack of personal guidance from education staff in a formal NRP during the survey process could have significantly altered the number and content of survey responses. NLNs that participated in the intervention may have disassociated the content of the educational intervention with responses on the post-intervention survey results. They were not given the opportunity to ask questions or discuss concerns with an NRP facilitator. With personal oversight from the education staff, the participation rates would have been higher which could have produced more statistical validity and reliability.

A secondary limitation can be associated with utilizing digital LMS educational formats. There is no way to control the amount of contact time or comprehension of education presented in digital format to participants. Within electronic learning formats, participants can rapidly proceed through each slide of the module without taking time to comprehend or absorb the content. The lack of in-person training also does not allow participants to ask pertinent questions and does not afford the opportunity for exchange of information that could positively affect perception of stress and burnout. To rectify this, it would be helpful to duplicate this project in the future utilizing two groups of NLNs. One group could be provided the survey and education via electronic format while a second group could be provided in-person education and training on the topic of reality shock and burnout. The pre- and post-intervention survey results for both groups could be compared to determine whether utilization of an in-person training format would provide more statistically significant change in scores.

Numerous considerations arise when one performs research during a national pandemic. The outcome of well-implemented DNP projects is essential for evolution of evidence-based practice. However, the COVID-19 pandemic required participants to provide patient care in abnormally stressful situations. During project intervention, all facilities within the hospital

system were operating under activated Emergency Management Protocols. Most staff members including the NLNs were working mandated overtime shifts. Due to a worldwide shortage of supplies, staff were working in conditions with limited PPE and reported fearing for their own personal safety. Depending on what working conditions existed for the participants, perceptions of reality shock and burnout could have certainly been exacerbated or altered due to the pandemic.

As a result of the pandemic, many colleges and universities were forced to transition to online learning modalities. NLNs faced potential delays in graduation because social distancing rules made it almost impossible for them to complete their required clinical hours as hospitals shuttered their doors to students. Many ended up having to perform virtual examinations while others were able to complete required hours in simulation labs. This creates a potential scenario for a NLN to begin their career with knowledge of theory but a gap in practice due to lack of hands-on experience. There are many nuances of “in person” patient care that are key drivers in an NLNs success. The lack of experience working as a member of an interdisciplinary healthcare team could create a significant gap in practice. Because of the lack of hands-on experience due to the pandemic, NLNs may have had skewed results on the MBI survey because they had never experienced a “pre-pandemic normal” prior to practice. The perceived stress and burnout that they felt may not have been caused by pandemic issues because they did not have knowledge of any other sort of “normal.”

Research conducted during previous epidemics such as SARS, H1N1, and Ebola have all documented negative psychological effects for nurses (Monforte-Royo & Fuster, 2020). Feelings of loneliness, anxiety, depression, fear, sleep disturbances and PTSD have been documented as

results of caring for patients during an epidemic (Sun, et al., 2020). It is recommended that the project be repeated during non-pandemic times.

## **Discussion**

Overall burnout was assessed in the NLN participant group ( $n = 26$ ) using the 22 question MBI survey along with subscales measuring emotional exhaustion, depersonalization, cynicism, and personal accomplishment. In nursing research, the MBI scale often uses the EE subscale as a proxy for overall nurse burnout (Havaei et al., 2016; Maslach et al., 1981). Higher scores on the EE (total score of 27 or higher) or DP subscales (total scores of 10 or higher) and lower PA scores (less than 33) indicate a higher incidence of burnout among healthcare workers (Maslach et al., 1981).

Survey results suggest that participants were suffering from high levels of stress and burnout both pre- and post-intervention. Fifteen out of the 26 participants (57%) had EE scores of 27 or higher pre-intervention and eleven out of the 26 participants (42%) had EE scores of 27 or higher post intervention.

Deeper analysis revealed that the total EE score was approaching significance. The most statistically significant mean difference occurred within three of the nine items in the EE subscale. Post intervention, NLNs reported feeling less stress working directly with people, less early morning fatigue and less “used up” at the end of the work day. One could conclude that the educational intervention was effective in bringing to light the existence of new nurse reality shock and early burnout and reducing some areas of perceived stress and fatigue. The finding is consistent with the literature in that when new nurses are experiencing reality shock and perceive that they are not supported by their work environment, they suffer emotional exhaustion (Havaei et al., 2016). An alternate explanation could also be rooted in the fact that the number of

COVID-19 patients that the participant was caring for had dropped by the time that the participant answered the post-intervention survey. This could have given a false sense that the NLN was working with less acute patients, which would drop their level of fatigue and feeling less “used up.”

Ten out of 26 NLN (38%) had scores of ten or greater on the DP subscale pre-intervention. Scores on the DP subscale increased post-intervention. There were 13 out of 26 (50%) NLNs who had scores equal to or greater than ten post intervention. One could purport that prolonged exposure to stress caring for COVID-19 patients would cause an NLN to mentally distance themselves which would manifest itself in unfeeling and overall impersonal response toward patient care.

There was a statistically significant change related to participants having increased self-efficacy and sense of personal accomplishment after the educational intervention. Overall, the NLN participants scored high on the PA subscale both pre- and post-intervention. Pre-intervention, only two of the 26 participants (7%) scored below 33 on the PA subscale. One hundred percent of the NLN scored above 33 on the PA subscale post-intervention.

One conclusion that can be drawn is that the introduction of the educational intervention provided information that eased the minds of the participants. When they realized that their symptoms of reality shock and burnout were real and a part of the “process of becoming”, their self-efficacy increased (Boychuk-Duchscher, 2008). Boychuck-Duchscher (2008) considers this process a journey that is a rite of passage for new nurses and can be transformative for those that experience it (Boychuk-Duchscher, 2008). An alternative conclusion surrounds the concept of COVID-19 induced stress and resilience as a coping mechanism. According to recent literature, resilience appears to be a protective factor for burnout among nurses (Jose, Dhandapani, &

Cyriac, 2020). Resilience is essential to fight against workplace stress and exhaustion (Jose et al., 2020). Multiple recent studies suggest there is a correlation between high resilience and enhanced autonomy, personal growth, and overall positive self-efficacy (Jose et al., 2020.) The participants in the survey may have scored high PA scores because resilience is what is essential for nurses to fight against stress, burnout, and reality shock.

Cynicism tends to increase with rising stress levels and can be tied in with perceived lack of job resources (Maslach & Leiter, 2016). Cynicism has proven to be one of the greatest predictors of turnover intention (Maslach & Leiter, 2016). Analysis revealed there was a statistically significant change to means related to participants experiencing an overall easing of their hardened and calloused view of patient care after educational intervention on the CY subscale. Maslach and Leiter (2016) provided research results that supported that theory that high levels of EE led to high levels of CY and diminished PA. Since analysis revealed that participant scores improved post-intervention on both the EE and PA subscales; this would support the improvement in CY scores post-intervention also.

The online educational modules did not translate into as much improvement in perception of burnout and reality shock as anticipated. There are several possible explanations for this result. Because of the pandemic and social distancing, the system's NRP had to be shuttered. It is unclear how much of the educational data was retained by the participants only utilizing the digital format.

Unique external factors specific to the pandemic likely influenced the overall results of the survey and might not be generalizable to NLN populations in "normal" circumstances. NLNs had to accept the challenge of caring for patients, families, and society, and had to learn to care during a national pandemic. These "coronial" nurses had to step up to the challenge and miss

traditional transition milestones (Monforte-Royo & Fuster, 2020). NLNs were forced to work in chaotic conditions in health systems that have never experienced such high rates of patient mortality and where treatment protocols and best practice was being updated daily during this pandemic (Monforte-Royo & Fuster, 2020). Add the stress of strict infection control measures, mandated overtime shifts, physical fatigue, fear of becoming infected, the feeling of being unprepared for working in the middle of a pandemic, the lack of personal protective equipment, the pressure to provide care, and isolation from their family and one has a recipe for extreme reality shock and burnout (Monforte-Royo & Fuster, 2020). It will now be the responsibility of nurse educators, leaders and of health systems to follow-up on the NLNs. It is imperative to understand the impact that these experiences have had in terms of retention efforts and negative effects that the pandemic had on their personal and professional development.

### **Relation to Literature and Theory**

As early as the 1970s, there was recognition of a high incidence of turnover in NLNs and published research on “reality shock” in the first year of nursing practice was released (Boychuk-Duchscher & Windey, 2018; Kramer, 1974). Researchers have reported that when new nurses are experiencing reality shock and perceive that they are not supported by their work environment, they suffer emotional exhaustion early on in their career and leave both their current jobs and the nursing profession (Havaei et al., 2016).

This project supported the literature findings that NLNs experience reality shock which contributes to dissatisfaction, burnout, and the desire to leave the nursing profession within the first year of practice. The responses by the participants on the MBI survey produced responses that indicated frustration, stress, and burnout was evident. The educational module provided to participants in the project discussed Kramer’s transition process that included honeymoon phase,

assault phase and recovery/resolution phase as well as Boychuk-Duchscher's phases of "becoming" (Kramer, 1974; Boychuk-Duchscher,2008). Boychuk-Duchscher recognized that it is important for members of academia and employers in health care to understand the often-difficult phases of "becoming" that NLNs need to navigate in order for them to reach professional role transition. This knowledge should not only be understood by instructors and employers; it also should be understood by NLNs themselves. It is only fair to new nurses that they possess the knowledge that they are facing a journey of "highs" and "lows." Having the opportunity to work through some of these issues in a variety of curricula and formats will help NLN transition to professional practice with less incidence of early burnout (Ortiz, 2016).

### **Contribution and Potential for Sustainability**

Increasing organizational awareness of new nurse reality shock and early burnout through the project contributed to development of initiatives to assess and address NLN burnout within the local healthcare organization. Since the beginning of the pandemic, turnover of NLN's within their first year of practice has hit an all-time high. A system wide retention committee has been formed to address engagement and assess and address early burnout of NLNs within the first year of practice. Data and research obtained during this DNP project has been disseminated at the local organizational level in the form of education to department leaders and staff. The digital educational has been transitioned to in-person training for local NLNs. Raising the awareness of organizational leadership regarding reality shock and early burnout will help support retention efforts. In person training will assist NLNs to feel understood and supported through their transition to practice. When NLNs feel they are well supported in their respective clinical work settings, retention occurs (Leong & Crossman, 2016).

## **Utilization and Dissemination of Results**

Educational electronic modules created for this project are currently in use by the system's educational training center in Southern Nevada. The module has been published to the organization's LMS and is available to any team member. The results of this project will be disseminated to organizational stakeholders and senior leadership in the corporation, highlighting the need for organizational awareness and support of NLN's during onboarding and during their NRP. Further dissemination will occur through national publications and presentations at local, state, and national levels through professional nursing organizations.

## **Conclusion**

In 2019, the World Health Organization (WHO) added burn-out to its ICD10 code classifications as an "occupational phenomenon" that is defined as occurring when one has workplace stress that has not been managed appropriately (Burn-out an "occupational phenomenon": International Classification of Diseases, 2019). WHO states that the phenomenon of burnout occurs when someone has feelings of emotional exhaustion, negativity, cynicism, and a reduced sense of professional efficacy (Burnout an "occupational phenomenon": International Classification of Diseases, 2019). According to a recent survey conducted by the American Nurses Association, 62% of U.S. nurses report feeling symptoms of emotional exhaustion, reduced energy, feelings of cynicism and lack of personal accomplishment (Schmidt, 2020; Maslach et al., 1981).

Common feelings reported by NLNs leading to reality shock and burnout within their first year of practice often involves exhaustion, cynicism, depersonalization, lack of personal accomplishment and decreased self-efficacy (Maslach & Jackson, 1981). High levels of NLN turnover poses a negative impact upon team members who must work extra hours or shifts to cover for the vacancy and experience increased stress and burnout from larger patient loads

(Jones, 2008). The result of early burnout leads to significant financial strain and patient quality concerns to our healthcare systems. The average cost to replace a nurse can range from \$37,700 to \$58,400 (Jones, 2008). There are ways for healthcare organizations to assist NLNs in combating these intense feelings of stress and early burnout. Finding effective ways to ease reality shock and curtail early burnout in NLNs will lead to increased satisfaction and overall retention in the first year of practice.

Actively addressing reality shock and burnout with NLNs, and providing a deeper understanding of this phenomenon, will significantly help to support their transition from student to professional in the first year of practice. Boychuk-Duchscher (2008) recognized that it is important for members of academia and employers in health care to understand the often-difficult phases of “becoming” that NLNs need to navigate in order for them to reach professional role transition. This knowledge should not only be understood by instructors and employers; it also should be understood by NLNs themselves. It is only fair to new nurses that they possess the knowledge that they are facing a journey of “highs” and “lows.” It is imperative that they understand that the transitional phases of doing, being, and knowing are not only normal, but to be expected.

Within the past year, NLNs had to accept the challenge of caring for COVID-19 patients, families, and society, and had to learn to care during a national pandemic. It is now the responsibility of nurse educators and of health systems to follow-up with NLNs to understand the impact that their experiences have in the short, medium, and long term, both in regard to negative effects and in terms of their personal and professional development.

Pairing the knowledge and understanding of the phenomenon of “reality shock” and “process of becoming” with researched retention tools will move towards positively supporting the

experiences of new nurses and support positive retention outcomes. Literature indicates that when NLNs feel they are well supported in their respective clinical work settings, retention occurs (Leong & Crossman, 2016).

## References

- (2017). *2017 National Health Care Retention & RN Staffing Report*. NSI Nursing Solutions Inc. Retrieved from <https://www.emergingrnleader.com/wp-content/uploads/2017/09/NationalHealthcareRNRetentionReport2017.pdf>
- (2019). *2019 NSI National Health Care Retention & RN Staffing Report*. NSI Nursing Solutions, Inc. Retrieved from [https://www.nsinursingsolutions.com/Documents/Library/NSI\\_National\\_Health\\_Care\\_Retention\\_Report.pdf](https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf)
- Altier, M., & Krsek, C. A. (2006, March-April). Effects of a 1-year residency program on job satisfaction and retention of new graduate nurses. *Journal for Nurses in Staff Development, 22*(2), 70-77. doi:10.1097/00124645-2006030000-00006
- Anderson, G., Hair, C., & Toderò, C. (2012, July-August). Nurse residency programs: An evidence-based review of theory, process, and outcomes. *Journal of Professional Nursing, 28*(4), 203-212. doi:10.1016/j.profnurs.2011.11.020
- Anderson, T., Linden, L., Allen, M., & Gibbs, E. (2009, April). New graduate RN work satisfaction after completing an interactive nurse residency. *The Journal of Nursing Administration, 39*(4), 165-169. doi:10.1097/00124645-2006030000-00006
- Asber, S. (2019). Retention outcomes of new graduate nurse residency programs. *Journal of Nursing Administration, 49*(9), 430-435. doi:10.1097/NNA.0000000000000780

- Beckstead, J. (2002, November). Confirmatory factor analysis of the Maslach Burnout Inventory among Florida nurses. *International Journal of Nursing Studies*, 39(8), 785-792.  
doi:10.1016/S0020-7489(02)00012-3
- Boamah, S., Emily, R., & Spence Laschinger, H. (2017). Factors influencing new graduate nurse burnout development, job satisfaction and patient care quality: a time-lagged study. *Journal of Advanced Nursing*, 1182-1195. doi:10.1111/jan.13215
- Boychuk-Duchscher, J. (2008, October). A process of becoming: The stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing*, 39(10), 441-450.
- Boychuk-Duchscher, J., & Windey, M. (2018, July/August). Stages of Transition and Transition Shock. *Journal for Nurses in Professional Development*, 228-232.  
doi:10.1097/NND.0000000000000461
- Brandford, A., & Reed, D. (2016, October). Depression in registered nurses. A state of the science. *Workplace Health and Safety*, 488-511. doi:10.1177/2165079916653415
- Brook, J., Aitken, L., Webb, R., MacLaren, J., & Salmon, D. (2018). Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, 47-59.  
doi:10.1016/j.ijnurstu.2018.11.003
- Burn-out an "occupational phenomenon": International Classification of Diseases.* (2019, May 28). Retrieved from World Health Organization: <https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases>

- Cleary, M., Horsfall, J., Muthulakshmi, P., Hapell, B., & Hunt, G. (2013). Career development: graduate nurse views. *Journal of Clinical Nursing*, 22, 2605-2613.  
doi:10.1111/jocn.12080
- Djukic, M. (2011). Review: Job satisfaction and intentions to leave of new nurses. *Journal of Research in Nursing*, 16(6), 549-550. doi:10.1177/1744987111422424
- Eckerson, C. (2018). The impact of nurse residency programs in the United States on improving retention and satisfaction of new nurse hires: An evidence-based literature review. *Nurse Education Today*, 84-90. doi:10.1016/j.nedt.2018.09.003
- Gardiner, I., & Sheen, J. (2016). Graduate nurse experiences of support: A review. *Nurse Education Today*, 7-12. doi:10.1016/j.nedt.2016.01.016
- Gellerstedt, L., Moquist, A., Roos, A., & Bergkvist, K. (2019). Newly graduated nurses' experiences of a trainee programme regarding the introduction process and leadership in a hospital setting - a qualitative interview study. *Journal of Clinical Nursing*, 28(1), 1685-1694. doi:10.1111/jocn.14733
- Haddad, L., & Toney-Butler, T. (2020, January). *Nursing shortage*. (StatPearls Publishing)  
Retrieved from StatPearls: <https://www.ncbi.nlm.nih.gov/books/NBK493175/>
- Havaei, F., Macphee, M., & Dahinten, S. (2016). RNs and LPNs: Emotional exhaustion and intention to leave. *Journal of Nursing Management*, 24(3), 393-399.  
doi:10.1111/jonm.12334

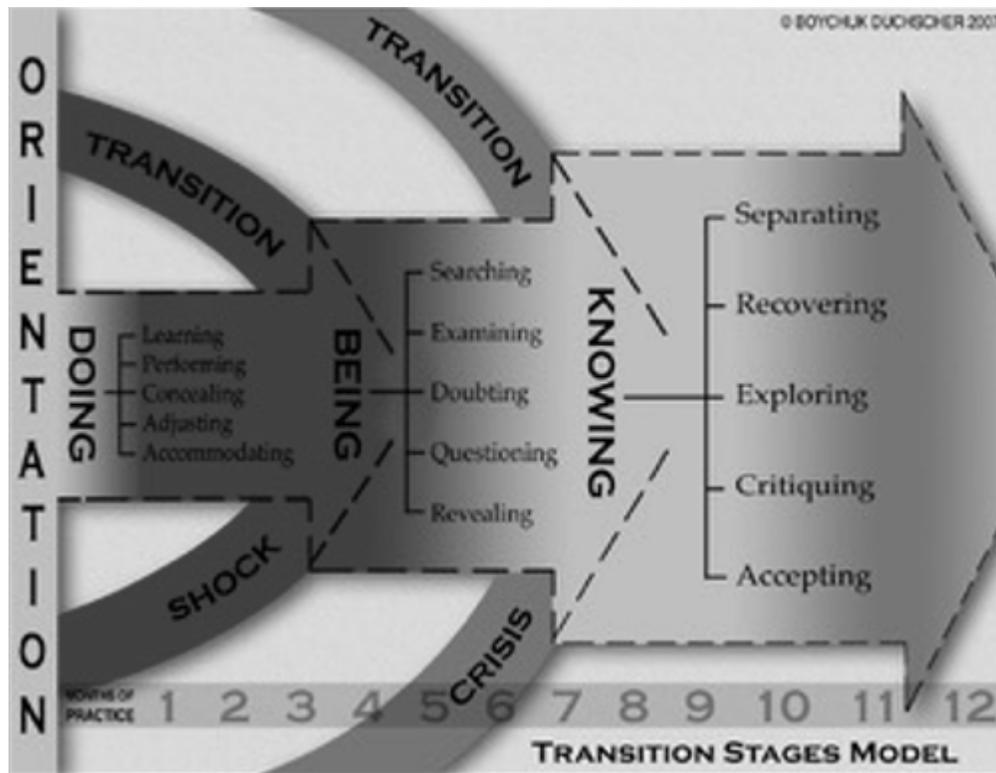
- Iwanicki, E., & Schwab, R. (1981). A cross validation study of the Maslach Burnout Inventory. *Educational and Psychological Measurement*, 1167-1174.  
doi:10.1177/001316448104100425
- Jones, C. (2008, January). Revisiting nurse turnover costs: adjusting for inflation. *Journal of Nursing Administration*, 38(1), 11-18. doi:10.1097/01NNA.0000295636.03216.6f
- Jose, S., Dhandapani, M., & Cyriac, M. (2020, November). Burnout and resilience among frontline nurses during COVID-19 Pandemic: A cross-sectional Study in the emergency department of a tertiary care center, North India. *Indian Journal of Critical Care Medicine*, 24(11), 1081-1088. doi:10.5005%2Fjcp-journals-10071-23667
- Kim, E.-Y., Yeo, J., Park, H., Sin, K., & Jones, C. (2018). Psychometric evaluation of the environmental reality shock-related issues and concerns instrument for newly graduated nurses. *Nurse Education Today*, 61, 106-111. doi:10.1016/j.nedt.2017.11.003
- Kodama, M. (2017). Functions of career resilience against reality shock, focusing on full-time employees during their first year of work. *Japanese Psychological Research*, 59(4), 255-265. doi:10.1111/jpr.12161
- Kramer, M. (1974). *Reality shock; why nurses leave nursing*. Saint Louis: C.V. Mosby Co.
- Mantler, J., Godin, J., Cameron, S., & Horsburgh, M. (2015). Cynicism in hospital staff nurses: the effect of intention to leave and job change over time. *Journal of Nursing Management*, 23(5), 577-587. doi:10.1111/jonm.12183
- Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, 2, 99-113.
- Maslach, C., & Leiter, M. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, 15(2), 103-111. oi:doi.org/10.1002%2Fwps.20311

- Masoudi Alavi, N. (2014, December). Self-efficacy in nursing students. *Nursing and Midwifery Studies*, doi:10.17795/nmsjournal25881.
- Monforte-Royo, C., & Fuster, P. (2020, November). Coronials: Nurses who graduated during the COVID-19 pandemic. Will they be better nurses? *Nurse Educator Today*, 94(104536). doi:10.1016/j.nedt.2020.
- Mun, Y., Leong, J., & Crossman, J. (2016). Tough love or bullying? New nurse transitional experiences. *Journal of Clinical Nursing*, 25, 1356-1366. doi:10.1111/jocn.13225
- Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence. *Nurse Education in Practice*, 19-24. doi:10.1016/j.nepr.2016.04.001
- Rudman, A., & Gustavsson, P. (2011). Early-career burnout among new graduate nurses: A prospective observational study of intra-individual change trajectories. *International Journal of Nursing Studies*, 292-306. doi:10.1016/j.ijnurstu.2010.07.012
- Rush, K., Janke, R., Duchscher, J., Phillips, R., & Kaur, S. (2019, February). Best practices of formal new graduate transition programs: An integrative review. *International Journal of Nursing Studies*, 139-158. doi:10.1016/j.ijnurstu.2019.02.010
- Salt, J., Cummings, G., & Profetto-McGrath, J. (2008, June). Increasing retention of new graduate nurses: A systematic review of interventions by healthcare organizations. *Journal of Nursing Administration*, 38(6), 287-296. doi:10.1097/01.NNA.0000312788.88093.2e
- Schmidt, A. (2020, October 20). *American Hospital Association*. Retrieved from We need to talk about burnout the same way we talk about benefits: <https://www.aha.org/news/blog/2020-10-20-we-need-talk-about-burnout-same-way-we-talk-about-benefits>

- Schmitt, C., & Schiffman, R. (2019). Perceived needs and coping resources of newly hired nurses. *SAGE Open Medicine*, 7, 1-9. doi:10.1177/2050312119833216
- Sparacino, L. (2016). Faculty's role in assisting new graduate nurses' adjustment to practice. *SAGE Open Nursing*, 2, 1-9. doi:10.1177/2377960816635182
- Sun, N., Wei, L., Shi, S., Jiao, D., Song, R., Ma, L., . . . Wang, H. (2020, June). A qualitative study on the psychological experience of caregivers of COVID-19 patients. *American Journal of Infection Control*, 48(6), 592-598. doi:10.1016%2Fj.ajic.2020.03.018
- The High Cost of Nurse Turnover*. (2016, November 30). Retrieved from The University of New Mexico: <https://rnbshonline.unm.edu/articles/high-cost-of-nurse-turnover.aspx>
- The RN work project*. (2013). Retrieved from Robert Wood Johnson Foundation: <https://www.rwjf.org/en/library/research/2013/11/the-rn-work-project.html>
- Tourangeau, A., McGillis-Hall, L., Doran, D., & Petch, T. (2006, March/April). Measurement of nurse job satisfaction using the McCloskey/Mueller satisfaction scale. *Nursing Research*, 55(2), 128-136.
- Van Camp, J., & Chappy, S. (2017). The effectiveness of nurse residency programs on retention: A systematic review. *AORN Journal*, 128-144. doi:10.1016/j.aorn.2017.06.003
- Vizient/AACN Nurse Residency Program*. (2019). Retrieved from American Association of Colleges of Nursing: <https://www.aacnursing.org/nurse-residency-program>
- Walker, A., & Campbell, K. (2013). Work readiness of graduate nurses and the impact on job satisfaction, work engagement, and intention to remain. *Nurse Education Today*, 1490-1495. doi:10.1016/j.nedt.2013.05.008

- Walsh, A. (2018, November-December). Nurse residency programs and the benefits for new graduate nurses. *Pediatric Nursing*, 44(6), 275-279.
- What is Reality Shock?* (2020). Retrieved February 11, 2020, from The law dictionary:  
<https://thelawdictionary.org/reality-shock/>
- Wheeler, D., Vassar, M., Worley, J., & Barnes, L. (2011). A reliability generalization meta-analysis of coefficient alpha for the Maslach Burnout Inventory. *Educational and Psychological Measurement*, 71(1), 231-244. doi:10.1177/0013164410391579
- Wildermuth, M., Weltin, A., & Simmons, A. (2019). Transition experiences of nurses as students and new graduate nurses in a collaborative nurse residency program. *Journal of Professional Nursing*, 1-7. doi:10.1016/j.profnurs.2019.06.006
- Williams, F., Scott, E., Deborah, T., & Swanson, M. (2018, May-June). New nurse graduate residency mentoring: A retrospective cross-sectional research study. *Nursing Economic*, 36(3).
- Wolford, J., Hampton, D., Tharp-Barrie, K., & Goss, C. (2019, March). Establishing a nurse residency program to boost new graduate nurse retention. *Nursing Management*, 50(3), 44-49. doi:10.1097/01.NUMA.0000553497.40156.4e
- Zinn, J., Guglielmi, C., Davis, P., & Moses, C. (2012, December). Addressing the nursing shortage: The need for nurse residency programs. *AORN Journal*, 96(6), 652-657. doi:10.1016/j.aorn.2012.09.011

## Appendix A



\*Duchscher J. (2008). A process of Becoming: The Stages of New Nursing Graduate Professional Role Transition. *J Contin Educ Nurs*. 39(10) 441-450. Doi: 10.3928/00220124-20081001-03. Reprinted with permission from SLACK Incorporated.

## Appendix B

# Maslach Burnout Inventory™

## Instruments and Scoring Keys

### Includes MBI Forms:

Human Services - MBI-HSS

Medical Personnel - MBI-HSS (MP)

Educators - MBI-ES

General - MBI-GS

Students - MBI-GS (S)

Christina Maslach  
Susan E. Jackson  
Michael P. Leiter  
Wilmar B. Schaufeli  
Richard L. Schwab

Published by Mind Garden, Inc.

info@mindgarden.com  
www.mindgarden.com

### Important Note to Licensee

If you have purchased a license to reproduce or administer a fixed number of copies of an existing Mind Garden instrument, manual, or workbook, you agree that it is your legal responsibility to compensate the copyright holder of this work — via payment to Mind Garden — for reproduction or administration in any medium. **Reproduction includes all forms of physical or electronic administration including online survey, handheld survey devices, etc.**

The copyright holder has agreed to grant a license to reproduce the specified number of copies of this document or instrument **within one year from the date of purchase.**

**You agree that you or a person in your organization will be assigned to track the number of reproductions or administrations and will be responsible for compensating Mind Garden for any reproductions or administrations in excess of the number purchased.**

*This instrument is covered by U.S. and international copyright laws. Any use of this instrument, in whole or in part, is subject to such laws and is expressly prohibited by the copyright holder. If you would like to request permission to use or reproduce the instrument, in whole or in part, contact Mind Garden, Inc.*

# MBI Human Services Survey for Medical Personnel

Christina Maslach & Susan E. Jackson

*The purpose of this survey is to discover how various people in the human services or the helping professions view their job and the people with whom they work closely.*

**Instructions:** On the following page are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number “0” (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

## Example:

---

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

---

**How often 0-6  
Statement:**

---

1. \_\_\_\_\_ I feel depressed at work.

If you never feel depressed at work, you would write the number “0” (zero) under the heading “How often.” If you rarely feel depressed at work (a few times a year or less), you would write the number “1.” If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number “5.”

**MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016  
Christina  
Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc.,  
www.mindgarden.com

# MBI Human Services Survey for Medical Personnel

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

**How often 0-6 Statement:**

1. \_\_\_\_\_ I feel emotionally drained from my work.
2. \_\_\_\_\_ I feel used up at the end of the workday.
3. \_\_\_\_\_ I feel fatigued when I get up in the morning and have to face another day on job.
4. \_\_\_\_\_ I can easily understand how my patients feel about things.
5. \_\_\_\_\_ I feel I treat some patients as if they were impersonal objects.
6. \_\_\_\_\_ Working with people all day is really a strain for me.
7. \_\_\_\_\_ I deal very effectively with the problems of my patients.
8. \_\_\_\_\_ I feel burned out from my work.
9. \_\_\_\_\_ I feel I'm positively influencing other people's lives through my work.
10. \_\_\_\_\_ I've become more callous toward people since I took this job.
11. \_\_\_\_\_ I worry that this job is hardening me emotionally.
12. \_\_\_\_\_ I feel very energetic.
13. \_\_\_\_\_ I feel frustrated by my job.
14. \_\_\_\_\_ I feel I'm working too hard on my job.
15. \_\_\_\_\_ I don't really care what happens to some patients.
16. \_\_\_\_\_ Working with people directly puts too much stress on me.
17. \_\_\_\_\_ I can easily create a relaxed atmosphere with my patients.
18. \_\_\_\_\_ I feel exhilarated after working closely with my patients.
19. \_\_\_\_\_ I have accomplished many worthwhile things in this job.
20. \_\_\_\_\_ I feel like I'm at the end of my rope.
21. \_\_\_\_\_ In my work, I deal with emotional problems very calmly.
22. \_\_\_\_\_ I feel patients blame me for some of their problems.

(Administrative use only)

EE Total score: _____	DP Total score: _____	PA Total score: _____
EE Average score: _____	DP Average score: _____	PA Average score: _____

**MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016 Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., [www.mindgarden.com](http://www.mindgarden.com)

## MBI – Medical Personnel, Scoring Key Emotional Exhaustion (EE) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on EE items # 1, 2, 3, 6, 8, 13, 14, 16, and 20 that correspond to the unshaded areas on this scoring key. Enter this EE total score on the survey form. Divide the EE total score by the number of answered EE items for an EE average score. Research usually reports the average score.

How Often 0-6	
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____
10.	_____
11.	_____
12.	_____
13.	_____
14.	_____
15.	_____
16.	_____
17.	_____
18.	_____
19.	_____
20.	_____
21.	_____
22.	_____

**MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., [www.mindgarden.com](http://www.mindgarden.com)

## MBI – Medical Personnel, Scoring Key Depersonalization (DP) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on DP items # 5, 10, 11, 15, and 22 that correspond to the unshaded areas on this scoring key. Enter this DP total score on the survey form. Divide the DP total score by the number of answered DP items for a DP average score. Research usually reports the average score.

How Often 0-6
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____

**MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., [www.mindgarden.com](http://www.mindgarden.com)

## MBI – Medical Personnel, Scoring Key Personal Accomplishment (PA) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on PA items # 4, 7, 9, 12, 17, 18, 19, and 21 that correspond to the unshaded areas on this scoring key. Enter this PA total score on the survey form. Divide the PA total score by the number of answered PA items for a PA average score. Research usually reports the average score.

How Often 0-6
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____

**MBI – Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. Published by Mind Garden, Inc., [www.mindgarden.com](http://www.mindgarden.com)

## MBI – Medical Personnel, Scoring Key Cynicism (CY) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on CY items # 8, 9, 13, 14, and 15 that correspond to the unshaded areas on this scoring key. Enter this CY total score on the survey form. Divide the CY total score by the number of answered CY items for a CY average score. Research usually reports the average score.

How Often 0-6	
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____
10.	_____
11.	_____
12.	_____
13.	_____
14.	_____
15.	_____
16.	_____

**MBI – Human Services Survey for Medical Personnel - MBI-HSS (MP):** Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. Published by Mind Garden, Inc., [www.mindgarden.com](http://www.mindgarden.com)  
All rights reserved in all media. Published by Mind Garden, Inc. [www.mindgarden.com](http://www.mindgarden.com).

## Appendix C

### Demographics Questions

- What is your age?
  - 18-22
  - 23-26
  - 27-30
  - 31+
- What is your gender?
  - Male
  - Female
  - Other (Please specify)
  - Prefer not to say
- What is your ethnicity?
  - White
  - Hispanic or Latino
  - Black or African American
  - Native American or American Indian
  - Asian / Pacific Islander
  - Other
- What is the highest Nursing Degree you have achieved?
  - Associate Degree
  - Diploma
  - BSN
  - MSN
- Is this your first career?
  - Yes
  - No – I have had other careers prior to nursing

## Appendix D

### Project Tasks

- Attain a copy of the Maslach Burnout Inventory (MBI) and request permission to use in the project.
- Discussion with Director the system's education center regarding the DNP project.
- Obtain letters of approval from the system's Department of Education to conduct the DNP project including surveys of VHS NLNs.
- Creation of enhanced LMS module to be assigned to 50 random VHS NRP participants. These curricula are designed to educate NLNs on new nursing graduate professional role transition including reality shock. Curricula will be in PowerPoint format. It will have professional voice over for attention and interactive purposes.
- Submit application for IRB approval from UNLV.
- Upon approval from IRB, the MBI survey tool will be assigned to the NLN's via LMS format. Deadline for completion of MBI survey tool will be assigned via LMS.
- Assign Reality Shock/Burnout Power Point presentation to the NLN group via LMS.
- Analyze initial data from return of MBI surveys from NLN's.
- 2 weeks post completion of the Power Point education module in LMS – re-distribute the MBI survey tool to group of NLN's.

Compare and contrast the pre- and post- MBI survey results to determine if education regarding reality shock and burnout changed perceptions in three domain areas of exhaustion, cynicism and personal efficacy

## Appendix E

### UNLV Biomedical IRB - Exempt Review Exempt Notice

**DATE:** November 5, 2020

**TO:** Angela Silvestri-Elmore, PhD, APRN, FNP-BC, CNE **FROM:** Office of Research Integrity - Human Subjects

**PROTOCOL TITLE:** [1621803-3] New Nurse Reality Shock & Early Burnout: Can Role Transition Education Received During New Nurse Residency Positively Affect Satisfaction?

**ACTION:** DETERMINATION OF EXEMPT STATUS

**EXEMPT DATE:** November 5, 2020

**NEXT REPORT DUE:** November 4, 2023

**REVIEW CATEGORY:** Exemption category # 2i

Thank you for your submission of Revision materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

**PLEASE NOTE:**

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials.

If your project involves paying research participants, it is recommended to contact the ORI Program Coordinator at (702) 895-2794 to ensure compliance with the Policy for Incentives for Human Research Subjects.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at [IRB@unlv.edu](mailto:IRB@unlv.edu) or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

Office of Research Integrity - Human Subjects  
4505 Maryland Parkway . Box 451047 . Las Vegas, Nevada 89154-1047  
(702) 895-2794 . FAX: (702) 895-0805 . [IRB@unlv.edu](mailto:IRB@unlv.edu)

## Appendix F

### COVID19 Survey Questions

- What level of involvement did you have in caring for COVID-19 rule out and positive patients during the pandemic?
  - Direct patient care every shift
  - Direct patient care occasionally
  - Indirect patient care or rare patient care
  - No care of COVID19 patients
  
- Please rate your stress level as it relates to the COVID-19 pandemic.
  - Extreme Stress
  - Moderate Stress
  - Mild Stress
  - No Stress

## Curriculum Vitae

### Bonnie L. Stolzman, MSN, MBA, RN

bonnie.stolzman@uhsinc.com

#### Professional Summary:

- Executive healthcare professional with proven effective progressive leadership and managerial skills in both urban and rural settings.
- Strong communication, interpersonal, analytical, administration, organizational, problem solving and leadership skills. Thrive in both independent and collaborative work environments. Readily develop rapport with patients, families, staff, and providers.
- Exceptional knowledge of accreditation standards and CMS COP.
- Maintains performance improvement initiatives, while focusing on safety and quality.
- Maintains productivity targets and strategic goals.
- Clinical nursing background in critical care, CVICU, MSICU, IMC, PCU, Cardiac Telemetry, Med/Surg, ER and Observation.
- Successful leader with hands-on approach upholding global view for long term success.
- Strategically views issues and solves problems with task-oriented perspective on outcomes resolution.
- At ease in fast-paced high stress situations with emerging, changing, and multiple responsibilities. Easily assess changing conditions and implements appropriate interventions.

#### Work Experience:

##### Chief Nursing Officer - CNO

Desert View Hospital, Pahrump NV

October 2017 – Current

- Develops departmental goals and objectives consistent with medical, administrative, legal, and ethical requirements of the health care delivery system.
- Maintains vigilant focus on service excellence standards and resulting patient experience scores.
- Oversees and monitors facility to maintain exemplary quality, safety, and infection prevention standards.
- Works collaboratively with CEO and members of the senior leadership team to promote strategic growth and positive vision while managing change.
- Directs clinical activities, including patient assessment, care plan development, service level determination, patient visits, and complaint management.
- Prepares and monitors budget(s) and ensures that assigned departments operate within allocated funds and meets productivity targets. Coordinates and directs internal and externally driven audits.
- Builds and maintains relationships with Med Exec and Providers.
- Assists with coordination and development, marketing, and strategic planning of new service lines.
- Extracts and analyzes data for use in strategic planning.

**Associate Chief Nursing Officer - ACNO**

Spring Valley Hospital, Las Vegas NV

February 2017 – October 2017

**Director Nursing – Multiple Service Lines – IMC, Telemetry, Observation, Med/Surg, Dialysis**

Spring Valley Hospital, Las Vegas NV

January 2017 – February 2017

**Nurse Manager – IMC, Observation, Telemetry**

Spring Valley Hospital, Las Vegas NV

January 2016 – December 2016

**Managing Director Patient Care Services Critical Care ICU/PCU/Telemetry/Med/Surg/Observation**

Ministry Saint Clare's Hospital, Weston, WI

2011 – December 2015

**House Supervisor/Clinical Supervisor**

Ministry Saint Clares Hospital, Weston, WI

2006 – 2011

**House Supervisor/Clinical Supervisor/Staff RN**

Wausau Hospital, Aurora Baycare, Aurora Medical Center Oshkosh

2003 – 2006

**Other Management Roles**

From 1985 – 2003 held numerous positions within the private insurance sector managing departments of up to 125 employees.

- Manager Stop Loss Division
- Senior Stop Loss Underwriter
- Stop Loss Group Lines Marketing Representative
- Supervisor Group Underwriting Division
- Individual Health Underwriter
- Senior Claims Examiner
- Subrogation/Workers Compensation Customer Service Representative

## **Education:**

- **DNP** – University of Nevada Las Vegas 2021
- MindBodyStrong Facilitator – NV Governor’s Office of Workforce Innovation & Dev.
- CNO Academy Graduate - 2018
- Certified UHS Service Excellence Facilitator
- **MSN** – Master of Science in Nursing with Emphasis in Healthcare Leadership – Grand Canyon University 2016
- **MBA** – Masters Business Administration – Grand Canyon University 2016 - \*dual master’s degree
- **M3** – Leadership Development – Valley Health System
- One of 50 chosen leaders in the Ministry Healthcare System to attend 24 month specialized Clinical Leader Formation Training from “The Advisory Board.”
- CAP Certified
- Lean Six Sigma Green Belt – Ministry Health System
- **BSN** – University of Wisconsin Oshkosh – 2013
- **Associate Degree Nursing/Minor Psychology** – North Central Technical College – 2003
- **LPN** – Madison Area Technical College - 1985