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Nurses' Occupational Trauma Exposure, Resilience, and Coping Education

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COLLEGE OF EDUCATION

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Abstract

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BSM, University of Phoenix, 2011

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Abstract

Nursing education courses and professional development (PD) do not include coping and resilience training for registered nurses (RNs) who work in emergency departments (EDs). Exposure to traumatic events, death, and dying may lead to health issues, substance abuse, stress symptoms, nursing staff turnover, and compassion fatigue among ED RNs. Without training, the pattern of adverse outcomes may continue. The purpose of this study was to explore ED RNs' experiences with occupational traumatic stress (OTS), and their recommendations for change to nursing PD programs, using a qualitative bounded intrinsic case study. The conceptual framework for this study included social learning and experiential learning theories. Data were collected through semi-structured interviews with 7 licensed and employed ED RNs with more than 1 year in EDs and who volunteered to participate in the study. Data were examined analytically using descriptive, emotion, and patterns coding strategies and In Vivo to identify categories and themes. Based on nurses' experiences, ED RNs require a collaborative team training approach in learning and sharing opportunities regarding preparatory, de-escalation, and self-care strategies to overcome OTS. Based on the findings, a 3-day interactive PD workshop program was created for ED nurses to address those needs. These endeavors may contribute to positive social change by increasing wellness, cohesive ED teamwork, healthy stress management practices, better patient care, and reduced turnover for ED RNs. Furthermore, nurse educators may benefit from adding coping and resilience training to the nursing education curriculum to address and possibly mitigate the effects of OTS.

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Dedication

To Mama and Dad, who taught me love, family, honor, respect, and service: Ti amo, mi manchi; la famiglia è tutto. To Nonie, who stepped into Mama's shoes:

Le sorelle sono una benedizione.

Acknowledgments

Heartfelt gratitude to Topher, Angie, and Sean Kovacs; Michele, Scott, and Andrew Campbell; and Gary Mayo, who sacrificed time, homemade goodies, and holidays together that *normal* families enjoy. You honored that school came first.

Dr. Debra Beebe, thank you for going above and beyond, keeping my study afloat, and maintaining a voice of calm and reason. Committee members, Dr. Janet Reid-Hector and Dr. Mary Howe, thank you for plugging data into my laboring cognitive processing unit PRN. My IJAG sisters and fellow M&Ms, Colleen Geier, Lisa Mercer, and Toni Chamberlain; thank you for the reality checks, laughs, and support.

Deb Horvath, my trauma nurse sister and cohort; Margarete Dawson and Wendy Sopoliga, who helped me plug into the other side; Victor Volkman, who publishes my convoluted thinking; and my trauma mentors for more than two decades, Victor Welzant, Mike Murphy, and Dennis Potter: Thank you for believing in and guiding me.

The heroes in this story remain anonymous. To those RNs: You shared your hearts because you care about other nurses; your stories are in these pages. Your passion for caring about others is evident; please remember to care for yourselves. I pray that you and other trauma nurses, *all* emergency services folks, do not suffer in silence, or worse, fall victim to the weight of the burdens we bear. Talk to someone. Please.

I am a retired paramedic, RN, writer, and crisis responder who names trees and talks to plants. I am mother and grandmother to two and four-footed babies who own my heart and keep me mindful. I am honored and humbled to be an advocate, a voice, for nurses, medics, and responders who deserve to be healthy, happy, and whole.

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Section 1: The Problem

The problem prompting the study was that at local emergency departments (EDs) and within the global community of nurses, standard nursing education and professional development (PD) did not include coping and resilience training (Attia, Adb-Elaziz, & Kandeel, 2012; Von Rueden et al., 2010). Resilience and coping strategies are designed to mediate the negative effects of workplace trauma exposures. Repeated exposures to violence, aggression, critical injuries, death, and dying increase nurses' vulnerability to adverse outcomes such as secondary traumatic stress (STS), posttraumatic stress (PTS), physical health problems, and decreased quality of life (Adriaenssens, De Gucht, Van Der Doef, & Maes, 2011; Bailey, Murphy, & Porock, 2011).

Training was not available to RNs for dealing with occupational traumatic stress (OTS), which can leave nurses without the coping skills necessary to mediate negative biopsychosocial consequences arising from traumatic exposures (Lavoie, Talbot, & Mathieu, 2011; Wlodarczyk & Lazarewicz, 2011). In some instances, researchers found nurses exhibiting compassion satisfaction (CS) in the face of trauma, confounding the relationship between trauma and coping (Cieslak et al., 2013; Hinderer et al., 2014; LaFauci Schutt & Marotta, 2011). A qualitative research approach with an intrinsic case study design was used for this study.

The Local Problem

The problem was that nursing education and PD did not include formal course work in coping and resilience training for ED RNs. Although some RNs may have acquired coping skills from nonacademic sources, resilience and coping skills course

work was not a standard training mandate or option. Because institutions and educators did not formally provide training addressing coping skills and resilience, nurses were subject to unpredictable responses that may have been personally and professionally disruptive (Everly, Welzant, & Jacobson, 2008; Hinderer et al., 2014).

Exposure to and involvement with distressing events is part of the fundamental experience of ED RNs. Research regarding the predictability of occupational trauma exposure outcomes is in its infancy, and the effectiveness of suggested strategies used for coping with occupational trauma remains unproven (Kirby, Shakespeare-Finch, & Palk, 2011). Coping with traumatic events is not an inherent or intuitive process, and ED RNs' occupational exposures to trauma can completely overwhelm existing resilience and coping mechanisms (Dasgupta, 2012; Lavoie et al., 2011). One urban trauma center, recognizing ill effects of STS among its staff nurses, instituted a critical incident stress management (CISM) program. In addition to posttrauma response interventions, the comprehensive, integrated, strategic CISM platform included preparatory education for resilience and coping. Acknowledging the need for responding to the ED RNs' traumatic exposures included gathering data from those nurses occupationally exposed to trauma.

The purpose of this study was to investigate the impact of OTS on ED RNs who lacked formal course work addressing resilience and coping skills. The goal was to understand how an absence of resilience and coping training could influence occupational traumatic stress effects like substance abuse, impaired performance, stress symptoms, and compassion fatigue. Different coping styles, innate or acquired, can influence coping choices based upon situational severity and perceptions of threats to safety and levels of

control (Vashdi, Bamberger, & Bacharach, 2012). Kirby et al. (2011) and Rosenstein and Naylor (2012) found a positive relationship between incidents of greater severity and higher levels of disruptive coping behaviors. The issues of resilience and coping skills reflect a global problem (Mosadeghrad, 2013).

Research Site

The research site was a Level II trauma center ED located in a suburb of Detroit, Michigan. At this hospital, as at other local EDs and within the global community of nurses, standard nursing education and practicing nurses' PD programs did not include coping and resilience training or address STS (Attia et al., 2012; Macomb Community College, 2014-2015; St. Clair County Community College, 2015; Von Rueden et al., 2010; Wayne State University, 2015). Crisis interventionists and trauma psychologists offer multiple theories and strategies designed to deal with the emotional aftermath of trauma exposure, but the efficacy of techniques intended to mediate posttrauma stressors and maintain psychological homeostasis is subject to debate (LeBlanc et al., 2011; Prati, Pietrantoni, & Cicognani, 2011). A traditional coping strategist's studies echo the medical model perspective of pathology without consideration of resilience and health promotion tactics (Benight, 2012). Nurses' input about the benefits of coping and resilience education clarified how to approach existing gaps in practice and knowledge.

Rationale

Evidence of the Problem at the Local Level

The ED RNs at the local Level II trauma center deal with death, attempted resuscitation of patients, exposure to horrific injuries, end-of-life care, trauma to children,

and unpredictable challenges in a fast-paced and demanding environment (Healy & Tyrrell, 2011). Accepting responsibility for the lives nurses touch can exacerbate the consequences of vicarious traumatizations for nurses lacking an algorithm for resilience and coping skills (Schmitz et al., 2012). Examples of e-mail communications exchanged with several local authorities and secured on my home computer follow. In one e-mail, the director of nursing at a local college wrote, "[in the curricula] we address coping and resilience strategies… from a client perspective. We do not have specific courses that cover such an issue [for nurses] (S. M., personal communication, February 10, 2015). Although resilience education, PD, and peer support programs for RNs may be effective, they are not locally instituted into practice (Chan, Chan, & Kee, 2012a; Lavoie et al., 2011).

An experienced trauma RN and ED manager for two local hospitals wrote about the challenges of emergency nursing through an e-mail exchange:

> An ED nurse with over 25 years' experience asked me, "Do you think it is possible for nurses to have PTSD?" This nurse was experiencing sleep disturbances, physical manifestations of stress, and had sought counsel. Basic nursing education programs provide skills, a series of tasks that assist in improving the health of the patient. When the difficult cases come, the ability to perform efficiently and effectively defines nurses' aptitude. [We] show no fear or emotion… skip breaks, [do] not care for self, and then come back tomorrow to do it again. Seasoned nurses are the best teachers of *keeping it together*. (S. H., personal communication, February 1, 2015)

A former ED RN and trauma center nursing administrative manager shared her thoughts through e-mail:

> Schools never addressed [traumatic stress] at all. Employers seem to turn a blind eye, like that will never happen, and the nurses will be fine. When an incident did happen, i.e. the shooting in the ED several years ago, counselors and CISM was provided [sic], but nobody was educated prior and [the ED] is a high traumatic stress area. (S. C., personal communication, February 8, 2015)

In an e-mail, a local hospital vice president described her perspective as a health care executive challenged with decisions based on tight budgets:

> Educational offerings for nurses are eliminated due to the expense. While we have "nursing education days," these sacred hours contain the most necessary on-going education/certifications that hospitals are held accountable for from regulatory agencies. We take for granted that nurses will know how to cope, how to deal with all of the horrific situations they deal with as part of their work. After all, they are nurses - isn't that why they are doing what they do? Nurses are never fully prepared. Caring for patients will continue to be a challenge with the changes in our health care industry, and hospitals should be better able to support their nurses. Nurses are caring for individuals under circumstances that most of us never see, or even think about, at their most vulnerable times and in the most horrific of circumstances. We have to commit to care for the caregivers. Even if it does present significant cost, we need to consider the cost of time off, health

> care expenses for employees, etc. Hospitals have to commit to a culture of support and healing. (A. M., personal communication, February 9, 2015)

Evidence of the Problem from the Professional Literature

The concepts of resilience and coping training programs appear throughout the literature as positive, dynamic, and useful, but rarely employed (Howe, Smajdor, & Stockl, 2012). High levels of occupational exposure to traumatic stress combined with few opportunities for resilience and coping training contribute to disengagement, crises of competence, and burnout. Nurses' thoughts about leaving the profession following occupational exposures to trauma materialize as early as nursing school (Rudman & Gustavsson, 2012). Nursing students' high stress transfers from nursing school to the workplace as poor resilience, poor coping skills, and maladaptive reactions that affect nurses' fitness for practice (Reeve, Shumaker, Yearwood, Crowell, & Riley, 2013). Researchers suggest that stressors from clinical training may translate into emotional or psychological impairments throughout nurses' professional lives, supporting the need for courses offering resilience and coping strategies (Shaban, Khater, & Akhu-Zaheya, 2012).

Leaving nursing school and entering the workplace unprepared to mitigate the negative effects of job-related stress reinforces the need for resilience and coping training and continuing education programs. Noting a paucity of research on nurses' occupational stress reduction, Happell et al. (2013) suggested prevention strategy initiatives like coping skills training to assist with organizational understanding and support. Peters et al. (2012) echoed the need for managers to provide coping strategies training and support

to reduce nurses' workplace stress. Mealer, Jones, and Moss (2012) emphasized the benefit of providing a resilient role model to facilitate observational learning and augment resilience and coping skills programs.

Without resilience and coping training, workers may sense a deficiency in organizational support, contributing to reduced self-efficacy, lowered sense of competence and control, learned helplessness, and failed coping (Bonanno, Pat-Horenczyk, & Noll, 2011; Meadows, Shreffler, & Mullins-Sweatt, 2011). As psychological coping resources decrease, nurses display fewer help-seeking behaviors (Kirby et al., 2011; LeBlanc et al., 2011). The stigma attached to seeking help for psychological distress also contributes to increased symptom occurrence, relapse, distress, and hopelessness (Vogel, Bitman, Hammer, & Wade, 2013). However, through the positive models of adaptive coping and resilience training, nurses may employ learned behaviors like seeking support, using appropriate humor, managing effectively negative emotions, incorporating positive moral beliefs, and processing reflectively for learning and growth (Howe et al., 2012). The dynamic aptitude of resiliency, a concept rarely used in training programs, allows nurses to thrive amidst stressful and seemingly impossible situations (Howe et al., 2012).

The purpose of the study was to investigate the impact of occupational traumatic stress on ED RNs who lacked formal course work addressing resilience and coping skills. Information provided by the nurses addressed how an absence of formal course work in resilience and coping influenced biopsychosocial and professional OTS effects like changes in eating or sleeping habits, impaired performance, hyperarousal, and STS

symptoms. Understanding how coping and resilience course work could affect nurses may provide data addressing problems of nurses' health, performance, job satisfaction, and the benefits of providing resilience and coping strategies training programs.

Definitions

Adaptive coping strategies: Positive responses to traumatic stress used to manage emotions and nurture the growth of personal resources like self-efficacy (Hayward & Tuckey, 2011).

Avoidance-focused coping: Strategies used to distance from the reality and emotional threats of the traumatic incident (Vashdi et al., 2012).

Burnout: Emotional exhaustion, patient depersonalization, lessened self-efficacy, and negative feelings toward patients (Hinderer et al., 2014).

Compassion fatigue (CF): Disengagement from patients and loss of empathy toward them resulting from cumulative exposures to trauma (Mealer & Jones, 2013).

Compassion satisfaction (CS): A positive feeling of accomplishment following rendering patient care (Hinderer et al., 2014).

Emotion-oriented coping: The process used to maintain equilibrium through cognitive-behavioral actions like dissociation (Everly et al., 2008).

Gallows humor: A cognitive coping mechanism used to reframe trauma by using dark and sometimes inappropriate humor (Southwick & Charney, 2012).

Level II trauma center: An American College of Surgeons and state authority based on one through four designations (American Trauma Society, n.d.).

Maladaptive coping strategies: Negative dysfunctional or avoidance-focused practices consistent with adverse outcomes (Kirby et al., 2011).

Posttraumatic stress disorder (PTSD): A psychological diagnosis given for specific posttrauma exposure mental disorders (Lavoie et al., 2011).

Posttraumatic stress symptoms (PTS): Intrusive thoughts about the traumatic event, increased arousal, and avoidance of event triggers (Frazier et al., 2011).

Psychological first aid (PFA): An early crisis intervention tool to mitigate stress responses through support and compassion (Everly, Barnett, Sperry, & Links, 2010).

Psychopathology: The medical model of psychological trauma, mental dysfunctions, and disorders which result from aversive events (Benight, 2012; Bonanno & Mancini, 2012).

Resilience: The innate, reinforced, or learned ability to bounce back or positively adapt in the aftermath of trauma exposure (Schiraldi, Jackson, Brown, & Jordan).

Secondary traumatic stress (STS): A negative consequence of trauma exposure with posttraumatic stress symptoms marked by intrusive thoughts, increased arousal, and avoidance of elements that may trigger memories of the trauma (Cieslak et al., 2013).

Task-focused coping: The process of remaining focused on job duties and procedures, the most positive of the three strategies of emotion, task, and avoidance coping practices (Vashdi, et al., 2012).

Vicarious traumatization: A term often used interchangeably with secondary traumatic stress, indicates a transfer of the psychopathology and ill effects of trauma from the patients to the helpers (Mairean & Turliuc, 2013).

Significance

Local experts and the literature support the need for training in coping and resilience for nurses, confirming gaps in education and practice. Beck (2011) called for continuing education whereby nurses may learn strategies to increase resiliency and prevent known STS symptoms. Unless programs addressing adaptive coping and resilience strategies become available to practicing nurses, negative stress outcomes may continue (Lavoie et al., 2011). Making area organizational leaders aware of the need for training strategies may encourage the adoption of training initiatives (Happell et al., 2013). Coping and resilience preparation used as an adjunct to ED RN skills training can decrease negative outcomes and increase CS, important to local and larger educational contexts (Hinderer et al., 2014).

Specialties like ED separate RNs from general practice, exposing them to extraordinary circumstances and increased levels of responsibility (Adriaenssens et al., 2011). The population of ED RNs cannot avoid exposure to traumatic stress (Chan, Chan, & Kee, 2012b; Cieslak et al., 2013; Hinderer et al., 2014). Nursing courses and continuing education programs do not mandate instruction identifying predictable biopsychosocial responses to occupational stressors, or supportive programs to reduce negative outcomes (Adriaenssens et al., 2011; Macomb Community College, 2014-2015; St. Clair County Community College, 2015; Wayne State University, 2015). This study may contribute to academic and professional nursing knowledge by addressing health-promotion for practicing nurses and informing educators of developments influencing nursing education trends within the health care landscape (Rosenstein & Naylor, 2012).

The culture of support and healing for emergency nurses will not materialize without active social change intention and effort.

Guiding Questions

Research focusing on the negative outcomes from vocational exposures to traumatic stress is ubiquitous across the landscape of emergency services' professionals and is progressing slowly into emergency nursing. Researchers publishing studies linking cause and effect relationships recognize the important and static element of OTS exposure and the possibility of negative biopsychosocial and professional outcomes for nurses. Deficient in coping and resilience strategies to mediate exposures to occupational trauma, nurses may fall into dysfunctional tactics like abusing alcohol and drugs. Nurses' maladaptive coping strategies may also result in adverse outcomes of CF, an inability to think clearly on the job to perform work functions, and burnout.

Some nurses flourish in the midst of trauma and chaos, experiencing posttrauma positivity and CS. Examining whether the coping skills of ED RNs are inherent or learned assists with using that knowledge to teach nurses how to become more resilient. Literature documenting that coping mitigates the negative appraisals and dysfunctional outcomes of vicarious traumatizations is universal. The missing element may be to understand the source of nurses' positive strategies and whether those tactics were innate or learned through training or observation. Using a qualitative study to gather nurses' input about the impact of occupational trauma on ED RNs not educated in coping and resilience strategies may assist in forming an action plan for addressing the local gap in practice: a deficiency in ED nursing coping and resilience training programs.

Guiding questions:

1. What are ED RNs' experiences with occupational traumatic stress for RNs who have not received coping and resilience education?
2. How might nursing education professional development programs be changed to assist ED RNs with occupational traumatic stress?

Review of the Literature

A literature review included studies I retrieved from EBSCO Host, ERIC, ProQuest Central, PsycARTICLES, and SAGE. Library searches about PD and nursing education, and materials from trauma psychology and emergency mental health professional journals augmented the literature review. Keywords included *emergency nursing*, *occupational trauma*, *coping, resilience*, *burnout, secondary traumatic stress, posttraumatic stress*, *self-efficacy, experiential learning*, and *vicarious traumatization*. The literature review separated into five sections: the studies' theoretical framework, information about coping and resilience education available for student and practicing nurses, the impact on nurses without formal coping and resilience course work, data from related occupations, and benefits of coping and resilience training for practicing nurses.

Theoretical Framework

The theoretical framework for this study included social learning theory (SLT) and experiential learning theory (ELT). Bandura and Jeffery (1973) and Bandura (2012) described SLT as knowledge that comes through cognitive processes by way of observations, environmental influences, experiences, and individual perceptions. Intertwined with SLT is Kolb's ELT, based on the work of John Dewey, a holistic model

expanding upon cognitive-behavioral learning theories whereby knowledge derives from transforming experiences, incorporating feelings, learning, and behavior (Finch, Peacock, Lazdowski, & Hwang, 2015; McDermott, 2012). Conceptualizations of events may be concrete or abstract, contributing to the idea that vicarious experiences, positive or negative, are a dimension of learning, connecting with and building upon prior incidents (McDermott, 2012). Finch et al. (2015) emphasized that ELT is a leading framework for studying the conversion of experience into learning. Hinshaw, Burden, and Shriner (2012) echoed the importance of modeling and social interactions, reflecting Bandura's concept of attention, retention, reproduction, and motivation for learning.

Bandura (2012) focused on observations more than imitating behaviors, as information acquisition can occur vicariously. Bandura and Jeffery (1973) provided early support for the relationship between vicarious observation and vicarious traumatizations, which may connect observational learning with the unintended consequences of STS. Nurses learn from other nurses through a *see one, do one, teach one* process bundling learning with meaning making (Bandura, 2012). The power of SLT can emerge in undesirable ways such as when the strength of witnessed behaviors, cognitively incongruent to the observer, may overshadow individuals' value systems and influence engagement in negative, attitude-discrepant activities (Bandura, Ross, & Ross, 1963).

Nurses derive satisfaction from their professional identification, academic accomplishments, and clinical competencies intrinsically and outwardly enmeshed in the meaning attached to their professional roles (Bandura, 2012; Johnson, Cowin, Wilson, & Young, 2012). Reflective of SLT, ED RNs partake in a community of practice through

shared interactions within a constantly changing environment (Adriaenssens et al., 2011). Experiential learning theory incorporates the challenge of discerning social influences and relevancy through discovering the tethers between past and present issues (McDermott, 2012). Making a distinction between routine, mechanical skills and conscious thinking and reasoning, nurses use ELT as an integrative process, a cornerstone of problem-based learning (Finch et al., 2015; Kantar, 2014; McDermott, 2012).

The qualitative case study approach permitted an in-depth examination of nurses' thoughts, feelings, and stories through the social and experiential learning frameworks of Bandura and Kolb. This study did not veer fully into Bandura's (2012) incorporation of personality and self-efficacy, as those concepts are too broad for this segment of research. Understanding nurse perspectives about resilience and coping linked Bandura's (1973) powers of observation, cognitive rehearsal, and processing of observations to the nursing education and practice. Experiential learning was used in the context of a bounded system of ED RNs, noting a critical component of experiential learning: making meaning of experiences (Merriam, Caffarella, & Baumgartner, 2007).

An alternative consideration, behavioral learning theory, relates to imitating skills, yet requires positive or negative reinforcement for learning (Weiten, 2008). In contrast to behavioral learning, which extinguishes in time without reinforcement, observational learning remains in memory (Bandura, 1973; Todd, Vurbic, & Bouton, 2014). Freire's methods of learning fall short of addressing the interaction between nurses, though students may perceive nursing preceptors as omniscient (Merriam et al., 2007). The banking education method suggested by Freire also fails for new nurses lacking coping

strategy education, as neither inexperienced nor experienced nurses respond effectively to problem-posing education if unaware of existing problem-solving strategies (Merriam et al., 2007). Therefore, the combination of experiential and social learning theories connects best with investigating the effect on ED RNs without resilience and coping training.

Coping and Resilience Education for Nurses

The paucity of literature about coping and resilience course work for ED RNs led to examination from related perspectives. Documenting the shortage of training programs for ED RNs began with noting the same coping and resilience education gap with student nurses. Without formal coping and resilience curricula, nursing students learn of professional skills toolkits that suggest incorporating coping concepts but fall short of teaching them (Adam & Taylor, 2014). Williams (2012) introduced the connection between emergency responders and nursing education, proposing combining them in courses for those caring professions sharing traumatic occupational exposures. Pines et al. (2012) found a correlation between students' resiliency and empowerment, suggesting coping education as a way to increase resilience for negotiating students' clinical and workplace stressors. When students become practitioners, their absence of coping strategy education can persist by forming a divide between optimal and actual competencies (Meretoja & Koponen, 2012).

Once nurses are engaged in professional practice, Meretoja and Koponen (2012) noted the importance of establishing continuing coping strategy education. In a study of Australian nurses, Drury, Craigie, Francis, Aoun, and Hegney (2013) acknowledged the

need for nursing stress management courses while conceding the shortage of resources to mandate those activities. A deterrent beyond organizational resources is an unwillingness of nurses to participate in training outside of paid hours (Drury et al., 2013). Acknowledging the sacrifice of private time necessary to engage in continuing education, nurses in a Delphi study either accepted the critical importance of engaging in training or failed to take personal responsibility to participate (Brekelmans, Poell, & Wijk, 2013). Nurses need the support and encouragement of employers and nurse educators to embrace, participate in, and prioritize continuing education courses and coping strategies training as an adjunct to skills maintenance (Brekelmans et al., 2013).

In response to work stressors, nurses lacking effective coping strategies are the most likely to leave nursing and move on to other occupations (Wu, Fox, & Adam, 2012). Research has shown that 18-50% of new nurses leave their jobs or the profession within the first year (Wu et al., 2012). Glynn and Silva (2013) emphasized the significance of role model preceptors for new ED RNs to increase retention during the transition between academics and practice, encouraging coping training for ongoing practice. Mosadeghrad (2013) and Hegney et al. (2013) urged psychosocial capacity building and training nurses in effective coping strategies, noting job stress and coping inabilities as contributory to nursing possessing the highest professional turnover rates.

Resilience and Coping Training Impact on Nurses

The influence on practicing nurses not educated in resilience and coping strategies is complex, reaching beyond patient care, job satisfaction, or turnover. ED RNs are part of a professional culture that has long claimed immunity to vicarious traumatizations,

creating a likelihood of social withdrawal and self-destruction rather than seeking support or discussing inner conflicts (Prati et al., 2011). Although ED RNs may possess some level of inherent resilience attributes, traumatic exposures' effects are cumulative and can overwhelm existing coping mechanisms (De Villers & DeVon, 2012; Healy & Tyrrell, 2011; Schwabe, Dickinson, & Wolfe, 2011). Requesting help is psychologically incongruent, carrying a negative stigma that encourages maladaptive strategies like overeating, drinking, and social withdrawal (Chan et al., 2012a, Healy & Tyrrell, 2011; LeBlanc et al., 2011; Pich, Hazelton, Sundin, & Kable, 2011).

Studies support that ED RNs repeated occupational exposures to death and violence place them at risk for STS (Cieslak et al., 2013; LaFauci Schutt & Marotta, 2011). Emergency nurses also have a 3.5 times greater likelihood of misusing drugs than other nurses (Healy & Tyrrell, 2011). Impaired performance can present through compromised cognitions and behaviors, like an inability to calculate drug dosages or provide cardiac resuscitation (LeBlanc et al., 2011). When coping mechanisms fail, emotional disequilibrium contributes to dysfunctional strategies, helplessness, and perpetuating failed coping (De Villers & DeVon, 2012; Por, Barriball, Fitzpatrick, & Roberts, 2011; Rosenstein & Naylor, 2012).

Nurses may exhibit PTS symptoms like emotional withdrawal, avoidant coping, CF, and burnout (De Villers & DeVon, 2012; LeBlanc et al., 2011; Vogel, et al., 2013). Risk factors that influence or contribute to PTS include prior distress, subjective interpretation, and absence of situational control (Frazier et al., 2011). Due to their traumatic exposures, nurses may develop intrusive recollections, numbing, avoidance of

stimuli, persistent increased arousal, symptom duration of more than one month, and clinically significant distress (U.S. Department of Veterans Affairs, 2015).

Healy and Tyrrell (2011) reported that ED occupations encourage poor sleep, increased absenteeism, and staff turnover. A more insidious cause of nurses' negative coping is empathetic engagement when they know or identify with victims of trauma, increasing vulnerability and amplifying levels of posttraumatic stress (Kirby et al., 2011). Adding a biological perspective to the psychosocial elements, chronic sympathetic nervous systems' fight or flight stress hormones secondary to traumatic stress exposures may promote pathology (Schwabe et al., 2011). An endorphin link between stress and addictions may surface among those using chemicals to cope (Schwabe et al., 2011).

Little information is available as to how emergency nurses assess or interpret traumatic stress, or what coping strategies they have developed or learned (Hayward & Tuckey, 2011; Meadows et al., 2011). When high-stress environments impair nurses, the results can be devastating as nurses battling STS while trying to care for themselves cannot adequately care for others (Healy & Tyrrell, 2011). For nurses without coping and resilience training, avoidance is a common reflex, a temporary buffer that often fails (Dasgupta, 2012; De Villers & DeVon, 2012). Task-focused coping can be adaptive during the trauma, but problematic if that dissociation continues (Kirby et al., 2011; Vashdi et al., 2012).

Context is another factor, as coping strategies used by ED RNs may not mirror those used by other nurses (Eley & Eley, 2011; Kirby et al., 2011). Contextually examining nurses' perceptions of responding to trauma includes the gamut of trauma

detachment, rumination, gallows humor, cognitive reframing, self-help coping, resiliency, optimism, humor, and adaptive coping strategies (Kirby et al., 2011; Prati et al., 2011; Westwood & Johnston, 2013). The types of coping strategies nurses use influence their posttrauma recovery (Bonanno et al., 2011; Kirby et al., 2011). Studying nurses' resilience and coping practices informs educators' choices for training course content.

Benefits of Resilience and Coping Training for Nurses

Researchers' findings in the literature indicate that coping skills assist with mitigating negative appraisals of serious events (Buurman, Mank, Beijer, & Olff, 2011). Adaptive coping skills permit nurses to manage cognitive appraisals and behavioral responses with problem-focused or emotion-focused tactics (Lavoie et al., 2011). Bonanno and Mancini (2012) veered away from psychopathology to relate inherent coping skills and resilience with positive and adaptive trauma exposures. Cieslak et al. (2013) related self-efficacy and perceived environmental control with mastery over the challenges of STS, a more adaptive view for coping with occupational trauma.

Everly et al. (2008) and Mealer et al. (2012) correlated resilience, coping skills, hardiness, and emotional intelligence as protective and positive for successful coping. Problem-focused coping relates to a decrease in psychological distress, emotional exhaustion, burnout, and conversely a higher sense of accomplishment (Adriaenssens, De Gucht, & Maes, 2012; Adriaenssens, De Gucht, & Maes, 2015). Meyer et al. (2012) suggested that some workers exposed to occupational trauma possess an intrinsic resilience influencing and moderating the severity of maladaptive responses.

Providing training with a focus on resiliency and preparation instead of reaction and burnout is crucial to health promotion (Schmitz et al., 2012). Noting the cumulative and debilitating occupational exposures of ED RNs, Flarity, Gentry, and Mesnikoff (2013) studied the effectiveness of an education program to increase CS and decrease CF. Results of the 4-hour training showed significant positive outcomes for CF symptom resolution, suggesting its value in nursing training and retention (Flarity et al., 2013). Following an integrative, holistic 8-week educational program, health care participants reported significant reductions in stress and increased confidence in coping self-efficacy (Tarantino, Earley, Audia, D'Adamo, & Berman, 2013). A 5-week CF intervention program for nurses showed reductions in STS scores immediately after the program with statistically significant reductions 6 months afterward (Potter et al., 2013).

Other educational models include training in resilience and coping strategies outside the mainstream of nursing education. Accelerated Recovery Program (ARP) and Mindfulness-Based Stress Reduction (MBSR) emphasize wellness, self-care, and coping strategies (Wentzel & Brysiewicz, 2014). A comprehensive crisis intervention model used successfully by emergency responders and recommended for nursing training by Blacklock (2012) is Critical Incident Stress Management (CISM), an adjunct training option addressing preparatory and posttrauma exposure programs. Problematic within these choices outside nursing education is their requirement for personal funding, as professional occupational structures normally do not supplement nursing continuing education beyond what institutions require for employment.

Trauma psychologists and crisis interventionists have suggested ways of dealing with trauma exposure and STS, but those strategies have not become standardized within nursing education (Prati et al., 2011). Contributing to the need for identified and systematized coping strategies is the fact that the trauma psychology model is comparatively new (Rocchio, 2010). The contributions of trauma psychology have not infiltrated into education, the nursing perspective of coping with occupational trauma has not penetrated into research, and applicable findings have not been adopted within nursing practice. These gaps punctuate the challenges for nurses lacking formal resilience and coping training.

The challenges of dealing with OTS without formal coping skills training are not limited to ED RNs and occur in similar occupations like firefighters, emergency responders, and emergency physicians (Jahnke, Gist, Poston, & Haddock, 2014; Kirby et al., 2011; Schmitz et al., 2012). A pilot study by Sood, Prasad, Schroeder, and Prathibha (2011) concluded that a brief training to enhance resilience and decrease stress with a Stress Management and Resiliency Training (SMART) program offered options for another group who experience occupational stress. Emergency responders have used posttrauma interventions for years, however, preventative and preparatory training for resilience, stress inoculation training, and addressing how individuals process stress are comparatively new (Cornum, Matthews, & Seligman, 2011; Hourani, Council, Hubal, & Strange, 2011a). A similar group, emergency responders, has followed the military by adopting the CISM or the United States Air Force (USAF) models of crisis intervention (Jahnke et al., 2014; USAF AFI44-153, 2014).

Related Occupations

Literature documenting problems in the emergency responder population regarding the paucity of preparatory resilience and coping strategies predates examination of the same problem within nursing. Emergency responders' occupational exposures to trauma, empathetic engagement, and vicarious traumatization have long generated a need for adaptive coping strategies (Miller, 1995; Mitchell & Bray, 1990; Palm, Polusny, & Follette, 2004; Regehr, Goldberg, & Hughes, 2002). Mitchell (1983) first published findings of responders' maladaptive coping in response to occupational trauma and the need for symptom mitigation over 30 years ago. An exploration into responder support systems, perceptions, and resilience factors opens a coffer of data that has shifted focus from maladaptive post-incident response treatments to adaptive preparedness and coping strategies (Everly et al., 2008). Approaching responders from a health-promotion construct provides entry into closed professional systems that may otherwise reject the suggestion of psychological coping strategies (Blaney, 2009; Miller, 1995).

Researchers' findings in the current literature support introducing resilience and coping training, steering away from the medically driven models of psychopathology and toward health promotion for addressing occupational stress exposures (Benight, 2012; Kirby et al., 2011). Education specific to the responder population, whose stress-response inclinations similarly align with my own as a paramedic and ED RN, shows promise through resilience and coping training programs (Salters-Pedneault, Ruef, & Orr, 2010; Schiraldi et al., 2010). Congruently, researchers examining occupational trauma exposures in the medical profession are also beginning to scrutinize resilience training

and coping education for physicians (Howe et al., 2012; Schmitz et al., 2012). The controversy lies within organizational support for ED RNs and other health care professionals for resilience and coping education programs.

Implications

The local ED had no education programs to address nurses' coping skills or the after-effects of OTS exposures. Findings from this study may attend to the knowledge gap, providing a PD project direction intended to inform nurses, educators, and managers of methods to address and possibly mitigate the effects of OTS. The ED management might benefit from findings identifying staff needs and perspectives as managers cannot take action without problem awareness.

Nurse educators could gain direction for PD training programs by combining existing data with study findings. Staff nurses could benefit from PD tailored to their needs mediating dysfunctional outcomes of negative assessments, enhancing the positive resilience benefits for compassion satisfaction. Study findings may also direct attention to resilience and coping, encouraging professional discussion.

Throughout the literature, coping and resilience training show promise for mitigating the negative biopsychosocial outcomes secondary to traumatic occupational exposures (Attia et al., 2012; Prati et al., 2011). Awareness of coping strategies can inform educators by combining literature knowledge with study results, revealing how participants' deficit in resilience and coping training may impact nurses and nursing practice (Bonanno & Mancini, 2012). There are three primary styles of coping used in responding to work-related exposures to trauma. Task-focused coping is the most

positive and adaptive, as nurses who bear some sense of situational control concentrate on duties, skills, and procedures to try to moderate stress (Vashdi et al., 2012).

Emotion-focused coping is a strategy using concentrated efforts to manage emotional reactions and maintain equilibrium, like using the fallback mechanism of gallows humor to distract from the trauma (Mesmer-Magnus, Glew, & Viswesvaran, 2012; Vashdi et al., 2012). The third strategy is avoidance-focused coping, employing efforts to distance from the emotional threats and reality of the situation, like using alcohol or overeating, post-exposure strategies employed by some participants (Vashdi et al., 2012).

Summary

Involvement in hazardous and traumatic events is part of the fundamental experience of ED RNs with the predictability of outcomes in its infancy and certainty of coping strategies elusive (Kirby et al., 2011). Contributory causes of negative outcomes include occupational exposures to horrific events, deficiency of an optimistic coping style, engaging emotionally with victims, and lacking adequate support resources. Problematic and maladaptive behaviors related to these causes add to enduring patterns of pathological after-effects (Kirby et al., 2011; LeBlanc et al., 2011). The data remind that nurses do not necessarily possess the inherent resilience or coping skills to handle extreme circumstances, and the destructive consequences of maladaptive coping strategies are ubiquitous (Adriaenssens et al., 2011).

Nurses are often unprepared to cope effectively with trauma exposures, and seeking help may be discouraged or not considered because of the stigma attached to

counseling, or inferences of reduced competency (Cieslak et al., 2013; Von Rueden et al., 2010). Many ED RNs leave nursing for other professions due to CF and burnout (Harkin & Melby, 2014). However, there is merit in surfacing research promoting the concept of resilience and coping as learned competencies, encouraging educational program development. Embracing resilience and adaptive coping strategies as health constructs may reframe perceptions of occupational trauma exposures by discarding the notion that all exposures result in pathology (Benight, 2012; Howe et al., 2012). The confounding relationship between trauma and coping remains a point of interest and ambiguity as nurses continue to experience CF or CS following occupational exposures to trauma (Cieslak et al., 2013; Hinderer et al., 2014; LaFauci Schutt & Marotta 2011).

Documenting the need for education in resilience and coping strategies brings attention to the importance of training nurses to manage traumatic occupational exposures. The gap is evident in the unanswered and mostly unaddressed question of how to implement those training programs into practice. As studies focus on the pathology occurring without occupational stress mediation efforts, another gap arises amid CF and CS. Further research is necessary to examine why some nurses exposed to trauma suffer negative biopsychosocial effects, while others flourish with similar challenges, experiencing job satisfaction. Taking the research into why nurses react as they do, understanding personality traits, training, environment, and support may guide educators toward mitigating the effects of vicarious traumatization.

In section 1, I documented a local problem, definition of that problem, rationale, pertinent definitions, guiding questions, and review of the literature. Noted were

implications of not having the training to mediate negative outcomes from STS, as were the mediating factors of programs addressing resilience and coping strategies for nurses. Bandura's SLT and Kolb's ELT provided the theoretical framework for the proposed study as observational and experiential learning shape the culture, practice, and insight of ED RNs. Implications for positive social change within the ED nursing community include understanding and mediating the negative effects following occupational exposures to traumatic stress, enhancing nurses' resilience, introducing more adaptive coping mechanisms, and introducing knowledge useful to ED managers and educators.

In section 2, I attended to the research methodology and focused on the design and approach, criteria for participants, sample size, and setting. The ethical protection of participants received attention intended to protect nurses' privacy and rights. I addressed the role of the researcher, professional experience, and bias. Data collection strategies, storage, participant interview information, aligning the guiding research questions and interview questions received consideration. Presenting the results of data analysis through coding and themes led to the development of the PD program in Section 3.

Section 2: The Methodology

The purpose of this study was to investigate what impact OTS had on ED RNs who lacked coping and resilience training. Seven nurses from a trauma center ED participated in interviews regarding their perspectives about OTS exposure effects on nurses lacking resilience and coping education. Data collection consisted of transcribed audiotaped interviews that were coded and analyzed to build descriptions and themes. Outlined in this section is the framework for research design, approach, rationale, participants, data collection, and analysis, aligning with guiding and interview questions, and describing the project deliverable.

Qualitative Research Design and Approach

Creswell (2009) described qualitative research as the systematic investigative process used for understanding what meaning individuals attribute to human or social problems using a framework of worldviews, inquiry strategies, and methods. This case study design included probing, open-ended questions and an inductive reasoning process for in-depth inquiry into real-world events and experiences (Bogdan & Biklen, 2007; Crowe et al., 2011). Audio-recorded one-on-one interviews with ED RNs provided data in response to the problem and guiding questions. Summaries and analysis of that data helped support and determine the direction of the project deliverable.

Rationale for Research Design

Creswell (2009) included worldview as a component of the research process. Social constructivism assumptions that people create subjective meaning from their background and experiences relate to this study's context, culture, and participants. The

qualitative constructivist concepts link to the multiple valid realities erected within individuals' minds instead of from points external to them (Kantar, 2014). Constructivism is used to explore nurses' experiences as self-created, within a social reality, context, and community of ED RNs (Kantar, 2014). Because the research occurred within a bounded, defined group of participants, the intrinsic case study design was suitable (Creswell, 2012). The study event was the lack of resilience and coping training for ED RNs. The setting was a trauma center ED.

The analyzed results of this intrinsic case study provided a detailed exploration of the bounded system of ED RNs separated from the public by their specific occupational experiences and responsibilities (Creswell, 2012). Through one-on-one interviews, seven ED RNs provided rich narratives about the impact of OTS on nurses lacking resilience and coping training. Incorporating qualitative research into nursing practice helps to identify contextual, relevant nurse issues, and capturing RNs' experiences with OTS may assist in improving nursing practice outcomes (Leeman & Sandelowski, 2012).

Other approaches did not suit the problem, guiding questions, or culture and context of ED RNs. For example, narrative research is a storytelling strategy that follows one or more individuals, addressing the meaning of their experiences (Creswell, 2012). Another consideration was phenomenological research, which requires prolonged engagement with participants around a particular event (Creswell, 2009). The grounded theory strategy is used to generate a general theory based on the data to explain a process of events over time instead of focusing on an education problem (Creswell, 2012).

Action research was not appropriate because this study did not involve participants in the research process (Merriam, 2009). A quantitative approach would not have permitted an in-depth exploration into the expressed thoughts and feelings of the ED RNs. Rather than making systematic comparisons and generalizations, as with quantitative studies, the desire was to illuminate perspectives and meanings of the participants in their words (Bogdan & Biklen, 2007). The scope of time and resources necessary to collect and analyze quantitative and qualitative data removed the mixed-methods design from consideration for this study (Creswell, 2009).

Participants

In qualitative research, the most often used procedure to gain appropriate and amenable participants is purposeful sampling (Lodico, Spaulding, & Voegtle, 2010). The type of sampling for this study was a nonprobability snowball sampling. Identifying RNs, who met selection criteria, began with a single nurse, which led to connecting with other nurses through word of mouth referrals (Lodico et al., 2010). Access to the sample population was limited to recruitment through flyers and communication with those nurses through telephone and e-mails. Considering and respecting the closed culture of ED RNs, referrals came through participants' trust of their cohorts.

Criteria and Justification for Participant Selection

Inclusion criteria. Participants were eligible based on the following:

- RNs without training in resilience and coping strategies,
- fully-licensed RN,
- currently employed as an ED staff nurse at the research site,

- at least 1 year of ED experience as a registered nurse,
- age 21 or older,
- ability to respond to interview questions and available for interview, and
- willing to sign an informed consent.

Exclusion criteria. Participants were ineligible for this study based on the following:

- nurses with less than 1 year in the ED as a RN, even if transferring from a different department at the research site, or ED experience in a different professional capacity and
- nurses on orientation or probation.

More experienced RNs receive higher acuity patients. New nurses may not have appreciated the problem and purpose of the study, as they did not have full trauma exposure. Demographics included a diverse nurse population representative of the locale, a minimum education of associate's degrees in nursing, and no exclusion for age, gender, race, ethnicity, religion, socioeconomic status, disability, sexual orientation, gender identity, or shift worked. Understanding the impact of nurses' occupational trauma, coping, and resilience required RNs with shared ED experience.

Setting

The setting for this study was a Level II trauma center. The nurses were skilled professionals trained in multiple levels of trauma intervention to treat critical and high acuity patients. Trauma center nurses have specialized emergency experience and training with mandated advanced cardiac life support and trauma certifications.

Procedure for Gaining Access to Participants

A nurse employed at the research site connected me with the ED director of patient care services (DPCS). After expressing interest in the goals of the study through telephone and email exchanges, the DPCS agreed to sponsor the study and advised me to contact corporate headquarters (HQ) for formal permissions. Corporate HQ required formal sponsorship and a gatekeeper to interview the ED RNs. The corporate manager at the center for innovation and research expressed interest while admitting the organization had never entertained a nonemployee, nonclinical study. After consulting with the human research protection programs' (HRPP) operations and administrative staff, the corporate institutional review board (IRB) analyst outlined requirements necessary to use any of their facilities for research:

- supply corporate headquarters with the name of an employee at the research site who will act as a sponsor (gatekeeper) for the study;
- formally request access to their e-Protocol for electronic submissions;
- review the corporate HRPP manual and all HRPP website materials to familiarize with corporate processes;
- complete the corporate IRB request for determination of nonhuman subjects form;
- contact the site's human resources vice president to notify of intent;
- complete specific course work modules through the Collaborative Institutional Training Initiative (CITI) to satisfy training requirements for social and behavioral research with human subjects

    - CITI training ID 4565301, completion ID 14846901, 01/26/2015
- ask my committee chair to complete the same CITI training modules to satisfy the IRB research requirements;
- inform the IRB analyst upon completion of mandated CITI courses by myself and my committee chair; and
- use the corporate IRB for project approval (before Walden's IRB)
    - corporate IRB expedited review approved without stipulation, protocol: 2015-00081, approval period 09/15/2015 - 08/31/2016
    - IRB approval included the corporate consent form, data collection form, corporate protocol document, study flyer, and gift-card letter
    - Walden IRB approval to conduct research: 10/01/2015 approval number 08-21-15-0291629.

All permissions and communications were processed through the organization's IRB representative, who wrote upon completion of the stipulations, "All we require now is that you conduct your study in the manner in which you submitted, using the materials we approved" (J. R., personal communication, October 5, 2015).

Permissions then transitioned to the DPCS, who supplied the formal letter of cooperation granting permission for access to participants and facility use. The DPCS assigned as gatekeeper the ED clinical manager (CM). The ED CM accepted a packet of flyers for distribution to the nurses, saying she would post them in the break room for 21 days, a limitation specified by the DPCS. The ED CM denied access to speak to or e-

mail the ED RNs directly. The ED RN interviews occurred on the site before and after shifts, and through video conferencing during off-duty hours.

Sharing my status as a peer ED RN served to cultivate a rapport and relationship with the ED RNs. I informed them of my experience as a trauma nurse at another local trauma center, relating that I had a basic understanding of their jobs but would not bias what they told me with my views or opinions. Addressing privacy concerns of the participants, I described the purpose of the study, advising of the study practice for de-identifying participants and disguising identities and information. I emphasized the need for their perspectives to help solve a problem and add to nursing knowledge and practice. Establishing a calm atmosphere and showing genuine concern for and interest in the participants contributed to a positive relationship.

Sample

In qualitative research, the sample size is not predetermined and usually includes just a few individuals (Creswell, 2012). This study included interviews of seven RN key informants based upon sample sizes used in similar qualitative studies (Drury et al., 2013; Glynn & Silva, 2013; Hayward & Tuckey, 2011; Lavoie et al., 2011). Meeting the original goal of 10 participants became problematic when the ED CM denied direct access to the ED RNs in opposition to the DPCS's original plan of allowing short presentations in the ED break room. The lack of awareness of the study, work schedules, and time-limited recruiting delayed and possibly diminished nurses' participation. Despite the challenges, the information gleaned from the seven interviews was sufficient,

and participant sampling was terminated upon redundancy when no new relevant information emerged (Creswell, 2012; Merriam, 2009).

To meet the qualitative research goal of providing an in-depth understanding of a specific group, the purposive samplings included participants who met the criteria of experienced trauma center ED RNs. The snowball sampling method was appropriate for this group of participants because of the ED RNs' closed culture and hesitancy to speak to outsiders. My introduction by nurses' cohorts, and their enthusiasm for the opportunity to participate in the study, also assisted in the process of establishing open communications and positive relationships.

Ethical Protection of Participants

Ethical treatment and protection of participants followed the IRB process as outlined within the site's corporate HRPP and the Walden University center for research quality (Walden University, 2015). The ED clinical manager acted as the site gatekeeper ensuring privacy and protection of participants, exercising the authority to restrict premises access, so I did not go beyond private rooms designated for interviews (Creswell, 2012). Preserving patient confidentiality, I did not enter treatment areas.

De-identification of the research site and participants provided anonymity to the organization and staff. The corporate IRB liaison received assurance that the study was concerned only with nurses' thoughts and feelings about resilience and coping. During interviews, nurses received reminders to keep identifying elements out of their stories.

The IRB liaison also received assurance that only I would know the identity of the nurses interviewed, and no one else would have access to interview data. I used the

snowball sampling recruitment method for ED RNs for distribution of my contact information to other ED RNs. As those interviews happened in private areas outside of the ER, no one observed interactions to identify participants.

The organization's IRB staff reviewed and approved the research proposal and my IRB application. The organization's HRPP maintains a process separate from Walden University to ensure participants' protection from harm and confidentiality of data (Lodico et al., 2010). Completing IRB applications and continuing to communicate with the organizational HRPP and IRB staff helped to prepare for ethical considerations from the vantage point of the researcher, research site, and Walden University. I was appropriately qualified and supervised in all methods of data collection. My CITI training certifications appear on the organization's electronic HRPP records, and my researcher training certification number from the National Institute of Health is 1496942, issued June 30, 2014.

Recruitment occurred in a noncoercive manner using the snowball method, with willing participants passing along fliers containing my contact information to other ED RNs. Because I worked in the same geographical area as a paramedic and trauma nurse, though not at this hospital, some participants were familiar with my name. We also had friends in common, a loose association that did not affect the researcher-participant relationship. I held no position of authority or influence over the study participants.

The study did not include vulnerable populations of students, patients, the researcher's subordinates, children, prisoners, facility residents, emotionally disabled, or mentally disabled participants. No known pregnant women participated, and data

collection presented minimal risk or demands. Screening for vulnerable populations, like those who may be pregnant, facility residents, mentally or emotionally disabled, elderly, or victims of crisis would be invasive. Participants knew that if they became uncomfortable discussing coping and resilience skills about occupational trauma exposures, they could self-exclude. Those nurses would have been treated respectfully and released from the study without stigma, though none chose to terminate.

Ethical considerations continued throughout data analysis and interpretation. Participants received a review copy of the consent form along with a letter of introduction three days before the interviews. All participants signed a hard copy of informed consent before interviews, with copies of those documents mailed to them via the United States Postal Service (USPS). The interviews began after receiving permissions from the organization's and Walden's IRBs.

Participant identifying labels arranged in a random order of letter and number combinations for privacy. The key connecting the labels with identifying information was locked in a cabinet accessed only by me. Written transcriptions of interviews remain in that locked cabinet. The participant labels appear in the research findings.

Each interview began with a reminder that information shared should remain private. The element of respect for persons included explaining details of the study, time involvement, data collection procedures, and potential risks of sharing thoughts and feelings. The risks and burdens were reasonable given the benefits of research and low potential for harm to participants. Plans included methods for handling adverse outcomes

from questions instigating traumatic memories (Lodico et al., 2010). We discussed resources if talking about coping triggered the need for intervention, which did not occur.

Role of the Researcher

Before attending nursing school, I spent many years on the road as a paramedic encountering pre-hospital OTS. As a trauma nurse, I faced similar occupational critical incidents. The different ways in which paramedics and nurses bounced back or suffered ill effects of OTS, thriving under the pressure or dissociating from the pain, appeared inconsistent and unpredictable. Over the years, I have developed coping methods and assumed that other nurses had inherent or learned resilience. By watching nurses who did not cope well during and after encounters with death and dying, harm to children, or severe physical trauma, it became apparent that we differed in resilience and coping skills. The constant factor: resilience and coping skills training was not included in my nursing education or PD, and they are not taught in nursing school or PD today.

Those who attend to the health and well-being of others, like paramedics and nurses, often fail to self-recognize STS symptoms. My focus for several years has been working with emergency responders and nurses using peer-support PFA following OTS exposures. However, I have not held any professional role nor have I any professional relationships with the study participants, and my function was as a student researcher, not crisis interventionist or RN. My employment as a trauma nurse was in a major city in the same state as the research site, but not the same organization. No professional interaction occurred with study participants to affect data collection. Nursing peer support interest

could bear influence, requiring awareness, checking, and review to avoid skewing data collection and analysis through the imposition of my beliefs and experiences.

Biases include loyalty and protectiveness toward other trauma nurses, so research occurred at a hospital with which I was not associated to avoid conflicts of interest. My values include high ethical standards, respect for participants' autonomy, and goals of working toward the greater good of ED RNs, which promoted objective data collection and analysis. My role as researcher required remaining separate and neutral from the role of the trauma nurse to avoid suggestive questions that might have influenced participants' responses (Lodico et al., 2010).

Data Collection and Storage

Data collection began after obtaining permissions from the organizational IRB and Walden University IRB. I reviewed privacy specifics with participants before they signed consent forms, and they received copies via USPS. Each ED RN received assurance of secure data storage and removal of all identifying facts. Participants' phone numbers and e-mail addresses, secured with consent forms, were kept for member checking. Qualitative data came through face-to-face semi-structured interviews using high-quality audio data-recording equipment (Lodico et al., 2010). I conveyed to participants the intent of summarizing ideas from interviews instead of using lengthy quotes for their anonymity. All participants verbalized understanding.

Within 24-hours of each interview, I manually transcribed and then deleted from my recording device each audio recording per the organization's HRPP requirement. The verbatim transcriptions were typed using double-spacing and wide margins to permit

hand-scribing on the printed transcripts thoughts, auditory cues, and observations, like "[inappropriate laughing]" or "[sudden stuttering]" when participants spoke of difficult situations. I had purchased a transcribing software program but found that the time spent reviewing the interviews while transcribing them provided a much richer understanding of subtleties, like a nervous giggle.

After each interview, I began the first cycle of coding by forming an excel sheet into a cross-grid listing participants and interview questions. Coding is an interpretive process of systematically ordering and classifying by word or phrase to capture the essence and attributes of qualitative data (Saldana, 2013). I summarized participant responses into topics and short phrases through descriptive coding methods. Combining three compatible first cycle methods, Descriptive Coding, In Vivo Coding, and Emotion Coding, I reviewed each interview, making notes to gain summary labels and a topic inventory (Saldana, 2013). Codifying and categorizing the data, I continually checked the codes against my rules of inclusion.

Detailed field notes, taken on preformatted sheets detailing date, time, and personal identification labels for interview enhancement, were summarized on a research log (Creswell, 2012). Pre-interview notations included dates and times of contact with each potential participant, comments from our conversations, method of interviews, and any special requests, like meeting places. Checklists tracked sending or receiving consent forms, ensuring that I met the required three days for consent consideration, sending gift cards, and member checking data. A potential participant who contacted me,

excluded as he was no longer in ER, was sent a gift card for volunteering, as per my agreement with the organization's HRPP.

Notes included physical setting descriptions, participants' body language, emotional reactions, and researcher perceptions during the interview and reflections after the process (Merriam, 2009). Written data, including the key linking nurses' names with participant labels, and signed consents, remain locked in a secure cabinet with access limited to me. Storing data in locked files minimizes links to participants' identity (Creswell, 2012). Per the organization's HRPP policy, research data will be destroyed after five years (Carlson, 2010; Walden University, 2015).

Interview Procedures

On-campus private rooms for one-on-one interviews helped avoid viewing of participants by other employees. Even though focus groups help to gain insight into perceptions, individual interviews were preferred to gain in-depth input without the distraction or influence of other nurses (Lodico et al., 2010). The essential strength of one-on-one interviews emerged through flexible interaction and questioning, revelations of nurses' unique perceptions, and gaining interpretations of meaning from nurses' experiences (Creswell, 2012; Merriam, 2009). The first participant encouraged other nurses' participation and shared recruiting flyers. Nurses communicated with me via e-mail and phone to review details of the study, the process, and set up interview times.

In addition to signing consent forms, each participant verbalized consent for the interview and audio recording before we began. For the 30-45 minute semi-structured interviews, I used bias-reduced language, inductive interviewing, probes, and follow-up

questions (Lodico et al., 2010). The process involved a researcher-developed interview protocol (Appendix B), beginning with icebreaker questions to help participants relax (Lodico et al., 2010). The process permitted the collection of rich, thick descriptions of nurses' perceptions. To indicate interest in and encourage elaboration, I maintained eye contact throughout the interviews.

Interviews occurred during nurses' off-duty times to avoid work interruptions. The participants chose the time, place, and method of interview, either in person or teleconferencing. Before the interviews, I reminded participants that they could withdraw from the study at any time without penalty; none withdrew. The final interview question asked if participants had questions or anything to add. At the end of the interviews, each participant received a $5 Tim Horton gift card in appreciation (Lodico et al., 2010). To rule out misinterpretation of meaning, perspectives, and validate responses, the nurses gave permissions for post-interview contact (Merriam, 2009).

As the researcher, I respected and observed standards of excellence regarding confidentiality, research validity and reliability, and the agreements made with the organizations' HRPP. The interviews occurred after an assurance by participants that the times, environments, and methods were comfortable and non-threatening. The hospital facilities were left clean and intact. Participants received the utmost respect and care during recruiting, interview, and follow-up contacts. Table 1 displays the connection between the guiding questions (left column) and interview questions (right column; see Attachment B).

Table 1

Guiding Questions Relationship to Interview Questions (Appendix B)

Guiding Questions	Interview Questions
What were ED RNs' experiences with occupational traumatic stress for those nurses who had not received coping and resilience education?	1. What makes working with trauma in the ED stressful? 2. What factors contribute to your traumatic stress? 3. How do you measure your traumatic stress? 4. How has traumatic stress affected your nursing performance? 5. What coping strategies have you used in the ED during traumatic stress exposures? 6. Were the coping strategies used helpful or a hindrance? 7. How did you acquire these coping strategies? 8. How do you prepare for further exposure to occupational traumatic stress? 9. What do you think makes an emergency nurse successful in coping with occupational exposure to trauma?
How might nursing education professional development programs change to assist ED RNs with occupational traumatic stress?	1. What courses or training have you taken in resilience or coping strategies 2. What suggestions would you make to include these strategies in course work or training? 3. What training would help emergency nurses cope with occupational traumatic stress? 4. What suggestions would you make for supporting emergency nurses to cope with occupational exposure to trauma? 5. What suggestions would you make to include (resilience and coping) strategies in course work or training? 6. Is there anything you would like to add?

Data Analysis

Data analysis, interpretation, and coding followed an analytical method after data collection reached saturation. The analysis was iterative and ongoing from data collection through transcribing, coding, querying, and reexamination (Creswell, 2012). Reviewing verbatim transcripts of interviews organized into sources, field notes, and researcher memos regarding impressions, and non-verbal communications assisted with preliminary open-coding by questioning and responding to collected data (Lodico et al., 2010; Merriam, 2009). Broadly examining the data and establishing connections and making notes helped identify repeated words, thoughts, and emerging themes (Lodico et al., 2010). I used Descriptive Coding, In Vivo Coding, and Emotion Coding methods (Saldana, 2013). Second cycle Patterns Coding identified similar data moving into themes (Saldana, 2013).

Following first and second cycle coding, transcribed interviews and notes were coded through NVivo 11 software. New codes emerged as data were reexamined and constantly compared. Checking each use against a code list with brief operational definitions helped to prevent shifts in definitions. Data were collected and examined in detail for developing, describing, and interconnecting themes that addressed the problem and guiding questions (Creswell, 2012). Discrepant data were examined rigorously, providing a counterbalance to any tendency to disregard the value of exceptions, emerging categories, and new perspectives (Kaplan & Maxwell, 2005). I cross-checked data by noting rules of inclusion that applied to each quote, code, category, and theme.

Qualitative Validity and Reliability

In qualitative research, validity is a relative goal in the process of data collection and analysis (Merriam, 2009). Triangulation is a method for strengthening a study by combining methods and sources (Golafshani, 2003). Questions were asked of different sources to gain multiple points of view within the context of the bounded system of ED RNs. During data collection, I carefully avoided imparting my thoughts or perceptions to honor the constructivism paradigm of the participants' perceptions and realities (Golafshani, 2003). Addressing the validity of assembled interview data, field interview notes compared to transcripts to ensure painting a congruent and accurate picture (Golafshani, 2003; Merriam, 2009). Reviewing interviews for transcription errors reduced the likelihood of data misinterpretation.

After data analysis, member checking was used to verify validity and accuracy and examine assumptions (Lodico et al., 2010; Merriam, 2009). Member checking also controlled for researcher bias by addressing whether written representations matched ED RNs' perceptions (Lodico et al., 2010). For feedback and response validation, I e-mailed data analysis and interpretations to interviewees, requesting e-mail responses within seven (7) calendar days. The member checking responses validated the accuracy of data analysis and interpretations, offering no additional participant comments or questions.

Qualitative validity indicates that researchers check for findings accuracy through employing intentional procedures. In addition to checking for transcription errors and drifts in code definitions, I used NVIVO 11 software to cross-check codes (Creswell, 2009). Self-reflection and bias clarification in narrative form explained how findings

took shape as influenced by my background and professional experience. The realism of presenting discrepant evidence contributed to a more valid accounting (Creswell, 2009). The random letter-number labels of participants organized into respondents A1-A7.

Discrepant Case

One variant perspective emerged from A3, contradicting an emerging pattern of the desire for additional training saying, "We have too many classes that we have to go through. Too many modules that we have to sit through. Too many trainings online." When asked how to deliver the desired information without formal classes, A3 responded, "I would want something that has an impact, that empowers them to look at a real thing. And it doesn't mean taking care of somebody else, or a piece of equipment. It's allowing them to take time for themselves." When I paraphrased, confirmation came that the desire was for direction in learning general stress management techniques and self-care skills -- in small increments -- and that formal classes belong in the nursing school curriculum. A3 clarified, "I think that there should be at least one semester in nursing school. They teach you how to perform the skills and think the things that you need to think, but they don't teach you how to take care of yourself."

The study will include examined discrepant case findings. One way of handling the discrepant view would be to alter the PD program, separating it into modules. The organization may want to consider shorter segments, used independently or together, and include action strategies for hands-on learners like A3. Allowing the learner to participate, set goals, and maintain some sense of control may encourage motivation, reflecting Bandura's (2012) social learning theory. Handouts and brochures on subjects

like self-care, stress symptom awareness, and steps for de-escalation can provide information at the learner's convenience. Printed and readily available reference sources for learners may prove valuable.

Limitations

In the culture of nursing, following protocols, honing skills, obeying mandates, and attending patient care continuing education courses are priorities. The issues of how nurses think and feel about their experiences and exposures to OTS are not treated with any sense of urgency unless problems surface. A qualitative case study gave these participants the opportunity to make their voices heard.

A limitation of this study was that it included a small number of participants, from a specific type of ED, and recruited over a short period. Excluding nurses with less than a year's experience also narrowed the field, omitting nurses who might not have yet developed coping skills. The restriction of accessing nurses only through posted flyers and not recruiting personally possibly reduced participation.

In future studies, I would recommend adjusting the purposeful sampling to include greater researcher recruiting presence. Opening the pool of respondents to those with less experience, from different areas and levels of trauma centers might provide more information regarding training needs. Examining evidence of a nurse personality related to resilience and coping might offer data as to whether nurses develop and enhance coping through experience, or if nurses with certain personalities and resilience seek out emergency nursing because it fits them. Most participants claimed that nurses are born not made; perhaps future research might support or dispel that theory.

The Data

The problem prompting the study was that locally and globally, nursing education and PD did not include resilience and coping skills training. The guiding questions that emerged from the problem addressed ED RNs' OTS experiences, and how PD programs might assist with stress management. The data collected through interviews revealed the participants' opinions and ideas about traumatic occupational exposures, coping and resilience, and the best ways to manage those challenges.

Coding Methods and Results of Interviews

First cycle coding was descriptive; examining transcripts initially using descriptive coding summarized the data into topics. This process helped to form a foundation for developing insights (Saldana, 2013). The codes led to a categorized inventory providing the groundwork for rules of inclusion and addressing the problem and guiding questions. Category inclusion rules appear in Table 2

Table 2

Category Inclusion Rules

Category	*Rule*
Stressors	Participants communicate factors influencing stress perceptions
Effects	Participants disclose reactions and responses to occupational stressors
Stress Management	Participants share thoughts, behaviors, and processes for managing OTS
Coping and Resilience	Participants discuss how they acquired coping and resilience strategies
Training	Participants consider how PD programs might assist in managing OTS

Topic and summary codes followed establishing and revising rules of inclusion to analyze what the study was about, providing the foundation for this particular qualitative inquiry (Saldana, 2013). The categorized inventory of codes appears in Table 3. The codes on the right are from the data, and their related categories are on the left.

Table 3

Categorized Descriptive Codes

Category	*Codes*
Stressors	Children, non-emergent patients/system abusers, fast pace, aberrant exposures, no breaks, safety and security, patient instability, death, cumulative incidents, anticipation of trauma, new nurses, new situations, stressed coworkers, hunger, and fatigue
Effects	Compassion fatigue, ruminating, changing/adding jobs, overeating, increased caffeine, RN mode at home, not sleeping, substance abuse, poor attitude, hyperarousal, physical/mental depletion, emotional, muscle tension, impaired performance, racing brain, cumulative stress, suicide
Stress Management	Deep breathing, task mode, get away, clean slate between patients, distraction, downtime, empathy, peer support, successful outcomes, team mentality, vent and validate, innate resilience, spirituality, knowledge, readiness, preparation, superstitions, training, gallows humor, internalization, introspection, introversion, helping others, work/life balance, hobbies, counseling, de-escalation strategies, meditation, mentor, music, online support groups, positivity, prayer, self-care, peer feedback, talk, Yoga, inoculation, familiarity with equipment, skills mastery, speaking same medical language, team of experienced nurses, peer support, go out together after work (bar)
Coping and Resilience	Experiential learning, self-developed, CISM training in EMS, sports team-focused training
Training	Stress management classes, brochures, class with group breakouts, lists of stress management tools, coping mini-courses, coping mechanisms awareness, post EAP information, give resource lists, follow EMS training examples for CISM, inoculation, affirmations, routine and ongoing training and interventions, cumulative stress awareness, self-care training, online training, group after work outlets for team building, self-care

The next phase of coding was to step from the literal into the inductive with In Vivo coding. Participants' direct quotes based on the rules of inclusion were generated from nurses' interviews individually and then compared collectively. The rules of inclusion changed throughout the coding and recoding process. The participants' quoted responses provided rich and thick descriptions from the data. In Vivo codes are included in Table 4.

Table 4

In Vivo Coding Examples

Code	*Excerpt*
Children	Anything involving kids is particularly difficult; Seeing kids who are injured or kids who have passed away
Cumulative Stress	Every incident builds on the last one; It stays with you; One right after another after another
Inoculation	So [learning from] each even small incident would build on the prior one … you're able to look back on those things, draw from that experience
Self-Developed Learning	I did not learn from anyone else; I figured it out for myself
Taking Care of Self	There's not a lot of stuff about self-care, and I think that's where we lose a lot of our people; You can teach people to do self-care with just simple things, and none of those are budget breakers

Considering the propensity for feelings in the environment of emergency nursing, the exploration of emotion coding came next. Although the expectation was to find rich passages, the culture of ED RNs' primary coping skill of pushing feelings away by

focusing on tasks surfaced. More revealing than what the nurses said during the interviews was what they did not say. When nurses' responses veered toward revealing "The dreaded 'F' word, feelings," they diverted attention away from themselves, and displayed behaviors indicative of discomfort, like averting their gaze, stuttering, or repositioning in their chairs (P. Volkman, Personal Communication, 2005). Becoming clinical instead of emotional reflects the culture of nurses.

A2, who began detailing experiences, like CPR on an infant, moved into an emotionally protective task mode and began focusing on patient care algorithms. "I was the one doing compressions [on the baby], but … We do not get a lot of pediatrics. And the ones we do [get], we usually just stabilize and then ship them off to [a children's] hospital." Examples of emotion coding appear in Table 5.

Table 5

Emotion Coding Examples

Code	*Excerpt*
Powerless	You lack the ability to actually do anything about death and carnage that you see in a trauma center
Sad	The kids would go to bed, and I would either cry myself to sleep or eat too much
Angry	It's frustrating. You get frustrated. I get frustrated.
Confused	You feel like you just need to get out for five minutes, to wrap your head around what happened
Judgmental	The person who made me feel inadequate, I made sure that I just patted myself on the back and made myself understand that everybody makes mistakes

Second cycle pattern coding helped to identify emerging themes within the professional and social network of ED RNs. Clumping data into like categories brought about an awareness of the overlapping of codes and the time elements involved. The realization soon arose of a cyclical pattern to the codes, as some were clearly before OTS, some during OTS, and some after OTS.

Answers to Guiding Questions

Making a connection between the problem, guiding questions, and data cemented the tripartite concerns of the nurses in dealing with OTS. The first guiding question asked about the ED RNs' experiences with OTS for those who lacked coping and resilience training. None of the nurses took formal courses in coping or resilience.

Addressing the factors that contributed to their stress, nurses noted empathy and personal connections: "People you fall in love with" (A3); "Emotional family at the bedside" (A4); and "How you relate to that person" (A7). Some experiences noted, "Patients dying… the tempo … visual factors like blood… the person's life in my hands" (A4); "You see things that people shouldn't see" (A5); and the normally unspoken fear of ED RNs, "A threat situation" (A7). The accumulation of stressors increased the negative aspect of stress perceptions, like the instability of patients, hunger, muscle tension, and cognitive debilitation. Nurses mentioned, "Situations that you're not mentally prepared for" (A7); "You are stressed out, but you have hours to go, so you internalize it" (A6); the fact that, "Older nurses still eat their young" and "People I know have committed suicide" (A5); and "We have to be strong" (A3).

Perceptions of these influences are individualized, and “What is traumatic for some is not to another” (A1); “It’s hard to get people to admit they’re experiencing stress” (A4); “Each person handles stress differently … the building itself is stressful” (A6). Nurses described how they measured stress by noting symptoms: “My mind is racing,” “Sometimes I take it home, I can’t sit still [or] relax” (A2). “I can feel the tension in my neck and my shoulders” (A3); “Mentally draining, physically draining, shakiness” and “Getting mentally lost … losing perspective (A4); “I stress eat” (A5); “At the end of the day you’re so exhausted” (A6); and “It hangs out in your head, and you keep going back to it,” “You have difficulty sleeping,” “You keep reliving it” (A7).

Traumatic stress affected nursing performance in different ways. “Nurses become bitter toward other nurses” (A1); “I’m always on higher alert” (A2); “I made a silly error” (A3); “You’re not thinking as clearly” (A6); and “I never have that moment to kind of break away from what we are dealing with, so it can be detrimental, potentially, to the next patient coming in” (A7). One positive perspective surfaced, “I know ahead of time what to expect” (A4), and one reflecting the need for professional change, “It pushed me into making the application for [another job]” (A5). Coping strategies used for stress management varied. The nurses developed a wide array of strategies.

Examples of nurses’ strategies are contained in the following paragraph:

“My friendship with the other nurses,” “Good group of people,” “solid support from the team,” “Supporting each other,” “Pull from the people I work with,” and “knowing there is someone there to talk to” were noted by A1-4 and A6-7, respectively. Four participants mentioned gallows or dark humor, with A1 adding, “The humor is what

keeps us sane." Although most of the participants relied on their peers, A5 took the position of an introvert, saying, "I need my solo time when there is no one around. I need to plug into my charger," and A7 mentioned the spiritual element and power of prayer.

How coping strategies were acquired was almost consistently attributed to self-development over time, experiential learning, and inoculation. "I figured it out for myself" (A1); "You learn coping things on your own" (A2); "I developed coping skills on my own" (A3); "Comes from being at this for so long" (A5); "I don't think I learned it, it just happens" (A6); and "From before I became an ER nurse" (A7). A4 attributed his coping to crisis intervention classes he took as a medic, before nursing school, and the experiences of working on the road as a medic, adding, "I think it has to be learned."

Nurses prepared for further exposures for traumatic stress using each of the three methods of task, emotion, and avoidance coping at different times, under different circumstances, and with different outcomes. Trying to "make a clean slate" between patients, A1 said, "I leave the last patient behind and go to the next one. It does not always work because every incident builds on the last one; it is cumulative."

Mental preparation begins before work, as A4 continues a childhood superstition. "When we were kids, whenever we went over the railroad tracks, we would touch a screw in the car, and pick our feet up off the floor and make a wish." Concentrating on "the intellect and the science," A5 focuses on tasks and charting to get through the day. A7 adds that sometimes she will "go to the bathroom or the break room and cry."

Successful ED RNs "have an outlet: I run" (A1); A2 and A3 both cited "flexibility"; A4 credits a "solid support from the team." A5 says, "Winning once in a

while helps … when that person is going to walk out of the hospital." A6 attributes success to "Balance: family, outside life, a support system, and God." "Talking about it," "Sick humor," and "Spiritualism" are the top three elements from A7's perspective.

When asked about the second guiding question, about nursing education or PD training in resilience and coping strategies, participants A1 and A2 answered "None" and A3 said, "Not that I know of." A4-A7 added, respectively, "When I was a medic I took crisis intervention," "There's not much out there," "I don't think I have taken any," and "I don't think I received any." All participants were paramedics before becoming RNs, and 4/7 are still working EMS shifts. Some medics, before nursing, received PFA training through the ICISF model of Critical Incident Stress Management (CISM).

Although most of the nurses felt their coping had improved over time and experiential learning exposures, they each welcomed the possibility of additional training, stressing that newer nurses needed to learn coping skills strategies. Suggestions for training inclusion ran the gamut from nursing school through orientation, ongoing training, and continuing education modules for practicing nurses. They stressed that responses after critical incidents were necessary, but not enough, and those single responses of debriefings fell short of addressing the need for comprehensive coping strategies. A1 said, "It has to happen after there is an incident, of course, but before is the most important, to prepare them for what they might see." A5 adds, "And even during, because it's all an ongoing thing."

Participants suggested mandatory training, handouts, pamphlets, posted resource lists, posters for OTS awareness, and how to handle stress. Nurses asked for lists of

stress signs and symptoms and tools for self-evaluation. Most (6/7) wanted interactive classes, online classes, and short bits of information on an ongoing and regular basis to support ED RNs, the inclusion of stress in annual competencies, and posted affirmations to offset the inherent negativity. A1 said, "There are not enough classes to prepare people," with A4 adding the nurses need "Ongoing training or retraining." A6 shared her use of affirmations to engender positive attitudes by owning "your own happiness, write your own story, enjoy your journey, and balance work and school with play."

The training suggestion made most enthusiastically involved teaching nurses to incorporate into practice, and at home, something often an anathema to them: "Teach you how to take care of yourself" (A3). The adage of "You can't take care of anybody else until you can take care of yourself" was the reminder offered by A5 to encourage teaching self-care elements. A7 asked for training where nurses can "learn to de-escalate yourself, how to focus on thoughts and feelings, release tension" during multiple exposures. "There are no magic wands, and you gotta be ready when you're going in, but you've gotta have some way to get rid of that coming out, too. And even during, because it's ongoing" (A5).

The interconnection between codes, when they occurred, and that none existed independently of the others emerged. Reorganizing and reexamining codes within the cycles of *before*, *during*, and *after* OTS clarified the overlapped items of before and after, and the singularity of many during strategies. Seeing the overlap also illuminated that many of the training elements are ongoing, interconnected, and between the formal stages provide opportunities to continue, enhance, or reinforce the PD training materials and

process. The cyclic pattern and emerging evolution revealed no clear beginning or end, and introducing the training elements can occur at any time during the ED RNs careers.

Theme: Preparation and Resilience

The first theme surfaced through separating descriptive codes by participants, comparing responses, and finding codes that reflected training needs specific to pre-incident exposures. Further sorting by In Vivo and emotion coding methods, participants, and comparing the tables supporting the preparatory training theme found crossovers between expectations, training, and experience. Comparing participants, rules of inclusion, the problem, and the guiding questions showed the same similarities between categories gathered beneath the umbrella of preparatory training. Preparatory training involved coping strategies used before and after critical and cumulative OTS.

The participants, though experienced in OTS, expressed a need for preparatory coping skills training. Participant A1 explained: “There is no training in nursing for dealing with stress. No preparation. All denial. We need classes, information on stress. Management thinks you learn it on the job, but there has to be more than preceptors telling new nurses ‘this is gonna be rough.’ It makes or breaks you.”

The analysis brought forward that preparatory training was not enough to manage experiences during the workday. Negative coping practices accelerated as participants lacked skills or outlets to handle cumulative stressors as they occurred. A second theme emerged as the data for preparation divided into two subcategories: pre-shift preparation, and training to address the expressed needs for *during* work coping strategies.

Theme: De-Escalation and Coping

The second theme surfaced in the Excel descriptive codes, supported by examination of In Vivo and patterns coding as before and after exposures, and during exposures, separated into two categories. The code of proximity emerged, speaking to mediating stressor effects by gaining distance between the person and stressor during exposures. The ED RNs shared coping strategies and mechanisms while requesting training in how to get through the multiple, ongoing traumas of each shift. "We need ... just stress training, like how to de-escalate yourself" (A7). Using the word de-escalate, A7 prompted a review of the data to see what the other participants had said about what they do or suggest for getting through the multiple traumas during the workday. Several codes were added, which formed the second theme.

"I kind of pull from the people I work with. Certain people who have been down here longer, too, that are more experienced maybe than me" (A2); "The strategies that I use are recognition of what happened, reviewing the events in my mind, or talking to someone else. And I have been very good with using meditation" (A3). The participants did not often share these strategies with coworkers but felt they should be included in training, as shared by A5. "We always joked about taking a deep breath, yet stepping aside and taking a deep breath, they call them cleansing breaths, well that works. Gives you a chance to let it out, focus, concentrate on something else. Things like that are much more helpful to people than we give them credit for. That's during."

Comparing participants, rules of inclusion, the problem, and the guiding questions showed the experiences warranted training for between-patient de-escalation strategies.

The desire for self-care training surfaced. Self-care is a subject well known by nurses, yet rarely practiced by them. The participants wanted to learn coping skills for themselves and others to use at work and home, forming an interlocking theme with preparation and de-escalation training strategies.

Theme: Self-Care and Renewal

The third theme appeared in the Excel sheet under descriptive codes, slowly gaining importance with reviewing interviews and revising codes to accommodate new codes and categories. Self-care appeared within other codes, like coping strategies, as participants suggested outlets after work, running, spending time with coworkers outside of the hospital, using meditation, acquiring hobbies, and using stress management for problems with eating and sleeping. Those things apply to taking care of oneself, and the theme erupted when RNs began sharing comments like, “They don’t teach you how to take care of yourself” and “There’s not a lot of stuff about self-care” (A3).

Creating tables of In Vivo, emotion, and patterns coding revealed the rich narratives that outlined ED RNs’ suggestions of positive and helpful strategies. Although the participants admitted deficiency in the practice of self-care, they were interested in learning more about how to achieve it. Pointing out the need for comprehensive coping strategies training for outside of work, A2 said, “I know sometimes I cannot sit still, and I think it’s because of this job. I can’t just relax. Little things they need to do for us, whether it’s like a quick session of doing exercises that help you, like maybe you could take home with you and get you to relax once you get home.”

Probing questions revealed participant ideas for practices that they would suggest for others and skills training inclusion. "Have a hobby that has nothing to do with nursing. You know, even if it's trashy Harlequin romances, have some way of spacing. One area is physical exercise, the treadmills. You know, something where half an hour a day you're doing something for yourself" (A5).

Participant A7 adds, "I just try going for walks, doing things that I like to do to just get my mind off stuff. I did art a lot, so I was painting a picture, or going and taking photography, or just going and spending time with [family]. That helps me get out of my mindset off what bothered me." Taking participants' ideas and adding suggestions from the literature may provide a structure for creating helpful training modules.

Professional Development Program for ED RNs

The data indicated that the participants received no coping and resilience education in nursing school or PD programs, and analysis suggested as a solution providing the training participants lacked. Because nurses function within a structure of problem-based learning, the order of interview questions (Attachment B) aligned with nurses' problem-solving, task-oriented mindset (Finch et al., 2015; Kantar, 2014; McDermott, 2012). Ideas for solutions expanded on a one-time PD course to encompass ongoing, routine, and regular training opportunities for comprehensive stress management. A PD program, beginning with a 3-day training that can repeat in part or whole, can address needs for managing OTS experiences. Professional development is a standard part of the nursing population, who live by skills training, retraining, and performance standards. Making coping skills training part of the operational theme of

continuing education and PD for practicing nurses may also assist in integrating coping as a standard within nursing education.

The coping and stress management (preparation, de-escalation, and self-care) PD program would include training in addition to existing nursing continuing education. The program would add to nurses' inherent and learned coping skills, and foster an environment embracing health promotion attitudes in response to the expressed comments of the participants. The data revealed that participants asked for tools to get through the aftermath of OTS exposures. Many stated that they did not know how to handle OTS and those who learned to cope were self-taught.

Promoting a classroom experience, A6 said, "I think the one-on-one training where people can relate and talk and say the things that they're going to learn out loud, so they can remember them better. I am a hands-on learner; I need to be there."

Supporting PD, A7 says, "I [like] having classroom time and breaking into groups. You're going to open up and learn things about people that you might not have known about, get to know their thoughts. They all have the same stress and deal with the same things but differently." Participant A2 suggested, "Some more classes, like quick little sessions that we could run through, or booklets, or pamphlets." A PD program would provide the opportunity to engage the learners and provide attention to the specific learning styles outside of the standard lecture format of nursing school and continuing education for coping skills training.

Asking for support and reinforcing the value of the nurse, A1 said, "If there is one thing, we have to train for preparedness, pre-emptive classes to deal with stress before the

fact, not after;" and "It's not just about teaching how to use the computer system, or where the fire extinguishers are in the department; a class, or lecture, or in one-on-one time with a professional that knows the psychology involved in working in those situations" (A4). Participant A6 added, "I do think there needs to be some training. I mean, we do OB and cultural diversity, and ethics, but there's nothing about how to handle stress. I think each person handles stress differently, and so you need to have a baseline of things to do, and have it more easily accessible than it is."

The proposed PD program would be a 3-day workshop divided into the coping skill segments of preparatory training, de-escalation strategies, and self-care stress management. A panel of experts proficient in dealing with OTS management would open and close each day to address nurses' concerns, to encourage engagement and participation. Learning activities would supplement lecture, and include group breakout sessions where nurses could share and interact. Breakout sessions would be designed to encourage participation, increase learning, foster socialization in a healthy environment, share ideas, promote peer support, and encourage ongoing discussions about coping and resilience. The training and networking could assist in mediating the negative effects and outcomes of maladaptive coping skills practice, increase solidarity with nurses, and engender positive attitudes of hopefulness and helpfulness within the nursing community.

Summary

In section 2, I presented the study's methodology, research design, approach, data collection, and study findings. Details included the criteria for selection of participants, research setting, sample, and procedure for gaining access to participants, and the

interview process and ethical protection of participants. This qualitative intrinsic case study was used to examine the guiding questions, the impact of occupational trauma exposures on ED RNs who lack resilience and coping skills education, and how PD might assist in mediating those effects. Described and justified were data collection interviews and processes of analysis. Member checking, the role of the researcher, and identified researcher bias addressed research reliability and credibility. Providing information about ED RNs perceptions of their OTS experiences and ideas about training, the results of the study offered ideas to create a PD program.

Themes identified through data analysis informed the project study. Outlined in Section 3 is the 3-day PD program based upon themes of preparation, de-escalation, and self-care. Project development, implementation, and evaluation criteria are in Section 3.

Section 3: The Project

The project is a 3-day PD workshop (see Appendix A) designed to provide coping, resilience, and self-care strategies for emergency nurses. Created from the qualitative case study findings, the workshop will be broken into three day long elements based on the study themes of preparation, de-escalation, and self-care. The workshop is interactive, involving icebreaker activities, lecture, instructional strategies, discussion, small and large group activities, and small group breakout sessions. The learning and sharing opportunities represent the input of the study participants.

Description and Goals

The findings from the study showed that the participants wanted to learn more about resilience, coping, de-escalation, and self-care. A 3-day PD program was developed to assist ED RNs' preparation for OTS occurrences through de-escalation, mindfulness, coping, team cohesion tools, and ways to build a home self-care repertoire for stress management and wellness practices. A pragmatic plan of action for the project is a PD workshop program found in Appendix A.

The goals for the PD program will be to provide tools for the nurses to prepare for OTS exposures. These tools will aid nurses to prepare for and de-escalate during OTS exposures, and practice self-care tools after OTS exposures. The training will help RNs to recognize cognitive, physical, behavioral and emotional reactions to OTS, learn how to establish self-care tools and resources to validate their experiences, establish a social support system, and identify peers from whom they can draw support. Goals include educating about OTS, resilience, adaptive and maladaptive coping practices, and

mindfulness techniques. Other goals embrace enhancing communications, team building, mentoring, peer support, social media networking, and technological options for stress management. The goals will also be to facilitate courageous conversation, share experiences, and share resources and tips for self-care.

Purpose

The purpose of this project study was to investigate the impact of OTS on ED RNs who lacked formal course work addressing resilience and coping skills. The institution providing IRB review granted approval without stipulation, protocol: 2015-00081, approval period 09/15/2015 - 08/31/2016. Data analysis from the qualitative interviews led to developing a PD program (See Appendix A) to address the study's guiding questions based on participants' responses. The guiding questions were the following:

1. What are ED RNs' experiences with occupational traumatic stress for RNs who have not received coping and resilience education?
2. How might nursing education professional development programs be changed to assist ED RNs with occupational traumatic stress?

The literature review provided direction in how best to approach the needs expressed by the study participants. The project outcome (Appendix A) will be a 3-day PD program designed to provide stress management skills training and resources. Section 3 describes the training plan of action.

Learning Outcomes

The learning outcomes for this program by day are the following:

- Day 1: Participants will be able to
    - define stress, resilience, coping, and positivity;
    - recognize signs and symptoms of stress;
    - recognize different coping methods;
    - identify personal resilience factors; and
    - discuss self-efficacy, positivity, and posttraumatic growth.
- Day 2: Participants will be able to
    - define de-escalation, peer support, and team cohesion;
    - discuss motivating factors for de-escalation, peer support, and team cohesion;
    - demonstrate the ability to practice mindfulness strategies;
    - discuss the impact of positive communication; and
    - recognize support resources.
- Day 3: Participants will be able to
    - define self-care, mindfulness, wellness;
    - articulate the importance of self-care and wellness practices;
    - discuss humor, spirituality, cognitive-behavioral strategies; and
    - discuss coping and self-care differences between introverts and extroverts.

Target Audience

The target audience for this training is emergency department RNs. Although the training could benefit other ED staff, management, and ancillary department nurses, opening the training to mixed groups could hinder open conversation, participation, and problem-solving directions of trauma nurses.

Components

Elements of the training that will contribute to its success include factors that are specific to the emergency nurses' experiences and OTS exposures. The components include the following:

- the training is relevant to the learners' needs;
- activities involve discussion, examination, and reflection;
- collaboration reinforces peer support and team cohesion;
- content developed in consideration of learners' professional knowledge;
- goals and expectations of the program are clear;
- nurses participate in and contribute to learning activities;
- nurses' experience and self-developed strategies are used as resources;
- the learning environment is non-judgmental and supportive;
- the learning environment promotes positivity; and
- each participant will be treated with respect.

Timeline

The timeline for the program would be approximately 90 days. Communications with the managers to gain approval, solicit funding and support, set dates, reserve rooms, obtain permissions from all managers, and complete CEU registration with the facilities' agency will occur 60 days before the course. After arranging for funding, securing the venue, addressing the IT and electronics availabilities, and posting flyers in the department, I will send announcements electronically through employee e-mail to

introduce the course 45 days before the training. Promoting the course to eligible participants should occur 45-60 days beforehand to accommodate nurses' scheduling.

Contacting the food and refreshment suppliers will happen 21 days in advance, with a reminder communication 7 days before the course. By 14 days before the training, registrations, allowing for cancellations and late registrations, will be secured. One week before the training, communications with the ED and nursing education managers, food service, administration, and IT will be revisited to finalize details and address any outstanding issues. The day before the course, the room(s) will be prepared and course materials organized for distribution, ensuring sufficient quantities for the final head count of attendees. If the training combines with other site-sponsored instruction like annual competencies, communication with the organizer will happen the day before the training.

Activities

Each day will begin with an icebreaker that encourages participation through a fun activity. Participants will link introductions of self to a particular nursing skill, take part in an opening activity to share reflections of the first days' training, and on the final day play a game encouraging sharing personal facts. Opening learning activities each day will take the participants progressively from safe factual information to personal reflection on training to disclosing something formerly unknown about themselves that they might choose to share. This process of encouraging the sharing of personal perceptions reflects the ICISF (formerly Mitchell) model of crisis intervention, in which trauma workers progress through non-threatening progressive sharing of facts, then thoughts, then feelings (Blacklock, 2012; Everly & Mitchell, 2010).

Daily instructor-led large groups, and breakout sessions in small groups, will permit examining and sharing thoughts and practices, and developing new coping and resilience strategies (Curran, 2014; Dennick, 2012). Cognitive behavioral activities and self-assessments will help participants evaluate their stress management skills and how they may build on existing knowledge (Dennick, 2012). Instructor demonstrations precede participants' practice of cognitive behavioral strategies like breathing exercises, relaxation, and meditation (Orly, Rivka, Rivka, & Dorit, 2012).

On the first day, participants will list examples of interweaving work and home stressors, self-assess resiliency, establish a preparatory resilience plan based on the day's learnings, and end the day with a positive exercise examining when things go well. During the second day, participants will develop plans of how they can support and mentor peers at work. Groups will discuss de-escalation strategies that have worked in the past and what they might try in the future, and present those options to the class. Groups will also strategize ways of gaining support and meeting training needs within their institution, and develop a list of ideas as to how they might increase team cohesion. On Day 3, learning activities will include small groups formulating strategies for moving away from nurse mode at home using mindfulness strategies, using available technology for performing self-care research and outlining a plan of action, and creating lists of how nurses can achieve wellness and relaxation activities at home. An opportunity for sharing and group discussion will follow each activity.

Trainer Notes

For this workshop, a RN trainer experienced in crisis management and response is preferred to instruct. The materials connect trauma nursing and the mental health and wellness strategies available to mediate OTS exposure challenges. Because of the closed culture of ED RNs, someone who can speak both nursing and crisis management languages would be more effective as a peer and course facilitator. The workshop has been designed primarily for emergency nurses at every stage of their careers. Nurse educators will provide support for representing the specifics of the institution, daily attendance, and CEU lists. There are no prerequisites for the workshop; supplies, snacks, and lunch will be provided.

An invitation to participants will be extended through the ED manager via the sponsoring organization's e-mail system. The ED nursing educator will coordinate volunteers for workshop support. For the sake of continuity, this 3-day workshop will be held on consecutive days, although reinforcement training, in-services, and segments of training for CEUs can be drawn from workshop materials for shorter training elements.

The workshop can be modified for different group sizes; this pilot group will be 20 nurses who can assemble into groups of 4-5 for breakout sessions. Arranging tables in a horseshoe design permits all participants to see the screen for the PowerPoint displays, use their tables for writing on large sticky-backed paper during their small group segments, and reconnect to participate in large group discussions with ease. During small group exercises when list development is required, each group will decide who will act as scribe(s) and representative(s).

Module Formats

The learning modules are split into themes for each of the 3 days: preparation, de-escalation, and self-care. Modules provide opportunities for interaction, brainstorming, planning for information integration into practice, and reflection. Each day begins with signing in, refreshments, introductions, and an icebreaker activity. The schedules for each day follow a similar pattern for consistency.

Following the icebreaker each day is an overview of the objectives, a review and reflection of the previous day's content after the first day, and an instructor-led discussion of the day's new material. The instructor leads the large group discussion. The volunteer nursing educators and the instructor move around the room to monitor and assist with group breakout sessions and are available for large-group questions. The day is filled with multiple instructor-led large group discussions, small group discussions, and interactive learning activities.

Each segment of instructional strategy, discussion, or learning activity takes 15 minutes, 30 minutes, or 45 minutes. The most significant exercises are those in which the learners in small groups take information and consolidate it into plans of action, essentially making it their own. The morning and afternoon breaks and lunch times are the same each day for consistency. Each day ends with a review, an opportunity for questions, an overview of the next day's material when applicable, and filling out a daily evaluation form. The evaluation forms will be used to revisit the format, make revisions, and improve the content and process for subsequent training opportunities.

Materials

Materials and resources necessary to present a professional and engaging training consider the budget and limitations of the training site. The PowerPoint presentation requires the provision of a laptop connected to a projector. The PowerPoint will act as a visual backdrop for discussions and activities, remain open for quick reference, and provide another technology tool to engage the millennial learner. Combined with individual and paired activities for active learning, and exchanging a strict lecture format with interactive discussions, the PowerPoint presentation guides participants toward relating to the material (Roehl, Reddy, & Shannon, 2013).

The resources required for the PD workshop will be a large classroom at the host hospital, a projector and screen for PowerPoint presentations, and Internet access. A flip chart with sticky-back adhesion strips and a flip chart stand are needed to record and post activity outcomes. Colored markers will be used on flip charts, and pens and note pads are required for all students. Each participant will receive handouts comprised of copies of schedules for all 3 days, teaching materials, and resource lists.

The corporate sponsor will provide refreshments and meals. Volunteers from nursing education or the ED will assist with sign-in, discussion groups, breakout sessions, and provide expert input about corporate resources. The number of volunteers necessary will depend on upon class size, using a ratio of 1:15 volunteer to student groups. The course requires one instructor with content experts contributing as available per facility. A sign-in sheet for each of 3 days for facility records and sign in sheet for RN CEUs (continuing education units) will be provided by nursing education.

Implementation Plan

The workshop is a training instrument intended to address the coping, resilience, and self-care needs of nurses. The plan's implementation requires the full cooperation and support of the sponsoring organization. Developing a training plan of action requires the commitment of physical, monetary, and human resources.

The PD program will be offered as a 3-day workshop sponsored by the hospital and will take approximately 90 days to plan. The workshop will be held in cooperation with nursing education, which will help to establish funding for resources, materials, and refreshments. The local coffee shop, frequented by the sponsoring organizations' employees and often used for corporate gatherings, will be asked to offset costs through donations. In exchange for their contributions, the coffee shop will be offered the opportunity to create a promotional display near the table offering their refreshments.

After securing funding, recruiting for the workshop will begin. E-mails sent through the hospital mailing system will advertise the workshop, and participants will be able to register through the nursing education department. Nursing education will also include the announcement for the workshop on their webpage's calendar of events.

The program will initially accommodate 20 students to ensure optimal learning opportunities. One instructor will teach the class with support volunteers from nursing education for administrative duties, troubleshooting, and distributing handouts. Nurse educators will act as support staff for breakout sessions, and as content and site experts during discussions. A tentative schedule has been established for each days' training and activities. The hourly training detail for the first day of the workshop follows in Table 6.

Table 6

Day 1 Schedule, Preparation (Appendix A)

Time	Instructional Strategies/Learning Activities	Length
0730-0800	Refreshments, registration	30 Minutes
0800-0830	Welcome, icebreaker activity	30 Minutes
0830-0900	Overview, background	30 Minutes
0900-0930	Learning styles	30 Minutes
0930-1015	Stress, OTS, preparatory education	45Minutes
1015-1030	Morning break	15 Minutes
1030-1115	Stress self-inventory (Appendix C)	45 Minutes
1115-1200	Resilience, empowerment, healthy lifestyle	45 Minutes
1200-1215	Resilience self-evaluation (Appendix D)	15 Minutes
1215-1300	Lunch	45 Minutes
1300-1330	Discuss resilience self-inventory	30 Minutes
1330-1345	CIS plan: Stress and resilience	15 Minutes
1345-1400	Increasing resilience in self and cohorts	15 Minutes
1400-1415	Participants will share results with class	15 Minutes
1415-1500	Coping methods and strategies	45 Minutes
1500-1515	Afternoon Break	15 Minutes
1515-1545	Three blessings exercise and discussion	45 Minutes
1545-1600	Positivity	15 Minutes
1600-1630	Review, overview next day, evaluations	30 Minutes

The hour-by-hour detail of training for the second day of the 3-day workshop appears in Table 7.

Table 7

Day 2 Schedule, De-Escalation (Appendix A)

Time	Instructional Strategies/Learning Activities	Length
0800-0830	Welcome back, coffee and icebreaker	30 Minutes
0830-0900	Objectives, terms, overview	30 Minutes
0900-0930	De-escalation during OTS exposures	30 Minutes
0930-1015	Mindfulness, humor, interventions, resources	45 Minutes
1015-1030	Morning break	15 Minutes
1030-1115	Mindfulness in de-escalation	45 Minutes
1115-1145	Peer support, motivating factors, benefits	30 Minutes
1145-1215	Mentoring, support, resources	30 Minutes
1215-1300	Lunch	45 Minutes
1300-1345	Plan for supporting and mentoring peers	45 Minutes
1345-1415	Meeting training needs	30 Minutes
1415-1500	Team cohesion, motivation	45 Minutes
1500-1515	Afternoon Break	15 Minutes
1515-1545	Team development planning	30 Minutes
1545-1600	Positive communication	15 Minutes
1600-1630	Review, overview next day, evaluations	30 Minutes

The hourly training detail for the third day of the 3-day workshop appears in Table 8.

Table 8

Day 3 Schedule, Self-Care (Appendix A)

Time	Instructional Strategies/Learning Activities	Length
0800-0830	Welcome back, coffee and icebreaker	30 Minutes
0830-0900	Learning objectives, terms, reflection	30 Minutes
0900-0930	Self-care and renewal	30 Minutes
0930-1015	Strategies, affirmations	45 Minutes
1015-1030	Morning break	15 Minutes
1030-1115	Self-care plan, collaboration, social media	45 Minutes
1115-1145	Mindfulness, MBSR techniques	30 Minutes
1145-1215	Practicing cognitive behavioral techniques	30 Minutes
1215-1300	Lunch	45 Minutes
1300-1345	Wellness with intention, relaxation	45 Minutes
1345-1415	Biopsychosocial health, journaling	30 Minutes
1415-1500	Life Stress Test assessment (Attachment E)	45 Minutes
1500-1515	Afternoon Break	15 Minutes
1515-1545	Groups develop plan of action	30 Minutes
1545-1615	Putting it all together	30 Minutes
1615-1630	Review, evaluations	15 Minutes

Note: The Life Stress Test self-assessment, Appendix E, is used with permission by the author (see Appendix F).

Rationale

Cottingham (2015) wrote of using knowledge as an empowering strategy. Nurses can learn to use emotion management to reframe the nursing role and maintain a healthy emotional distance while using training and knowledge to handle grief, failure, and helplessness (Richardson & Rothstein, 2008). Participant A1 said, "There are not enough classes to prepare people," A7 asked for, "Stress training, like how to de-escalate yourself," and A5 reported, "There's not a lot of stuff about self-care, and I think that's where we lose a lot of our people." Other study participants repeated these requests for preparatory education, de-escalation strategies, and self-care tactics. The challenge for a PD program arises in how best to present this information to nurses.

Nurse educators have followed a longstanding tradition of teaching methods that may not apply to contemporary learners, as millennial nurses, most of whom have advanced technological abilities, expect PD to reflect current culture and global information access (Yoder & Terhorst, 2012). Newer graduates have been raised in an environment removed from consequence, reflecting a generation of entitlement in which everything was planned around them (Yoder & Terhorst, 2012). This 3-day PD workshop will be structured to accommodate different learning pathways and preferences. Learning by doing, visual aids, instant feedback, information that is fun, applicable, and relevant will structure the PD training (Yoder & Terhorst, 2012). Resource lists will include information about e-learning through iPads and smartphones, which, at the learner's convenience, transforms the learner from static to mobile learning.

The PD program conceptualization builds on an instructional design called the ADDIE (Analyzing, Designing, Developing, Implementing, Evaluating) model, which mirrors the nursing process of assessing, diagnosing, planning, implementing, and evaluating (Yoder & Terhorst, 2012). Comparing the two processes aligns this PD program with how nursing education is structured while integrating the newer possibilities in learning provided by technology. Proactively addressing new issues, stressors, and health care practices in ways appropriate to the evolving learning culture of nurses can help guide them through benefitting from the tools and strategies available to manage OTS. The ADDIE model provided for *analyzing* the audience of nurses to determine project needs; systematically *designing* the course objectives, content, and exercises; *developing* by assembling content and revisiting nurses' learning preferences; *implementation* of structure for training; and an *evaluation* process for continuing feedback about the program's efficacy.

The data analysis in Section 2 outlines an expressed need for nurses to learn how to build resiliency for OTS exposures, acquire present-moment tools for getting through OTS experiences during work, and train in developing self-care practices, and stress management resources outside of work. A PD program can address the issues of resilience building and self-care strategy development, and present them in ways that are current, relevant, active, and visual, provide resource information for future reference, encourage peer support, and permit exchanging information between participants. The problem that nursing education does not offer formal classes in resilience and coping training is addressed by providing that education through this 3-day PD workshop.

Review of the Literature

The literature review was conducted through purchasing books and retrieving studies from EBSCO Host, ProQuest, Elsevier, Psycnet, and SAGE electronic databases. Searches included the keywords resilience, coping, stress management, peer support, posttraumatic growth, mindfulness, self-care, and inoculation, singularly and combined with the word nurse. The review separated into four segments: PD programs within theoretical frameworks and learning; preparatory training for stress, coping, and resilience; de-escalation and coping tactics during OTS exposures; and self-care within general stress management strategies.

The effectiveness of stress management intervention programs has been a source of debate for many years (Kirby et al., 2011; Prati et al., 2011). A study by Everly et al. (2008), considering teaching and enhancing resilience, contributed to a new era of stress management by anticipation. That same year, Richardson and Rothstein (2008) published a meta-analysis regarding the overall contributions of stress management intervention and training programs, adding to the theme of stress management from an anticipatory perspective. Before 2008, primary interventions, such as redesigning jobs, secondary interventions like peer support groups, and tertiary interventions like employee assistance programs, were met with mixed reviews and difficult to assess in determining effectiveness (Palm et al., 2004; Regehr et al., 2002). Consistently, cognitive-behavioral interventions, which are active and encourage adaptive coping strategies through changing thoughts, feelings, and behaviors, produced larger and stronger effects than other mediations (Richardson & Rothstein, 2008). The synthesized analysis by

Richardson and Rothstein (2008) helped to define interventions, suggesting the teachability of techniques designed to reduce and ameliorate stress symptoms.

Blacklock (2012) recognized the importance of a comprehensive model of crisis management and response and adapting the CISM model of peer support for hospitals. Establishing CISM and peer support requires specific training and ongoing education. As part of a comprehensive model of stress management, Flarity et al. (2013) acknowledged the need for multi-faceted training programs designed to increase resiliency, decrease symptoms of CF, and increase CS for preparatory and continuing nurse education. Positive outcomes from nurse training programs included the ability to develop self-care methods for maintaining resilience and mitigate future CF threats (Flarity et al., 2013).

Rose (2014) offered another perspective through technology-based stress management programs, as few have addressed training stressed populations who are otherwise healthy people. Rose et al. (2013) supported the efficacy of stress management training and stress inoculation training and introduced a multi-media stress management and resilience training program (SMART-OP). The SMART-OP plan of action provides an evidenced-based, confidential, interactive video training focusing on the needs of those whose preferences, fear of stigma, or time constraints cause them to veer from standard classrooms (Rose et al., 2013).

The SMART-OP program includes established cognitive-behavioral skills training as developed for NASA, and is relevant for military and emergency providers (Rose et al., 2013). Expanding technology use for stress management training, Webster, Beehr, and Love (2011) studied an innovative method of delivering stress inoculation

training (SIT) via online self-help interactive videos. Through this training, nurses learned ways in which to alter how they process stressful situations, and identify active-coping adaptive strategies to replace maladaptive strategies like denial.

The most successful adaptive coping methods come from the cognitive, behavioral, and psychological domains that individuals access in attempts to deal with internal and external threats to individual complexities of psychological equilibrium (Varvogli & Darvin, 2011). Evidence-based techniques for managing OTS include activities like progressive muscle relaxation, guided imagery, diaphragmatic breathing, and Mindfulness-Based Stress Reduction (MBSR). Research supports these interventions as contributing to lowering stress levels, reducing disease symptoms, and improving the quality of life. Although research on these processes is ongoing, researchers suggest that health care providers can be trained to use safely and effectively these coping and resilience strategies (Varvogli & Darvin, 2011).

Military Influence

Adaptive coping, which can be taught, and social support, which can be encouraged, are two attributes of resilience. The military as an organization stands behind the concept that you live what you learn, and training to mastery of skills equates with survival. The U.S. Army instituted the Comprehensive Soldier Fitness (CSF) program to strengthen resilience based upon the input of behavioral health findings (Simmons & Yoder, 2013). The CSF program designed to enhance resilience holds five domains: physical, spiritual, emotional, social, and familial. The concept analysis

provided by Simmons and Yoder (2013) emphasized the importance of understanding the challenges to resilience in high-risk environments.

The CSF program and military resilience building training incorporate the attributes of positive psychology, as with the three blessings exercise, where participants reflect daily on what went well and why (Cornum et al., 2011). Performing the exercise for a week linked with increased happiness and decreased depression for up to six months. Part of the CSF training includes establishing working groups to identify qualities, skills, and behaviors necessary to meet resilience goals. Addressing the conundrum of how the same circumstances can result in CF or CS among those exposed to trauma, combat-related psychology presents the concept of posttraumatic growth (PTG). Whereas traditional psychology addresses pathology, positive psychology emphasizes resilience building and positivity, presenting the military CSF program as a possible model for psychological fitness in other organizations (Cornum et al., 2011).

The United States Air Force (USAF) echoed the necessity for addressing traumatic stress encounters before, during, and after trauma exposure through the USAF instruction AFI-44153, guiding disaster mental health response and stress control (USAF AFI44-153, 2014). Acknowledging that everyone has the potential for negative responses following stress exposures, the instruction proposes preparatory training to foster resilience in those who may meet with significant or high-stress events. Regularly scheduled training modules address prevention, PFA, referral, secondary trauma, and burnout. Another program within the AFI 44-153 is the Combat Operational Stress Control (COSC) training, designed to teach pre-exposure planning, identify and manage

adverse reactions, and promote unit cohesion and resilience. Military literature and training programs provide a model for many elements of the nursing PD program.

Another military training strategy to mitigate the possible negative effects following trauma exposures is Predeployment Stress Inoculation Training (PRESIT). This preventative effort includes education in relaxation and operational stress control. Hourani et al. (2011a) acknowledge the paucity of information about preventive and preparatory coping practices; Stress Inoculation Training (SIT) is a relatively new program reflecting the coping mechanism of task-focus under stress to bolster resilience.

Military psychoeducational preparation approaches of pre-deployment training are designed to prevent or mitigate negative posttrauma exposure outcomes. The philosophy behind preparatory training is lessening negative trauma perceptions by providing awareness of possible posttrauma symptoms and normalize disturbing reactions. For example, if persons recognize the possibility of nausea or anxiety in certain situations, and nausea or anxiety occur, persons can identify the symptoms as predictable reactions. Training can modify negative perceptions through reframing, boosting resilience, and identifying practical self-help actions (Hourani, Council, Hubal, & Strange, 2011b).

A military program for developing competencies to operate under stress, SIT is an exemplar for high-stress occupations. Component stages of the training are education about stress, behavioral skills training to mitigate or manage stress responses, and practicing those skills under simulated stress conditions (Robinson & Manacapilli, 2014). Robinson and Manacapilli (2014) echoed the findings of Richardson and Rothstein

(2008) and their description of primary, secondary, and tertiary interventions, providing a comprehensive training strategies module. Addressing resilience, Robinson and Manacapilli reinforce the value of cognitive and behavioral skills training for performance enhancement and promoting well-being.

Theme: Preparation

Resiliency as a preparatory mechanism is a critical training element that can be acquired through stress management teaching concepts of modifying perceptions, positive self-talk, workplace buddy systems, work/life balance, relaxation training, and mindfulness (Everly et al., 2008). The Johns Hopkins Tripartite Model of disaster mental health (DMH) is comprised of three main concepts: to build resistance pre-event, enhance resiliency acute event, and facilitate recovery post-event (Everly et al., 2010). Training nurses in enhancing inherent resiliencies serves to mitigate further distress. Nurses can benefit personally while assisting other emergency responders and ED cohorts by learning PFA and resilience models, which empower nurses by building on principles of resilience and self-care (Everly et al., 2010).

A brief stress-reduction and resilience-enhancing training, SMART, was piloted by physicians to test the program's efficacy (Sood et al., 2011). The study proved feasible with the potential to improve scores in measures of quality of life, resilience, and stress. Expanding resilience and proactive programs to include physicians, like those developed by the military and encouraged for other organizational use, can also serve to legitimize wellness programs as a whole (Rose, 2014).

Educating about known stressors and their effects can raise awareness and reduce the stigma of training programs for stress management. Physicians' exposures and habits mirror those of ED RNs, challenged by maintaining good exercise and nutrition habits, circadian disruptions, sleep deprivation, patient mortality, and the shared need for wellness strategies and managing stress (Schmitz et al., 2012). The culture of training and focus on resilience is emerging in health care, yet attention to preparatory training necessary for members of emergency health care is sparse.

Theme: De-Escalation

Initiatives to reduce stress during work emphasize the value of taking breaks, positive team support and interaction, and participating in coping skills training (Happell et al., 2013). Airosa et al. (2011) suggested stress reduction practices may include a quiet room away from patients, tactile massages, and relaxation tactics to increase energy and concentration. Psychological interventions in a stress management training plan, like stress inoculation training, may prove beneficial to staff. Training modules should also include signs of traumatic stress, stress management strategies, and resources like professional counselors, chaplains, or a peer support team (Gillespie, Bresler, Gates, & Succop, 2013).

Awareness of signs and symptoms of stress, and when stress reduction strategies would be helpful, are part of comprehensive programs like CISM (Mueller-Leonhardt, Mitchell, Vogt, & Schurmann, 2014). Specially trained CISM peers facilitate defusing and de-escalation. Training includes awareness of preventative measures like time-outs,

establishing peer support providers, and awareness of post-work resources like employee assistance programs (Mueller-Leonhardt et al., 2014).

Lavoie et al. (2011) promote peer support system development, with training in early recognition of the type of events and symptoms that may indicate distress in self and coworkers. Social support through venting and talking with coworkers, chaplains, or social workers during stress proved to be a helpful coping mechanism (Harris, 2013). The repeated use of humor and prayer as strategies to get through the day are also tactics to manage workplace stress, with laughter as a key cohort-shared approach, coping maneuvers which Harris (2013) proposes for training opportunities.

Mindfulness is a cognitive state attentive to the present moment in a nonjudgmental way while living in the present moment (Hulsheger, Alberts, Feinholdt, & Lang, 2012). Augmenting cognitive-behavioral training with mindfulness and relaxation techniques decreases rumination, an important factor in improving sleep quality and posttrauma recovery. Mindfulness-Based Stress Reduction (MBSR) is an evidence-based solution easily and inexpensively adapted to health care communities.

Extending beyond the effects of OTS, Zeller and Levin (2013) proposed a nursing job stress model that considers workers' personalities, job demands, family stressors, sleep deprivations, and self-care practices. MBSR training may also appeal to nurses' scientific reasoning as post-MBSR training imaging studies showed increased activity in the areas of the mind related to concentration and positive disposition (Zeller & Levin, 2013). Proposing MBSR training as a component of wellness practice, Zeller and Levin

(2013) suggested incorporating adaptations, like breathing exercises to improve cognition and relaxation.

Group cohesion provides an effective protective factor against the negative effects of occupational stress. Merging preparatory training with de-escalation strategies, Pines et al. (2012) showed a relationship between psychological empowerment and stress resiliency, encouraging nurse educators to include resilience as a conflict management tool for increasing team solidarity. The positive effects of group cohesion may be enhanced by mentoring and teaching adaptive coping skills, informing educators of the value of including these factors in training curriculums (Li et al., 2013). Moreland and Apker (2015) suggested ways to engage nurses positively and improve collaboration through training in the use of crucial conversations about conflicts and viewing a lack of cohesion as an opportunity to implement change. Practical insights included suggestions of skills improvement through mentoring programs, social gatherings, and social media platforms to facilitate relationship building (Moreland & Apker, 2015). Training to empower nurses through engagement, DeVivo, Quinn Griffin, Donahue, and Fitzpatrick (2013) suggested mentoring and shared governance programs.

Theme: Self-Care

Recovery training programs promoting detachment from stressful work experiences, relaxation, increased self-efficacy, and positive wellness outcomes enhance self-care concerns like sleep quality, an indicator of well-being (Hahn, Binnewies, Sonnentag, & Mojza, 2011). Combining education, visual presentations, printed materials, and group exercises, Hahn et al. (2011) supported that recovery experiences

are mutable and can be facilitated by training. Educational programs and cognitive behavioral interventions (CBI), using activities like relaxation and breathing techniques, were found to be more successful stress management and self-care strategies than organizational changes (Orly et al., 2012). Nurses who participated in CBI training achieved a higher sense of coherence scores and reportedly felt a greater ability to cope with work stressors, indicating resilience (Orly et al., 2012).

Resilient nurses' worldviews reflect the mindfulness perspective accepting that death is part of life, that outcomes are out of the nurses' control (Mealer et al., 2012). Cognitive behavioral training helps already resilient and adjusted nurses learn better coping tools. Mealer et al. (2012) recommended preventative resilience training for nurses' personal and professional work environment improvement, identifying and including elements that support and strengthen nurses into their training. These wellness and resilience perspectives merge within the self-care spectrum and include a supportive social network, spirituality, optimism, work-life balance, cognitive flexibility, and observing resilient role models.

Mindfulness training extends from mediating OTS exposures to assisting with stress management outside of the workplace, as ED nurses attempt to change roles from professional to personal. Mindfulness practices help to reduce rumination, mitigating against destructive thoughts, improving health, and decreasing stress and anxiety at home (Fourer, Besley, Burton, Yu, & Crisp, 2013). Positive Emotions/Engagement, good Relationships, Meaning and Purpose in life (PERMA) is a new agenda proposed by Seligman (2011) to insert positive psychology and mindfulness training as an overall

wellness and self-care approach supporting health care workers. Roeser et al. (2013) suggested for teachers, another high-stress occupation, the social cognitive perspective of mindfulness training as an effective coping stratagem.

The foundation of mediating the negative outcomes from OTS, like CF, is self-care (Wentzel & Brysiewicz, 2014). Empowering health care providers to examine susceptibility and employ self-care tactics, Wentzel and Brysiewicz (2014) suggested stress management support. Neville and Cole (2013) found a significant inverse relationship between CF and health promotion, and a moderate association between CS and engaging in self-care initiatives. Training programs in self-directed meditation demonstrated a reduction in stress and anxiety (Cutshall et al., 2011). For those who are busy or elect not to attend formal classes, computer-guided programs are available to promote self-care, wellness practices, and boost resilience (Cutshall et al., 2011).

Resilience characteristics of emergency nurses reach beyond personal abilities to bounce back, as thoughts, attitudes, and behaviors affect nurses' cohorts. Tubbert (2015) noted benefits of resilience training as affecting interpersonal connectedness of teams, increasing job satisfaction, and creating supportive relationships between nurses during and after work. Role-modeling resilience, important in a formal mentor relationship and part of nurses' observational learning, was introduced by Tubbert as affecting cohesiveness. Positive self-talk, self-awareness, and self-care are elements that nurses consistently advocate for others but often fail to practice themselves (Wicks, 2006).

Theoretical Framework and Learning

The two theoretical frameworks used to inform this PD plan of action were Bandura's social cognitive learning theory and Kolb's experiential learning theory (ELT). As part of the social cognitive theory, Bandura's (1977) triadic reciprocal determinism provided a framework of self-efficacy and functioning through interactions between individuals, the environment, and behaviors. Shoji et al. (2014) linked Bandura's (2012) self-efficacy to managing more effectively OTS demands, relating social support and self-efficacy as mediators between STS and secondary traumatic growth. The importance of this theoretical base and connection with positivity is the spotlight on tentative pathways chosen by individuals either to outcomes of positivity and posttraumatic growth, or biopsychosocial pathology. Shoji et al. suggested self-efficacy facilitates adaptation in trauma exposures, emphasizing the value of training opportunities for coping strategies skill attainment. The connections with positivity reinforced the theoretical base of social cognitive learning and teaching cognitive-behavioral coping and stress management skills to the learners.

Kantar (2014) linked the formation of groups and social interaction within Bandura's learning theory to the benefits of peer interaction, motivation, and learner satisfaction. Making a connection to knowledge and grasping its personal benefits motivates learners to store the new information, critically reflect, take ownership, and transfer knowledge to their behaviors (Curran, 2014). With perceived self-efficacy, and adding knowledge transfer to Bandura's (2012) social cognitive learning, the component of reciprocal determinism helps transfer learning into practice (Curran, 2014).

The second theory used to inform the project study PD program was Kolb's ELT, based upon cognitive behavioral learning whereby knowledge stems from experiences (Finch et al., 2015). Finch et al. (2015) suggested that ELT is becoming the principal theoretical lens used for examining the conversion of experience into learning, a higher order and integrative process whereby the learner makes meaning of and individualizes new events. McDermott (2012) added that experiences need to be relevant and connect with prior learning to be meaningful.

To address the lack of nurses' training in coping and resilience, the ADDIE design model helped to reinforce the concepts of cognitive-behavioral interventions and the social learning observations, environmental influences, experiences, and perceptions of the social learning theory (Bandura 2012; Bandura & Jeffery, 1973; Yoder & Terhorst, 2012). The criteria from the research noting the variety of ways in which adults learn, including the technology and visual needs of millennials, helped to shape the formation of the training plan for this project study in conjunction with the ADDIE model. Yoder and Terhorst (2012) proposed including the ADDIE model for effective nursing experiences and PD programs. Table 9 compares the ADDIE model of instructional design to the nursing process (Yoder & Terhorst, 2012).

Table 9

ADDIE Model and the Nursing Process

ADDIE	*Nursing Process (ADPIE)*
Analyzing	Assessing
Designing	Diagnosing
Developing	Planning
Implementing	Implementing
Evaluating	Evaluating

Bandura's SLT provided a base onto which a constructivism mode may build to improve teaching methods (Kantar, 2014). Kantar (2014) posited that students develop concepts within learning events, using prior knowledge as a guide to process new information. Motivation is a key to this process, connecting constructivism to Bandura through social and peer interaction as key to cognitive-behavioral social learning (Kantar, 2014; Rutherford-Hemming, 2012). The process of teaching using the ADDIE model within the constructs of SLT will provide a structure upon which to build learning and cognitive behavioral interventions and skills. Experiential learning brings together cognitive and behavioral perspectives, the ADDIE and nursing processes, and dynamics of interactions between individuals and their environments (Kolb & Kolb, 2012).

Experiential learning provides a system whereby experience may transmute into knowledge, skills, and attitudes (Dennick, 2012). Dennick (2012) touted ELT as quintessentially suited for clinical learning environments, speaking to the training interventions applied by peers and mentors with teams and cohorts in the workplace. As

a framework for designing a PD training program, Kolb's ELT contributed the concept that learning is a process of reconstructing experience and learning through interactions between learner and environment (Kolb & Kolb, 2012). The cycle of ELT is a series of transformations whereby learners experience, reflect, think, and act in response to what is learned and the situation (Kolb & Kolb, 2012). Kolb and Kolb (2012) differentiated between learning approaches contained within the construct of ELT as diverging, assimilating, converging, and accommodating.

The person with a divergent style of learning is best at seeing concrete events from different vantage points, permitting them to work well in brainstorming situations, generating ideas in a broader cultural sense, and are known as information gatherers (Kolb & Kolb, 2012). Those who have an assimilating style are good at approaching a broad base of information and integrating abstract concepts and are interested more in logic than practicality (Kolb & Kolb, 2012). The third style is converging, whereby the individuals are best at finding practical applications for ideas, solve problems, make decisions, and deal more readily with technical tasks than social issues (Kolb & Kolb, 2012). Finally, those with an accommodating style of learning respond to gut feelings, learn by hands-on experiences, rely on others for information, and prefer working together with others to complete projects (Kolb & Kolb, 2012).

Nurses' *see one, do one, teach one* process of learning also speaks to ELT and the experiential approach to group learning. For that learning to be the most effective, the peers must reflect and talk about experiences, which aligns with peer support cognitive-behavioral interventions. Kolb and Kolb (2012) noted that beyond learning facts, ideas

need to organize into a conceptual framework whereby they can be recovered to apply and transfer into other contexts. Encouraging nurses to take responsibility for their learning, rather than attend passively to meet the obligations of showing up and taking courses, may help them to engage more in the team and ELT approach to learning (Kolb & Kolb, 2012). An awareness of nurses' cognitive processes, engagement with peers, experiential and observational learning, and how nurses integrate experiences into knowledge encourages instructors to integrate SLT and ELT elements into training.

Project Description

The project created from the study results is a 3-day PD workshop broken into training segments of preparation, de-escalation, and self-care. The interactive workshops will feature the activities and sharing opportunities the study participants requested in the form of breakout sessions. There will also be discussions between the instructor(s) and trainees to encourage critical thinking, providing the opportunity for nurses to make the knowledge their own by applying what they learn to their circumstances and understanding (Brekelmans et al., 2013; Finch et al., 2015).

As learners require tactile, auditory, and visual cues for learning, those experiences will be included in the training (Yoder & Terhorst, 2012). The focus of the training will be to provide nurses with tools, strategies, and resources to affect resilience building, coping, greater group cohesion, and wellness practices (Li et al., 2013). The program becomes more flexible with adjustments to the training format, using a single subject or single day segment for nursing education. Modernizing training from traditional teaching methods into learner-centered focus for the more mobile,

contemporary learners, who prefer synergistic, collaborative learning opportunities, could increase learner interest and participation (Yoder & Terhorst, 2012).

The training will include a PowerPoint presentation, outline of the 3-day PD, handouts, and lists of institutional and local resources. Participants will learn about stress, resilience, coping, and posttraumatic growth, aligning with the categories of *stressors, stress managemen*t, *effects, coping and resilience, and training* that emerged through descriptive coding (Table 3). Data analysis revealed the need for training in these areas as study participants shared, "There are not enough classes to prepare people" (A1); acknowledging the need for, "Stress management to keep us being able to cope" (A2); "Tools to recognize signs and symptoms [of stress]" (A3); "Ongoing training in terms of trauma [and] stress" (A4); "I've learned how to bounce and change" (A2; "We need to focus on mutual respect and positive communications" (A5); and "All that positive stuff has to be there; inspiring things that make me not be stressed" (A5).

The data also revealed the necessity for reviewing communications skills, mindfulness, using mentors, peer support, and team building. The need for communicating and being in the present: "That way to communicate, especially in the moment, that makes things easier to handle" (A5); the need for mentoring, "It would be more manageable to ask them to assist other people" (A3); support, "It's always good to be a co-peer as opposed to just a coworker" (A7); and building cohesive cohorts, "Relying on your team members, working together for the same goal" (A4). The analysis revealed intertwining vantage points, as these suggestions revealed, leading to the consideration for continuing after work hours.

Participants will develop strategies for post-work socialization, using social media to enhance group cohesion, and exercising solidarity and support for promoting de-escalation during OTS exposures. As discovered through the data, socializing was a strength recommended by respondents that related to team building. "We go out after work; we hang out" (A1); "We need to have some external type of programs or activities … get-togethers after work" (A4). The data revealed nurses' opinions about using social media, "On Facebook we have a support group, you can vent, you get feedback, you get support" (A3); and "We need stress training, like, how to de-escalate yourself" (A7).

Attendees will discuss several coping mechanisms, including humor and spirituality, practice cognitive behavioral exercises like relaxation and guided meditation, and receive resource lists naming who they may contact for further information, instruction, or assistance. Data analysis brought forth coping mechanisms used, and nurses stated, "We have a darker side, a darker humor. It helps us to get through the hard stuff. We can look at each other and joke about things, and we know we understand" (A1); "The ever popular dark humor of emergency medicine that goes a long way in terms of stress reduction" (A4); and "We use sick humor, but I do think that helps a lot of people to talk through what we see and do, and I am, like spiritualism [*sic*]" (A7).

The need for relaxation instruction was evidenced strongly through one nurse, who said, "I can't just relax; I think there are things they need to do for us, [like] a quick session of doing some exercises [that] you could take home with you and get you to relax once you get home" (A3); or using "A drink to relax and unwind" (A7); giving evidence to the need for alternative coping strategies. The data also revealed that participants did

not know where to find resource information. Accessing resources is impossible if they are unknown, and one participant said it most succinctly: "There should be mandatory training on it. We have this resource; this is how you use it" (A5).

The connection between codes in the data analysis clarified the overlapping themes of *before, during,* and *after* OTS exposures. That overlap reinforced the consistent need declared by participants that training was necessary, it must address more than one element of OTS and a more holistic view of the nurse as a person. The cyclic pattern of preparation, de-escalation, and self-care called for a comprehensive resolution that could embrace opportunities for training in ongoing, interconnected systems.

Purpose

The purpose of the PD workshop (Appendix A) is to provide a PD program to ameliorate the coping, resilience, de-escalation, and self-care strategies of ED RNs. Interviews with seven emergency nurses revealed the need for training in overlapping areas of before, during, and after OTS exposures. The data from those interviews developed into themes of preparation, de-escalation, and self-care, guiding the project (Appendix A). A PD program that permits nurses to discuss collectively and develop strategies for resilience, coping, and stress management from the nurses' perspective is a new nursing educational training approach (Howe et al., 2012).

Support and Barriers

The corporate headquarters of the research site took an interest in this project study before the data collection phase and expressed hope that rather beyond completing a doctoral process the deliverable would benefit nurses. On-site training would require

an invitation by each of the sites within the corporate system through the Nursing Education and Emergency Department managers. The PD training workshop could also be offered to neighboring trauma center emergency and nursing education departments, as the research site holds no propriety over project contents.

Potential barriers would be financial support, accommodating training with the required technology, convincing managers of the need for and value of the program, and interesting nurses in participating. If the ED is unionized, the nurses might insist upon being paid their hourly wages for the training. Potential solutions to these barriers include gaining donations of refreshments from local retailers, like Costco, who have made donations in the past. Failure to secure funding for refreshments could mean that participants would supply meals and refreshments on their own. Working with the nursing education offices to make this training part of their annual competencies is another possibility as training rooms, and refreshments are budgeted. Waiving instructor fees to establish the course would reduce organizational financial commitments.

Roles and Responsibilities

The role of the student is as an independent, professional, self-directed learner. Each learner is responsible for taking the information and integrating it into their wellness plan and practice (Beck, 2011). The student is expected to show respect to the instructor(s) and other students, to engage in the discussions and breakout sessions, to consider new ways of thinking and learning, and to support their peers' learning.

Instructors' responsibilities include providing a safe, non-judgmental learning environment, maintaining a positive, supportive attitude and friendly demeanor, and

providing students with a positive and enlightening learning experience. As the class may contain technology-savvy millennials and mature students, the instructor must ensure that all remain engaged (Kahu, Stephens, Leach, & Zepke, 2013; Yoder & Terhorst, 2012). The instructor is also a mentor and resilient role model, which bears the responsibility of acting as an example in this environment of observational and experiential learning (Mealer et al., 2012).

Project Evaluation Plan

To ensure the success of the program in delivering to nurses stress management and coping training, students will have input to see what works for them and what needs improvement (Caffarella & Daffron, 2013). In addition to a paper evaluation, participants will be encouraged to provide feedback throughout the training days. The evaluation plan is goal-based with objectives for each of the three (3) days of the workshop. Evaluations will be collected from participants at the end of each day as some participants may not attend all three (3) days of the training.

The PD program is set up as goal-oriented based upon needs detailed by the research participants, what they saw as problematic, what they wanted to learn, and suggestions they had for improving stress management training (Yoder & Terhorst, 2012). In the evaluations, participants will detail learning according to objectives, critical nursing assessment, and evaluate outcomes as measurable goals (American Nurses Association [ANA], 2010). Evaluations are an important part of the key shifts in PD, and the short evaluations can be completed quickly at the end of each day, paying heed to nurses' time constraints and competing priorities (Govranos & Newton, 2014; Yoder &

Terhorst, 2012). The evaluation is a formative assessment tool whereby participants may offer input for future workshops, contributing to the positive evolution of nurse training (ANA, 2010).

An analysis of evaluation forms will inform instructors and site managers about whether the training met its goals; if training was effective; if it should be repeated; what might be revised or deleted; and what overall changes in the course might increase its value to participants. Critical evaluation of the success in reaching goals and outcomes is a part of the nursing ADPIE process. Participants, assistants from nursing education, and the instructor will evaluate the workshop from their perspectives. The workshop will be mutable to meet the needs of the participants, organization, and ongoing research developments. Daily and post-workshop input will be used to make changes in the workshop format, content, and materials to address future effectiveness.

Nursing science builds upon the analytical structure of the ADPIE process and evidence-based practice (ANA, 2010). To further evaluate the effectiveness of the workshop, management, and nursing education, should meet at established intervals post-workshop to discuss ongoing education in stress management. Those reflections may inform as to whether learners successfully applied skills to practice as part of social cognitive theory and reciprocal determinism (Curran, 2014). Ongoing peer input through systematic, criterion-based evaluation increases professional knowledge and ownership of the assessment and improvement of nursing education systems (ANA, 2010).

Stakeholders

Key stakeholders are the institution's ED manager, ED clinical manager, site nursing educator, director of nurses (DON), ED nurses participating in the training, their cohorts, course facilitators, and course instructor(s). Each of the stakeholders plays a role in the preparation, development, delivery, and services provided through the training. The ED manager and clinical manager are the gatekeepers for each site, and training can only occur with their support. These lower level managers must work with the approval and guidance of the DON to permit training outside of the standard nursing curriculum to meet hospital-specific education and gain funding for those endeavors. The site Nursing Educator is responsible for collaborating with the ED managers to develop training modules within specified budgets, time constraints, and subject matter determined as vital to nursing, and as part of their educational and employee support goals.

The importance of the project to the students is that they will receive training that can mediate the negative effects of OTS exposures in a more positive and healthy way. They will learn how to use mindfulness to center themselves in the present moment in a nonjudgmental way that decreases anxiety, supports clearer thinking and functioning, and decreases ruminating about work stressors (Fourer et al., 2013). They will learn skills to separate home from work through relaxation techniques, know when to vent to a peer, and know when to seek a higher level of intervention and help.

The training is important to the trainees' peers because the trainees will learn to watch over themselves and others in a more supportive way, bringing tools that may assist in team cohesion and peer support (Pines et al., 2012). The ED educators and

management benefit by a staff that is less likely to take personal days to escape the stress of work once they have more tools to deal with those stressors (Glynn & Silva, 2013; Wu et al., 2012). The ED managers and DON may benefit from a staff less likely to seek employment elsewhere.

The classroom attendees will benefit by sharing what is in their minds and hearts, often putting an end to the ubiquitous and ongoing fallacy of uniqueness many feel when they think they are the only ones suffering from negative feelings and symptoms of OTS (Miller, 1995). Everyone present will benefit by the emotional think tank that collectively develops as participants share tips and tricks for handling situations unique to ED RNs. The instructor(s) will benefit from exchanges with nurses who, through sharing, will educate in how to help other nurses deal with OTS, and remind of the value in sharing coping, resilience, and stress management knowledge.

Project Implications

Within the closed culture and context of trauma nursing, what happens in the ED stays private as nurses do not often share with outsiders or family. The myth that nurses are impervious to emotional trauma remains and trial by fire sometimes consumes caregivers exhausted by CF (Prati et al., 2011). To dispel the delusion that everyone *else* is tough enough, and to discover that affected nurses are not broken or mentally impaired because OTS bothers them, is a life-changing experience (Miller, 1995).

If the participants, stakeholders, and leaders in nursing see the change in employees following the pilot program and continue its efforts, the training could expand to other departments within the institution, producing greater change. This hospital could

stand as a beacon, inspiring nursing education to include stress management, de-escalation, preparatory resilience and response, and self-care training for nurses in other departments, and other hospitals. Hospital staff could share with collegiate nurse educator cohorts to include resilience, coping, and stress management training into nursing student programs as a preparatory strategy (Reeve, et al., 2013).

Introducing knowledge useful to ED managers and educators will help them to assist employees and address employee turnover (Mosadeghrad, 2013). The implications for positive social change embrace understanding and mediating the negative effects following OTS exposures. Enhancing nurses' resilience and introducing adaptive coping mechanisms may mitigate the pathological outcomes possible when overwhelming stress causes biopsychosocial illness and loss (Lavoie et al., 2011; Wlodarczyk & Lazarewicz, 2011). Because nurses are a valued part of society as caregivers for people at their weakest and worst, taking care of nurses can translate into a healthy boost for the global society of nurses. If nurses cannot take care of themselves, if no one will mediate the problems that could take nurses from nursing, society will suffer losses within an important profession on which they depend.

Summary

Section 3 concentrated on the elements necessary to construct a 3-day PD workshop for emergency nurses. The workshop format was chosen as an ideal method for training ED nurses in concepts and strategies surrounding resilience preparation, de-escalation, and self-care practices. The classroom arrangement permits training small

and large groups, supporting and encouraging information sharing among participants, skills rehearsal and reinforcement, and group interaction.

Section 4 will contain strengths and limitations of the project, recommendations for alternative approaches, and what nurses learned throughout the processes regarding research and development. Personal reflective analysis and my growth as a scholar-practitioner, project developer, and the importance of the work will also be discussed. Finally, Section 4 will close with potential implications for social change and recommendations for future research.

Section 4: Reflections and Conclusions

This project study addressed the community of nurses, who are expert at skills that improve the lives of people in crisis, and that meet patients' biopsychosocial needs. Nurses are among the last professionals who either believe or who have been told they are tough enough to manage intuitively what they do and see at work. This project addresses resilience and coping by providing a glimpse into the possibility of what might be given to this closed culture of professionals. Nurses should be trained to live so that they might come away with compassion satisfaction and a sense of accomplishment instead of compassion fatigue from caring too much for others and not enough for themselves (Hinderer et al., 2014).

This project study was inspired by a challenge from two Detroit emergency physicians, Dr. Marson Ma, and Dr. Don Benson, who promoted lifelong learning. They often said it was not enough to just know; individuals should ask what they are going to do with that information. Through the deliverable, I will address the latter.

Section 4 presents the project's strengths and limitations, additional training approaches, and alternative solutions to the problem studied. I share information gleaned from the process as a scholar, practitioner, and project developer. Reflecting on the importance of the work, I reveal my thoughts about implications, applications, and directions for future research. Through Walden University, I have reaffirmed my commitment to acting as an agent of social change, a lifelong practice following my mother's constant imperative of *how can you make this better*?

Project Strengths and Limitations

I have worked with emergency responders for more than 20 years. That experience provided a foundation for understanding the complexity of crisis management and the expectations of inherent resilience in nurses (Everly et al., 2010). Both responders and nurses share similar struggles with OTS, yet the organizational response and support for each group are light years apart. My experience served as a project strength: I have spent time with the literature, taught CISM in the field for emergency responders, and found support for translating that information into the nursing realm. Within the professional culture of nursing, the project development and presentation by a peer strengthens its value and relevancy (Hart, Person, Spiva, & Hart, 2013).

Another strength of the deliverable is that it mirrors positive training patterns used in military and emergency responder communities with good outcomes (Flarity et al., 2013). This project provides cognitive and behavioral training reinforcement of educating, building, and reinforcing resilience, and including self-care strategies in toolkits. The project represents the recognition of a need, and if implemented, establishes a pathway for nurses to follow toward wellness instead of biopsychosocial pathology.

The length of the workshop is its greatest limitation as it competes with nurses' priorities, time constraints, and indifference about continuing education (Govranos & Newton, 2014). Nursing requires mandated training modules to meet license and organizational requirements. Unless nurses recognize the need and have funding for the workshop, they may be less inclined to attend. Also, the newer generations, specifically millennials, desire a more technology-driven source of continuing education that they can

access from home. Addressing alternative approaches for providing training may mitigate the limitations of additional and lengthy training elements.

Recommendations for Alternative Approaches

Alternative ideas surfaced through suggestions made by study participants and observing related occupations' approaches. Existing training programs could be modified to assimilate themes of preparation, de-escalation, and self-care. Annual mandated competencies could include stress management training as a professional skill with measurable goals and outcomes. Department education could also incorporate stress management themes using skills, goals, and training elements as part of annual evaluations. Orientation could make wellness awareness and strategies part of new employee training modules. Departments could institute a voluntary or formal mentoring program that integrates coping and self-care training and practice, providing ongoing resilience and support resources.

Online resources could provide training through self-paced, private, and easily resourced systems for busy nurses. Programs today can be accessed by desktop or smart phone, affording options for stress management resources, training, and collaboration. Social media provides platforms where thinkers can share information, vent, validate one another's thoughts and feelings, and provide peer support in the context of their professional community. LinkedIn, Facebook, nursing and emergency responder blogs, and crisis management websites are a few of the online choices available to provide information, support, information exchange, and training.

Organizations might consider establishing a CISM program for training and response, variations of which are commonly used by military and emergency responder groups (Blacklock, 2012). Evaluating and revising current policies, or establishing them where none existed, could align nursing training and practice with others involved in high OTS exposure professions. Evaluating and revising orientations to include CISM could address training and response elements, different views, and varying OTS definitions. Posting educational handouts with preparation, de-escalation, and self-care themes could provide information in small increments to supplement or reinforce training. Making visual reminders within the work space of positive affirmations, resources like EAP, and team support are other alternatives to address learning needs.

Scholarship, Project Development, Leadership, and Change

Learning about qualitative research from classroom readings and assignments was minor compared to the depth of project execution. Familiar with the difference between reading and doing from nursing school, I expected an intricate and multistep experience for which I would rely heavily on resource materials. I was not disappointed. Conducting interviews, coding and analyzing data, and translating that information was a challenge that preceded the equal challenge of constructing a deliverable. Learning how to transfer accumulated knowledge into a palatable and effective product for nurses was the motivation for this doctoral journey.

The importance of continuing lifelong formal learning alongside other methods became critical to contributing to higher learning and nurses' continuing education. Creating an environment conducive to learning, taking into consideration the various

ways in which people learn, and holding individuals responsible for their learning are key to successful crisis intervention training processes (Curran, 2014; Rutherford-Hemming, 2012). Walden's imperative to act as a social change agent helped me to fuse the pieces of knowledge, experience, and desire to make things better into a learning platform. Centered on the works of Bandura's social cognitive learning theory and Kolb's experiential learning theory of adding meaning to knowledge and experience, that platform was ideal for the nursing population (Bandura, 2012; Curran, 2014; Finch et al., 2015; Kantar, 2014; McDermott, 2012).

During the research and development phase of the project, a new appreciation for the literature surfaced. There are many sources of information available from which to choose new material, establish training resources, and create effective programs that can change nurses' lives. Those resources provide guidance for holistic practices, cognitive positivity, mindfulness, wellness, a better relationship with coworkers, and a healthier self (Happell et al., 2013; Schmitz et al., 2012).

The process of project development provided additional learning experiences from planning to final deliverable. At each step, I reviewed books from previous courses to clarify each point and phase of the process. This journey challenged my intellect, stamina, and dedication. I wanted to honor those nurses who willingly participated in the research. I wanted them to know that their voices were heard, that change was possible.

Leadership, according to Knowles, Holton, and Swanson (2012), can be measured by a set of behavioral characteristics like executing the role of a change agent, describing theories, and formulating policies and procedures. Seligman (2011) described experience

as a basis for establishing the standard of leadership. Throughout the interviews and in developing this project, leadership has come forth as an expectation from nurses, that those with experience who have gone before will act as leaders. I hope nurses will embrace the concept of responsibility for an entirely new generation of nurses.

As a practitioner, I have reaffirmed and hope to share the credo that we are servant leaders. Serving nurses in ways that will help them learn and enhance skills in resilience and coping lays a solid path toward effecting change personally, professionally, and within nursing practice. I have also reaffirmed through this process of research, development, project developer, and reflecting on those steps, that to know is not enough. One absolutely must do.

Reflection on the Importance of the Work

Researchers, mental health professionals, crisis interventionists, and peers have gained access to the closed cultures of emergency responders and military personnel affected by occupational traumatic stress. Fallacies of uniqueness, like veils of ignorance, are beginning to fall away from those experiencing OTS. Military and emergency services have programs, policies, and procedures in place, but not nurses, who are expected to be resistant and resilient, coping by inherent qualities outside of training (Cornum et al., 2011; Hourani et al., 2011b; Jahnke et al., 2014). The implications of this knowledge are that the practice of caring for the caregiver needs to evolve. Without the appropriate training and attention to issues of resilience and coping secondary to OTS, nurses have been lost to burnout, suicide, PTSD, and stress-related illnesses (Lavoie et al., 2011; Wu et al., 2012).

What I learned through this process of reviewing the importance of the work is that nurses are now in the same infancy of critical incident stress recognition and management that military and emergency responders were in the past. I learned nurses in the field are suffering the same pathological sequelae as related occupations. During the interviews, I heard nurses, more concerned for other nurses than for themselves, asking for help. That knowledge has rekindled the passion for making a difference while reminding how daunting a task this has been for all those working toward that end. Applying this knowledge is the challenge, as integrating training for preparation, de-escalation, and self-care strategies is a project that will take many dedicated hands.

Future research might benefit by addressing nurse personality. Researchers may investigate whether the nurse is drawn to nursing because of trait characteristics, if those properties develop during the experience of nursing and OTS, or if both may be significant contributors. Knowing if there is a nurse personality may inform how to approach resistance, resilience, self-care, and training. Having a stronger understanding of personalities of successful nurses may also guide organizational hiring practices.

Almost all of the respondents to my research study were paramedics before becoming RNs; researchers might explore whether prehospital work enhances resilience and coping skills and strategies. Researchers might also try to identify whether those with prior emergency medical experience, like EMTs, police, and firefighters, are a better fit for becoming ED nurses. Comparing the expectations of those who had no previous emergency experience and those who were paramedics first could inform nurse managers

and educators in hiring and could help nurses in their senior years determine specialty choices.

The potential impact for positive social change is mostly individual as each nurse bears responsibility for beginning a positive chain of events toward wellness strategies (Wicks, 2006). Because stress management training is not part of standard nursing education or continuing education for practicing nurses, the nurse has to choose and possibly finance learning about resilience and coping strategies. Outside the boundaries of this project are organizational implications. No change in policy or procedure was addressed through this deliverable, though they are strongly suggested. Social change requires intention and effort; equipping nurses with tools to care for themselves and each other is the beginning of a long and involved process that could have a tremendous impact. Nurses are the group who cares for people in their most vulnerable moments; having healthy, engaged, clear-thinking nurses who maintain a passion for their work affects society as a whole.

Conclusion

Section 4 provided a summary of a journey undertaken with seven emergency nurses who shared thoughts, feelings, experiences, and ideas. I discussed project strengths, limitations, alternative approaches, scholarship, project development, leadership, and change. My reflections on the importance of the work, directions for future research, and the potential impact for positive social change were also presented.

Without training to provide and enhance nurses' resilience and coping skills, the negative effects of working in high stress environments without adequate strategies can

overpower even the strongest nurses' natural resiliencies (Dasgupta, 2012; Lavoie et al., 2011; Wlodarczyk & Lazarewicz, 2011). There are no mandates for stress management training in nursing programs or practicing nurses' continuing education (Adriaenssens et al., 2011). The research participants for this project study echoed that the patient continues to be the primary focus for nurses, setting a standard that the nurse comes after patients, equipment, policies and procedures, and anyone else needing nurses' attention. Enhancing resiliencies through training positive attitudes and perspectives, acknowledging the value of nurses, and giving meaning and purpose to their roles and accomplishments would represent forward motion (Hourani et al., 2011b). Nurses need to learn how to self-advocate and manage that care.

References

Adam, D., & Taylor, R. (2014). Compassionate care: Empowering students through nurse education. *Nurse Education Today*, *34*, 1242-1245. http://dx.doi.org/10.1016/j.nedt.2013.07.011

Adriaenssens, J., De Gucht, V., & Maes, S. (2012). The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. *International Journal of Nursing Studies*, *49*, 1411-1422. http://dx.doi.org/10.1016/j.ijnurstu.2012.07.003

Adriaenssens, J., De Gucht, V., & Maes, S. (2015). Determinants and prevalence of burnout in emergency nurses: A systematic review of 25 years of research. *International Journal of Nursing Studies*, *52*, 649-661. http://dx.doi.org/10.1016/j.ijnurstu.2014.11.004

Adriaenssens, J., De Gucht, V., Van Der Doef, M., & Maes, S. (2011, June). Exploring the burden of emergency care: Predictors of stress-health outcomes in emergency nurses. *Journal of Advanced Nursing*, *67*(6), 1317-1328. http://dx.doi.org/10.1111/j.1365-2648.2010.05599.x

Airosa, F., Andersson, S. K., Falkenberg, T., Forsberg, C., Nordby-Hornell, E., Ohlen, G., & Sundberg, T. (2011). Tactile massage and hypnosis as a health promotion for nurses in emergency care: A qualitative study. *Complementary and Alternative Medicine*, *11*(83), 1-8. http://dx.doi.org/10.1186/1472-6882-11-83

American Nurses Association. (2010). *Nursing: Scope and standards of practice* (2nd ed.). Retrieved from www.nursingworld.org/

American Trauma Society. (n.d.). Trauma center levels explained. Retrieved from http://www.amtrauma.org/?page=TraumaLevels

Attia, A. K., Adb-Elaziz, W. W., & Kandeel, N. A. (2012). Critical care nurses' perception of barriers and supportive behaviors in end-of-life care. *American Journal of Hospice & Palliative Medicine*, *30*(3), 297-304. http://dx.doi.org/10.1177/1049909112450067

Bailey, C., Murphy, R., & Porock, D. (2011). Professional tears: Developing emotional intelligence around death and dying in emergency work. *Journal of Clinical Nursing*, 20, 3364-3372. http://dx.doi.org/10.1111/j.1365-2702.2011.03860.x

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215. Retrieved from http://www.apa.org/journals/rev/

Bandura, A. (2012, September 27). On the functional properties of perceived self-efficacy revisited. *Journal of Management*, *38*(9), 9-44. http://dx.doi.org/10.1177/0149206311410606

Bandura, A., & Jeffery, R. W. (1973). Role of symbolic coding and rehearsal processes in observational learning. *Journal of Personality and Social Psychology*, *26*(1), 122-130. Retrieved from http://www.apa.org/journals/psp/

Bandura, A., Ross, D., & Ross, S. A. (1963). Vicarious reinforcement and imitative learning. *Journal of Abnormal and Social Psychology*, *67*(6), 601-607. Retrieved from https://archive.org/details/journalofabnorma08ameruoft

Beck, C. T. (2011, February). Secondary traumatic stress in nurses: A systematic review.

Archives of Psychiatric Nursing, *25*(1), 1-10. http://dx.doi.org/10.1016/j.apnu.2010.05.005

Benight, C. C. (2012, January). Understanding human adaptation to traumatic stress exposure: Beyond the medical model. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(1), 1-8.

Blacklock, E. (2012). Interventions following a critical incident: Developing a critical incident stress management team. *Archives of Psychiatric Nursing*, *26*(1), 2-8. http://dx.doi.org/10.1016/j.apnu.2011.04.006

Blaney, L. S. (2009). Beyond 'knee jerk' reaction: CISM as a health promotion construct. *The Irish Journal of Psychology*, *30*(1-2), 37-57. http://dx.doi.org/10.1080/03033910.2009.10446297

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods* (Custom ed.). Boston, MA: Allyn & Bacon.

Bonanno, G. A., & Mancini, A. D. (2012, January). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(1), 74-83.

Bonanno, G. A., Pat-Horenczyk, R., & Noll, J. (2011, June). Coping flexibility and trauma: The perceived ability to cope with trauma (PACT) scale. *Psychological Trauma: Theory, Research, Practice, and Policy*, *3*(2), 117-129.

Brekelmans, G., Poell, R. F., & Van Wijk, K. (2013). Factors influencing continuing professional development: A Delphi study among nursing experts. *European Journal of Training and Development*, *37*(3), 313-325.

http://dx.doi.org/10.1108/03090591311312769

Buurman, B. M., Mank, A. P., Beijer, H. J., & Olff, M. (2011). Coping with serious events at work: A study of traumatic stress among nurses. *Journal of the American Psychiatric Nurses Association*, *17*(5), 321-329. http://dx.doi.org/10.1177/1078390311418651

Caffarella, R. S., & Daffron, S. R. (2013). *Planning programs for adult learners: A practical guide* (3rd ed.). San Francisco, CA: Jossey Bass.

Carlson, J. A. (2010, September). Avoiding traps in member checking. *The Qualitative Report*, *15*(5), 1102-1113. Retrieved from http://srmo.sagepub.com/view/sage-encyc-qualitative-research-methods/n354.xml

Chan, A. O., Chan, Y. H., & Kee, J. P. (2012a). Awareness and utilization of peer support programs in Singapore public general hospitals. *International Journal of Emergency Mental Health*, *14*(3), 217-224.

Chan, A. O., Chan, Y. H., & Kee, J. P. (2012b). Improving resistance and resiliency through crisis intervention training. *International Journal of Emergency Mental Health*, *14*(2), 77-86.

Cieslak, R., Shoji, K., Lusczynska, A., Taylor, S., Rogala, A., & Benight, C. C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment*, *25*(3), 917-928. http://dx.doi.org/10.1016/j.apnu.2010.05.005

Cornum, R., Matthews, M. D., & Seligman, M. E. (2011, January). Comprehensive soldier fitness: Building resilience in a challenging institutional context. *American Psychologist*, *66*(1), 4-9. http://dx.doi.org/10.1037/a0021420

Cottingham, M. D. (2015, February). Learning to deal and de-escalate: How men in nursing manage self and patient emotions. *Sociological Inquiry, 85*(1), 75-99. http://dx.doi.org/10.1111/soin.12064

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (Custom ed.). Boston, MA: Pearson Education, Inc.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology, 11*(100), 1-9. http://dx.doi.org/10.1186/1471-2288-11-100

Curran, M. K. (2014, May). Examination of the Teaching Styles of Nursing Professional Development specialists, part I: Best practices in adult learning theory, curriculum development, and knowledge transfer. *The Journal of Continuing Education in Nursing*, *45*(5), 233-240. http://dx.doi.org/10.3928/00220124-20140417-04

Cutshall, S. M., Wentworth, L. J., Wahner-Roedler, D. L., Vincent, A., Schmidt, J. E., Loehrer, L. L., ... Bauer, B. A. (2011, March/April). Evaluation of a biofeedback-assisted meditation program as a stress management tool for hospital nurses: A pilot study. *Explore, 7*(2), 110-112. http://dx.doi.org/10.1016/j.explore.2010.12.004

Dasgupta, P. (2012). Effect of role ambiguity, conflict and overload in private hospitals' nurses' burnout and mediation through self-efficacy. *Journal of Health*

Management, 14(4), 513-534. http://dx.doi.org/10.117/0972063412468980

Dennick, R. (2012). Twelve tips for incorporating educational theory into teaching practices. *Medical Teacher*, *34*, 618-624. http://dx.doi.org/10.3109/0142159X.2012.668244

De Villers, M., & DeVon, H. A. (2012, November). Moral distress and avoidance behavior in nurses working in critical care and noncritical care units. *Nursing Ethics*, *20*(5), 589-603. http://dx.doi.org/10.117/0969733012452882

DeVivo, D., Quinn Griffin, M. T., Donahue, M., & Fitzpatrick, J. J. (2013, November). Perceptions of empowerment among ED nurses. *Journal of Emergency Nursing*, *39*(6), 529-533. http://dx.doi.org/10.1016/j.jen.2010.10.011

Drury, V., Craigie, M., Francis, K., Aoun, S., & Hegney, D. G. (2013). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Phase 2 results. *Journal of Nursing Management*, 1-13. http://dx.doi.org/10.1111/jonm.12168

Eley, D. S., & Eley, R. M. (2011, May). Personality traits of Australian nurses and doctors: Challenging stereotypes. *International Journal of Nursing Practice*, *17*, 380-387. http://dx.doi.org/10.1111/j.1440-172X.2011.01952.x

Everly, Jr., G. S., Barnett, D. J., Sperry, N. L., & Links, J. M. (2010, Winter). The use of psychological first aid (PFA) training among nurses to enhance population resiliency. *International Journal of Emergency Mental Health*, *12*(1), 21-31.

Everly, Jr., G. S., & Mitchell, J. T. (2010). A primer on critical incident stress management. Retrieved from http://www.icisf.org/who-we-are/what-is-cism

Everly, Jr., G. S., Welzant, V., & Jacobson, J. M. (2008). Resistance and resilience: The final frontier in traumatic stress management. *International Journal of Emergency Mental Health*, *10*(4), 1-10.

Finch, D., Peacock, M., Lazdowski, D., & Hwang, M. (2015). Managing emotions: A case study exploring the relationship between experiential learning, emotions, and student performance. *The International Journal of Management Education*, *13*, 23-36. http://dx.doi.org/10.1016/j.ijme.2014.12.001

Flarity, K., Gentry, J. E., & Mesnikoff, N. (2013). The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses. *Advanced Emergency Nursing Journal*, *35*(3), 247-258. http://dx.doi.org/10.1097/TME.0b013e31829b726f

Fourer, M., Besley, K., Burton, G., Yu, N., & Crisp, J. (2013, August). Enhancing the resilience of nurses and midwives: Pilot of a mindfulness-based program for increased health, sense of coherence and decreased depression, anxiety and stress. *Contemporary Nurse*, *45*(1), 114-125. DOI:10.5172/conu.2013.45.1.114

Frazier, P. A., Gavian, M., Hirai, R., Park, C., Tennen, H., Tomich, P., & Tashiro, T. (2011, March). Prospective predictors of posttraumatic stress disorder symptoms: Direct and mediated relations. *Psychological Trauma: Theory, Research, Practice, and Policy*, *3*(1), 27-36.

Gillespie, G. L., Bresler, S., Gates, D. M., & Succop, P. (2013). Posttraumatic stress symptomatology among emergency department workers following workplace aggression. *Workplace Health & Safety*, *61*(6), 247-254.

http://dx.doi.org/10.3928/21650799-20130516-07

Glynn, P., & Silva, S. (2013, March). Meeting the needs of new graduates in the emergency department: A qualitative study evaluating a new graduate internship program. *Nurse Educator*, *39*(2), 173-178. http://dx.doi.org/10.1016/j.jen.2011.10.007

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-607. Retrieved from http://www.nova.edu/

Govranos, M., & Newton, J. (2014, April). Exploring ward nurses' perceptions of continuing education in clinical settings. *Nurse Educator Today*, 34(4), 655-660. http://dx.doi.org/10.1016/j.nedt.2013.07.003

Hahn, V. C., Binnewies, C., Sonnentag, S., & Mojza, E. J. (2011). Learning how to recover from job stress: Effects of a recovery training program on recovery-related self-efficacy, and well-being. *Journal of Occupational Health Psychology*, *16*(2), 202-216. http://dx.doi.org/10.1037/a0022169

Happell, B., Dwyer, T., Reid-Searl, K., Burke, K. J., Caperchione, C. M., & Gaskin, C. J. (2013). Nurses and stress: Recognizing causes and seeking solutions. *Journal of Nursing Management*, *21*, 638-647. http://dx.doi.org/10.1111/jonm.12037

Harkin, M., & Melby, V. (2014). Comparing burnout in emergency nurses and medical nurses. *Clinical Nursing Studies*, *2*(3), 152-163. http://dx.doi.org/10.5430/cns.v2n3p152

Harris, L. J. (2013, December). Caring and coping: Exploring how nurses manage workplace stress. *Journal of Hospice & Palliative Nursing*, *15*(8), 446-454.

http://dx.doi.org/10.1097/NJH.0b013e3182a0de78

Hart, P., Person, J., Spiva, L., & Hart, P. (2013). The culture of the emergency department: An ethnographic study. *International Emergency Nursing*, *21*, 222-227. http://dx.doi.org/10.1016/j.ienj.2012.10.001

Hayward, R. M., & Tuckey, M. R. (2011). Emotions in uniform: How nurses regulate emotion at work via emotional boundaries. *Human Relations*, *64*(11), 1501-1523. http://dx.doi.org/10.1177/0018726711419539

Healy, S., & Tyrrell, M. (2011, July). Stress in emergency departments: Experiences of nurses and doctors. *Emergency Nurse*, *19*(4), 31-37. http://dx.doi.org/10.7748/en2011.07.19.4.31.c8611

Hegney, D. G., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V. (2013). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Study 1 results. *Journal of Nursing Management*, 1-13. http://dx.doi.org/10.1111/jonm.12160

Hinderer, K. A., VonRueden, K. T., Friedmann, E., McQuillan, K. A., Gilmore, R., Kramer, B., & Murray, M. (2014, July-August). Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses. *Journal of Trauma Nursing*, *21*(4), 160-169. http://dx.doi.org/10.1097/JTN.0000000000000055

Hinshaw, R. E., Burden, R., & Shriner, M. (2012). Supporting post-graduates' skill acquisition using components of constructivism and social learning theory. *Creative Education*, *3*, 874-877. http://dx.doi.org/10.4236/ce.2012.326131

Hourani, L. L., Council, C. L., Hubal, R. C., & Strange, L. B. (2011a, July). Approaches to the primary prevention of posttraumatic stress disorder in the military: A review of stress control literature. *Military Medicine*, *176*, 721-730. http://dx.doi.org/10.7205/MILMED-D-09-00227

Hourani, L. L., Kizakevich, P. N., Hubal, R., Spira, J., Strange, L. B., Holiday, D. B., ... McLean, A. N. (2011b, Spring). Predeployment stress inoculation training for primary prevention of combat related stress disorders. *Journal of Cyber Therapy & Rehabilitation*, *4*(1), 101-116. Retrieved from http://journalofcybertherapy.webs.com/

Howe, A., Smajdor, A., & Stockl, A. (2012). Towards an understanding of resilience and its relevance to medical training. *Medical Education*, *46*, 349-356. http://dx.doi.org/10.1111/j.1365-2923.2011.04188.x

Hulsheger, U. R., Alberts, H. J., Feinholdt, A., & Lang, J. W. (2012). Benefits of mindfulness at work: The role of mindfulness in emotion regulation, emotional exhaustion, and job satisfaction. *Journal of Applied Psychology*, *98*(2), 310-325. http://dx.doi.org/10.1037/a0031313

Jahnke, S. A., Gist, R., Poston, W. S., & Haddock, C. K. (2014). Behavioral health interventions in the fire service: Stories from the firehouse. *Journal of Workplace Behavioral Health*, *29*, 113-126. http://dx.doi.org/10.1080/15555240.2014.898568

Johnson, M., Cowin, L. S., Wilson, I., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges.

International Nursing Review, 562-569. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291466-7657

Kahu, E. R., Stephens, C., Leach, L., & Zepke, N. (2013). The engagement of mature distance students. *Higher Education Research & Development*, *32*(5), 791-804. http://dx.doi.org/10.1080/07294360.777036

Kantar, L. (2014). Incorporation of constructivist assumptions into problem based instruction: A literature review. *Nurse Education in Practice*, *14*, 233-241. http://dx.doi.org/http://dx.doi.org/10.1016/j.nepr.2013.08.010

Kaplan, B., & Maxwell, J. A. (2005). Qualitative research methods for evaluating computer information systems. In J. G. Anderson, & C. E. Aydin (Eds.), *Qualitative research methods for evaluating computer information systems* (pp. 30-55). http://dx.doi.org/10.1007/0-387-30329-4_2

Kirby, R., Shakespeare-Finch, J., & Palk, G. (2011, March). Adaptive and maladaptive coping strategies predict posttrauma outcomes in ambulance personnel. *Traumatology*, 17(4) 25 –34. http://dx.doi.org/10.1177/1534765610395623

Knowles, M. S., Holton, E. F., & Swanson, R. A. (2012). *The adult learner: The definitive classic in adult education and human resource development* (7th ed.). New York, NY: Taylor & Francis.

Kolb, A. Y., & Kolb, D. A. (2012). Experiential learning theory. In N. M. Seel (Ed.), *Encyclopedia of the sciences of learning* (pp. 1215-1219). New York, NY: Springer.

LaFauci Schutt, J. M., & Marotta, S. A. (2011, March). Personal and environmental

predictors of posttraumatic stress in emergency management professionals. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(1), 8-15.

Lavoie, S., Talbot, L. R., & Mathieu, L. (2011). Post-traumatic stress disorder symptoms among emergency nurses: Their perspective and a 'tailor-made' solution. *Journal of Advanced Nursing, 67*(7), 1514-1522. http://dx.doi.org/http://dx.doi.org/10.1111/j.1365-2648.2010.05584.x

LeBlanc, V. R., Regehr, C., Birze, A., King, K., Scott, A. K., MacDonald, R., & Tavares, W. (2011). The association between posttraumatic stress, coping, and acute stress responses in paramedics. *Traumatology, 17*(4), 10-16. http://dx.doi.org/10.1177/1534765611429078

Leeman, J., & Sandelowski, M. (2012). Practice-based evidence and qualitative inquiry. *Journal of Nursing Scholarship, 44*(2), 171-179. http://dx.doi.org/10.1111/j.1547-5069.2012.01449.x

Li, A., Early, S. F., Mahrer, N. E., Ba, Ma, Klaristenfeld, J. L., & Gold, J. I. (2013, January/February). Group cohesion and organizational commitment: Protective factors for nurse residents' job satisfaction, compassion fatigue, compassion satisfaction, and burnout. *Journal of Professional Nursing, 30*(1), 89-99. http://dx.doi.org/10.1016/j.profnurs.2013.04.004

Lodico, M. G., Spaulding, D. T., & Voegtle, K. H. (2010). *Methods in educational research: From theory to practice*. San Francisco, CA: Jossey-Bass.

Lowenstein, T. (n.d.). Life stress test. Retrieved from http://www.cliving.org/DOWNLOAD%20PRINTABLE%20LIFE%20STRESS%

20TEST.html

Macomb Community College. (2014-2015). Course descriptions. Retrieved from http://www.macomb.edu/resources/catalogs-schedules/attachments/MCC-Catalog.pdf

Mairean, C., & Turliuc, M. N. (2013). Predictors of various trauma beliefs among medical staff. *Journal of Loss & Trauma: Perspectives on International Coping*, *18*(5), 414-428. http://dx.doi.org/10.1080/15325024.2012.714200

McDermott, J. (2012). Looking back to move forward: A view of nursing education through the theoretical lens of Dewy, James and Tyler. *Nurse Education Today*, *32*, 839-841. http://dx.doi.org/10.1016/j.nedt.2012.06.020

Meadows, M. P., Shreffler, K. M., & Mullins-Sweatt, S. N. (2011). Occupational stressors and resilience in critical occupations: The role of personality. *Occupational Stress and Well Being*, *9*, 39-61. http://dx.doi.org/10.1108/S1479-3555(2011)0000009006

Mealer, M., & Jones, J. (2013, October-December). Posttraumatic stress disorder in the nursing population: A concept analysis. *Nursing Forum*, *48*(4), 279-288. http://dx.doi.org/10.1111/nuf.12045

Mealer, M., Jones, J., & Moss, M. (2012). A qualitative study of resilience and posttraumatic stress disorder in United States ICU nurses. *Intensive Care Medicine*, *38*, 1445-1451. http://dx.doi.org/10.1007/s00134-012-2600-6

Meretoja, R., & Koponen, L. (2012). A systematic model to compare nurses optimal and actual competencies in the clinical setting. *Journal of Advanced Nursing*, *68*(2),

414-422. http://dx.doi.org/10.1111/j.1365-2648.2011.05754.x

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Merriam, S. B., Caffarella, R. S., & Baumgartner, L. M. (2007). *Learning in adulthood: A comprehensive guide* (3rd ed.). San Francisco, CA: Jossey-Bass.

Mesmer-Magnus, J., Glew, D. J., & Viswesvaran, C. (2012). A meta-analysis of positive humor in the workplace. *Journal of Managerial Psychology*, *27*(2), 155-190. http://dx.doi.org/10.1108/02683941211199554

Meyer, E. C., Zimering, R., Daly, E., Knight, J., Kamholz, B. W., & Gulliver, S. B. (2012). Predictors of posttraumatic stress disorder and other psychological symptoms in trauma-exposed firefighters. *Psychological Services*, *9*(1), 1-15. http://dx.doi.org/10.1037/a0026414

Miller, L. (1995, Winter). Tough guys: Psychotherapeutic strategies with law enforcement and emergency services personnel. *Psychotherapy: Theory, Research, Practice, Training*, *32*(4), 592-600. http://dx.doi.org/10.1037/0033-3204.32.4.592

Mitchell, J. T. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Services*, 8, 36–39

Mitchell, J., & Bray, G. (1990). *Emergency services stress: Guidelines for preserving the health and careers of emergency services personnel*. Englewood Cliffs, NJ: Simon & Schuster.

Moreland, J. J., & Apker, J. (2015). Conflict and stress in hospital nursing: Improving

communicative responses to enduring professional challenges. *Health Communications*, 1-9. http://dx.doi.org/10.1080/10410236.2015.1007548

Mosadeghrad, A. M. (2013). Occupational stress and turnover intention: Implications for nursing management. *International Journal of Health Policy and Management, 1*(2), 169-176. http://dx.doi.org/10.15171/ijhpm.2013.30

Mueller-Leonhardt, A., Mitchell, S. G., Vogt, J., & Schurmann, T. (2014). Critical incident stress management (CISM) in complex systems: Cultural adaptation and safety impacts in health care. *Accident Analysis and Prevention, 68*, 172-180. http://dx.doi.org/10.1016/j.aap.2013.12.018

Neville, K., & Cole, D. A. (2013). The relationships among health promotion behaviors, compassion fatigue, burnout, and compassion satisfaction in nurses practicing in a community medical center. *The Journal of Nursing Administration, 43*(6), 348-354. http://dx.doi.org/10.1097/NNA.0b013e3182942c23

Orly, S., Rivka, B., Rivka, E., & Dorit, S. (2012). Are cognitive-behavioral interventions effective in reducing occupational stress among nurses. *Applied Nursing Research, 25*, 152-157. http://dx.doi.org/10.1016/j.apnr.2011.01.004

Palm, K. M., Polusny, M. A., & Follette, V. M. (2004). Vicarious traumatization: Potential hazards and interventions for disaster and trauma workers. *Prehospital and Disaster Medicine, 19*(1), 73-78. http://dx.doi.org/10.1017/S1049023X00001503

Peters, L., Cant, R., Sellick, K., O'Connor, M., Lee, S., & Burney, S. (2012). Is work stress in palliative care nurses a cause for concern: A literature review.

International Journal of Palliative Nursing, *18*(11), 561-567. Retrieved from http://www.magonlinelibrary.com/toc/ijpn/current

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2011). Patient-related violence at triage: A descriptive qualitative study. *International Emergency Nursing*, *19*, 12-19. http://dx.doi.org/10.1016/j.ienj.2009.11.007

Pines, E. W., Rauschhuber, M. L., Norgan, G. H., Cook, J. D., Canchola, L., Richardson, C., & Jones, M. E. (2012). Stress resiliency, psychological empowerment and conflict management styles among baccalaureate nursing students. *Journal of Advanced Nursing*, *68*(7), 1482-1493. http://dx.doi.org/10.1111/j.1365-2648.2011.05875.x

Por, J., Barriball, L., Fitzpatrick, J., & Roberts, J. (2011). Emotional intelligence: Its relationship to stress, coping, well-being and professional performance in nursing students. *Nurse Education Today*, *31*, 855-860. http://dx.doi.org/10.1016/j.nedt.2010.12.023

Potter, P., Deshields, T., Berger, J. A., Clarke, M., Olsen, S., & Chen, L. (2013, March). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum*, *40*(2), 180-187. http://dx.doi.org/10.1188/13.ONF.180-187

Prati, G., Pietrantoni, L., & Cicognani, E. (2011, February 14). Coping strategies and collective efficacy as mediators between stress appraisal and quality of life among rescue workers. *International Journal of Stress Management*, 1-15. http://dx.doi.org/10.1037/a0021298

Reeve, K. L., Shumaker, C. J., Yearwood, E. L., Crowell, N. A., & Riley, J. B. (2013). Perceived stress and social support in undergraduate nursing students' educational experiences. *Nurse Education Today*, *33*, 419-424. http://dx.doi.org/10.1016/j.nedt.2012.11.009

Regehr, C., Goldberg, G., & Hughes, J. (2002). Exposure to human tragedy, empathy, and trauma in ambulance paramedics. *American Journal of Orthopsychiatry*, *72*(4), 505-513. http://dx.doi.org/10.1037//0002-9432.72.4.505

Richardson, K. M., & Rothstein, H. R. (2008). Effects of occupational stress management intervention programs: A meta-analysis. *Journal of Occupational Health Psychology*, *13*(1), 69-93. http://dx.doi.org/10.1037/1076-8998.13.1.69

Robinson, S., & Manacapilli, T. (2014). *Enhancing performance under stress: Stress inoculation training for battlefield airmen* [Report]. Retrieved from Rand Corporation: http://www.rand.org/

Rocchio, L. M. (2010, March). *Trauma psychology: What the anxiety disorders specialist needs to know*. Paper presented at the Anxiety Disorders Association of America Conference, Baltimore, MD.

Roehl, A., Reddy, S. L., & Shannon, G. J. (2013, Spring). The flipped classroom: An opportunity to engage millennial students through active learning. *Journal of Family and Consumer Sciences*, *105*(2), 44-49. Retrieved from http://www.aafcs.org/Resources/Journal.asp

Roeser, R. W., Schonert-Reichl, K. A., Jha, A., Cullen, M., Wallace, L., Wilensky, R., ... Harrison, J. (2013). Mindfulness training and reductions in teacher stress and

burnout: Results from two randomized, waitlist-control field trials. *Journal of Educational Psychology*, *105*(3), 787-804. http://dx.doi.org/10.1037/a0032093

Rose, R. D. (2014). Self-guided multimedia stress management and resilience training. *The Journal of Positive Psychology*, *9*(6), 489-493. http://dx.doi.org/10.1080/17439760.2014.927907

Rose, R. D., Buckley Jr., J. C., Zbozinek, T. D., Motivala, S. J., Glenn, D. E., Carteine, J. A., & Craske, M. G. (2013). A randomized controlled trial of a self-guided, multimedia, stress management and resilience training program. *Behaviour Research and Therapy, 51*, 106-112. http://dx.doi.org/10.1016/j.brat.2012.11.003

Rosenstein, A. H., & Naylor, B. (2012). Incidence and impact of physician and nurse disruptive behaviors in the emergency department. *The Journal of Emergency Medicine*, *43*(1), 139-148. http://dx.doi.org/10.1016/j.jemermed.2011.01.019

Rudman, A., & Gustavsson, J. P. (2012). Burnout during nursing education predicts lower occupational preparedness and future clinical performance: A longitudinal study. *International Journal of Nursing Studies*, *49*, 988-1001. http://dx.doi.org/10.1016/j.ijnurstu.2012.03.010

Rutherford-Hemming, T. (2012, August). Simulation methodology in nursing education and adult learning theory. *Adult Learning*, *23*(3), 129-137. http://dx.doi.org/10.1177/1045159512452848

Saldana, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). Thousand Oaks, CA: Sage.

Salters-Pedneault, K., Ruef, A. M., & Orr, S. P. (2010). Personality and

psychophysiological profiles of police officer and firefighter recruits. *Personality and Individual Differences*, 49(3), 210-215. http://dx.doi.org/10.1016/j.paid.2010.03.037

Schiraldi, G. R., Jackson, T. K., Brown, S. L., & Jordan, J. B. (2010, Spring). Resilience training for functioning adults: Program description and preliminary findings from a pilot investigation. *International Journal of Emergency Mental Health*, *12*(2), 117-129.

Schmitz, G. R., Clark, M., Heron, S., Sanson, T., Kuhn, G., Bourne, C., ... Coomes, J. (2012, Jan-Mar). Strategies for coping with stress in emergency medicine: Early education is vital. *Journal of Emergencies, Trauma, and Shock*, *5*, 64-69.

Schwabe, L., Dickinson, A., & Wolfe, O. T. (2011). Stress, habits, and drug addiction: A psychoneuroendocrinological perspective. *Experimental and clinical psychopharmacology*, *19*(1), 53-63. http://dx.doi.org/10.1037/a0022212

Seligman, M. E. (2011). *Flourish*. New York, NY: Simon & Schuster.

Shaban, I. A., Khater, W. A., & Akhu-Zaheya, L. M. (2012). Undergraduate nursing students' stress sources and coping behaviours during their initial period of clinical training: A Jordanian perspective. *Nurse Education in Practice*, *12*, 204-209. http://dx.doi.org/10.1016/j.nepr.2012.01.005

Shoji, K., Bock, J., Cieslak, R., Zukowska, K., Luszczynska, A., & Benight, C. C. (2014). Cultivating secondary traumatic growth among health care workers: The role of social support and self-efficacy. *Journal of Clinical Psychology*, *70*(9), 831-846. http://dx.doi.org/10.1002/jclp.22070

Simmons, A., & Yoder, L. (2013, January - March). Military resilience: A concept analysis. *Nursing Forum*, *48*(1), 17-25. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1744-6198

Sood, A., Prasad, K., Schroeder, D., & Varkey, P. (2011). Stress management and resilience training among department of medicine faculty: A pilot randomized clinical trial. *Journal of General Internal Medicine*, *26*(8), 858-861. http://dx.doi.org/10.1007/s11606-011-1640-x

Southwick, S. M., & Charney, D. S. (2012). *Resilience: The science of mastering life's greatest challenges*. New York, NY: Cambridge University Press.

St. Clair County Community College. (2015). Associate degree nursing: AAS. Retrieved from http://catalog.sc4.edu/preview_program.php?catoid=1&poid=62&returnto=59

Sundermann, O., Hauschildt, M., & Ehlers, A. (2013). Perceptual processing during trauma, priming and the development of intrusive memories. *Journal of Behavior Therapy and Experimental Psychiatry*, *44*, 2013-220. http://dx.doi.org/10.1016/j.jbtep.2012.10.001

Tarantino, B., Earley, M., Audia, D., D'Adamo, C., & Berman, B. (2013, January/February). Qualitative and quantitative evaluation of a pilot integrative coping and resiliency program for health care professionals. *Explore*, *9*(1), 44-47. http://dx.doi.org/10.1016/j.explore.2012.10.002

Todd, T. P., Vurbic, D., & Bouton, M. E. (2014). Behavioral and neurobiological mechanisms of extinction in Pavlovian and instrumental learning. *Neurobiology*

of Learning and Memory, 108, 52-64. http://dx.doi.org/10.1016/j.nlm.2013.08.012

Tubbert, S. J. (2015). Resiliency in emergency nurses. *Journal of Emergency Nursing*, 1-6. http://dx.doi.org/http://dx.doi.org/10.1016/j.jen.2015.05.016

U.S. Department of the Air Force. (2014). *Disaster Mental Health Response & Combat and Operational Stress Control: Air Force Instruction 44-153.* Retrieved from http://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-153/afi44-153.pdf

U.S. Department of Veterans Affairs. (2015). DSM-5 criteria for PTSD. Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp

Varvogli, L., & Darvin, C. (2011). Stress management techniques: Evidence-based procedures that reduce stress and promote health. *Health Science Journal, 5*(2), 74-89. Retrieved from http://www.hsj.gr/

Vashdi, D. R., Bamberger, P. A., & Bacharach, S. (2012). Effects of job control and situational severity on the timing of help seeking. *Journal of Occupational Health Psychology*, *17*(2), 206-219. http://dx.doi.org/10.1037/a0026858

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013, April). Is stigma internalized: The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*, *60*(2), 311-316. http://dx.doi.org/10.1037/a0031889

Von Rueden, K. T., Hinderer, K. A., McQuillan, K. A., Murray, M., Logan, T., Kramer, B.,...Friedmann, E. (2010, October-December). Secondary traumatic stress in trauma nurses: Prevalence and exposure, coping, and personal/environmental characteristics. *Journal of Trauma Nursing*, *17*(4), 191-200.

http://dx.doi.org/10.1097/JTN.0b013e3181ff2607

Walden University. (2015). Research ethics planning worksheet. Retrieved from http://academicguides.waldenu.edu/researchcenter/orec/application

Wayne State University. (2015). College of nursing curriculum. Retrieved from http://nursing.wayne.edu/bsn-traditional/curriculum.php

Webster, J. R., Beehr, T. A., & Love, K. (2011). Extending the challenge-hindrance model of occupational stress: The role of appraisal. *Journal of Vocational Behavior*, *79*, 505-516. http://dx.doi.org/10.1016/j.jvb.2011.02.001

Weiten, W. (2008). *Psychology: Themes and variations: Briefer version* (7th ed.). Belmont, CA: Wadsworth, Cengage Learning.

Wentzel, D., & Brysiewicz, P. (2014, January). The consequence of caring too much: Compassion fatigue and the trauma nurse. *Journal of Emergency Nursing*, *4*(40), 95-97. http://dx.doi.org/10.1016/j.jen.2013.10.009

Westwood, R. I., & Johnston, A. (2013). Humor in organization: From function to resistance. *Humor: International Journal of Humor Research*, *26*(2), 219-247. http://dx.doi.org/10.1515/humor-2013-0024

Wicks, R. J. (2006). *Overcoming secondary stress in medical and nursing practice: A guide to professional resilience and personal well-being*. Oxford, NY: Oxford University Press.

Williams, A. (2012). Emotion work in paramedic practice: The implications for nurse educators. *Nurse Education Today*, *32*, 368-372. http://dx.doi.org/10.1016/j.nedt.2011.05.008

Wlodarczyk, D., & Lazarewicz, M. (2011). Frequency and burden with ethical conflicts and burnout in nurses. *Nursing Ethics*, *18*(6), 847-861. http://dx.doi.org/10.1177/096973311408053

Wu, T., Fox, D. P., & Adam, C. (2012). Work-related stress and intention to quit in newly graduated nurses. *Nurse Education Today*, *32,* 669-674. http://dx.doi.org/10.1016/j.nedt.2011.09.00

Yoder, S. L., & Terhorst, R. (2012). Beam me up, Scotty: Designing the future of nursing professional development. *The Journal of Continuing Education in Nursing*, *43*(10), 456-462. http://dx.doi.org/10.3928/00220124-20120904-78

Zeller, J. M., & Levin, P. F. (2013). Mindfulness interventions to reduce stress among nursing personnel: An occupational health perspective. *Workplace Health & Safety*, *61*(2), 85-89. http://dx.doi.org/10.3928/21650799-20130116-67

Appendix A: Professional Development Program

Preparation, De-Escalation, and Self-Care Strategies for Nurses

by

Sherry Lynn Jones

Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

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Professional Development Program for Nurses

The project is a Professional Development (PD) program designed for nurses to provide preparatory education and skills development in resilience, coping, and stress management. Nurses do not receive preparatory, de-escalation, or self-care training in nursing school or through mandated continuing education within their institutions. The stressors particular to the closed professional culture of nurses points to the need for providing training of peers in a safe, supportive, and nonjudgmental environment whereby they may share thoughts, feelings, experiences, and strategies.

Purpose

The purpose of this project is to provide an educational PD program containing tools, strategies, and resources to prepare nurses for OTS, to manage the challenges of the workday, and to learn methods of renewal and self-care to mitigate the negative effects of OTS. This project outlines a 3-day PD program, *Preparation, De-Escalation, and Self-Care Strategies for Nurses,* designed specifically for the nursing population. Providing nurses with the ability to meet face to face, discuss, vent, validate, and collectively develop new strategies for resilience, coping, and stress management outside the normal skills and patient care focus of nursing education is a new training approach.

Background

This project is the result of study findings gleaned through qualitative interviews of seven emergency department RNs. Findings of the study revealed that nurses desired to supplement their training with personal self-help strategies to deal with OTS exposures, and support coworkers under those same strains. Those nurses who had been

in practice for many years, some as paramedics before entering nursing, shared their desire to improve or enhance existing skills in addition to learning new skills. This PD program was designed to address those needs in practical and succinct ways, giving the nurses material for their personal and professional tool kits.

Target Audience

The target audience for this training is emergency department RNs. Although the training could benefit other ED staff, management, and ancillary department nurses, opening the training to mixed groups could hinder open conversation, participation, and problem-solving directions of trauma nurses.

Goals

The first goal is to provide preparatory training as a resilience-boosting tool to prepare for OTS occurrences. The second goal is to provide de-escalation, mindfulness, team cohesion, and coping tools to apply during work for stress mediation. The third goal is to assist the nurses in building a self-care and stress management repertoire outside of work to bolster wellness attitudes and practices.

Learning Objectives

The learning objectives for this program by day:

- **Day 1:** Participants will be able to:
    - define stress, resilience, coping, and positivity;
    - recognize signs and symptoms of stress;
    - describe different coping methods;
    - identify personal resilience factors; and

  - discuss self-efficacy, positivity, and posttraumatic growth.

- **Day 2**: Participants will be able to:
  - define de-escalation, peer support, and team cohesion;
  - discuss motivating factors for de-escalation, peer support, and team cohesion;
  - demonstrate the ability to practice mindfulness strategies;
  - discuss the impact of positive communication; and
  - recognize support resources.
- **Day 3:** Participants will be able to:
  - define self-care, mindfulness, and wellness;
  - state the importance of self-care and wellness practices;
  - discuss humor, spirituality, cognitive-behavioral strategies;
  - discuss coping and self-care differences between introverts and extroverts; and
  - develop a plan to incorporate resilience, de-escalation, and self-care strategies for work and home.

Implementation

The PD program will be offered as a 3-day workshop sponsored by the hospital. The workshop will be held in cooperation with the sponsoring hospital's nursing education department. E-mails sent through the hospital mailing system will advertise the workshop, and participants will be able to register for the workshop through the nursing education department.

The program will initially accommodate 20 students to ensure optimal learning

opportunities. One instructor will teach the class with support volunteers from the administration for signing in and distributing handouts. Nurse educators will act as support staff for breakout sessions, and as content and site experts during discussions. A tentative schedule has been established for each days' training and activities.

Materials needed for each of the three days follows:

- flip chart with sticky-back adhesion strips;
- flip chart stand;
- computer linked to projection equipment and screen;
- colored markers for flip chart $\geq$ 12 (no yellow);
- pens and note pads/paper for each participant; and
- copies of the PowerPoint outline, daily class schedule, handouts, resource lists, daily evaluation forms.

Student supplies, the institution's CEU sign-in form, and handouts will be on a table just inside the classroom entrance door. The instructor will supply the treats and trinkets for Day 2 icebreaker activity.

Day 1 Schedule: *Preparation*, De-Escalation, and Self-Care *Strategies for Nurses*

Day 1	Instructional Strategies/Learning Activities	Time
Registration 0730-0800	Refreshments and signing in	**30 Minutes**
Icebreaker 0800-0830	Welcome and icebreaker activity (instructor and participants self-introduce, state goals)	**30 Minutes**
Instructional Strategy (IS) #1 0830-0900	Overview/purpose of 3-day PD program, background, research, and literature leading to 3-day workshop; review Day 1 objectives.	**30 Minutes**
Learning Activity (LA) #1 0900-0930	Instructor led discussion: Different learning styles, learner's preferred style, how that contributes to new knowledge retention	**30 Minutes**
IS #2 Discussion 0930-1015	Instructor led discussion about stress, signs and symptoms of OTS; preparatory education	**45Minutes**
1015-1030	**Morning break**	**15 Minutes**
LA #2 Part 1 of 2 1030-1045	Participants will complete self-inventory of stressors (Appendix C)	**15 Minutes**
LA #2 Part 2 of 2 1045-1115	Participants will discuss the self-inventory and share results/thoughts in open discussion	**30 Minutes**
IS #3 Discussion 1115-1200	Instructor led discussion about resilience, background, empowerment, healthy lifestyle.	**45 Minutes**
LA #3 Part 1 of 2 1200-1215	Participants will individually complete the resilience self-evaluation (Appendix D)	**15 Minutes**
1215-1300	**Lunch** – boxed meals provided	**45 Minutes**
LA #3 Part 2 of 2 1300-1330	Participants will discuss resilience self-inventory, sharing results in open discussion	**30 Minutes**
IS #4 1330-1345	Instructor led discussion: establishing a CIS plan to recognize stress, increase resilience	**15 Minutes**
LA #4 Part 1 of 2 1345-1400	Small groups: Writing ideas for increasing resilience in self and cohorts	**15 Minutes**
LA #4 Part 2 of 2 1400-1415	Participants will share results with class	**15 Minutes**
IS #5 1415-1500	Instructor led discussion about coping methods and practical strategies	**45 Minutes**
1500-1515	**Afternoon Break**	**15 Minutes**
LA #5 Part 1 of 2 1515-1530	Small groups: Three blessings exercise	**15 Minutes**
LA #5 Part 2 of 2 1530-1545	Participants will share results with class	**15 Minutes**
IS #6 1545-1600	Instructor led discussion: Positivity	**15 Minutes**
1600-1630	Review of Day 1, overview Day 2	**30 Minutes**

Instructor Guidelines Day 1: Introduction and Preparation

- Welcome participants; make staff introductions; icebreaker.
- Describe the workshop purpose, goals, and expectations.
- Review the learning objectives for day one.
- Review ground rules (phones/electronics off, respect for all participants, lunches/refreshments supplied and on premises).
- Encourage participation; there will be breakout groups, we value everyone's input.
- Review facility (exits, bathrooms, etc.).
- Remind to sign in, sign CEU form, fill out evaluations at end of day.
- Review schedule for the day.
- **PowerPoint Presentation: Welcome/Icebreaker:** Activity with self-introductions of staff/participants regarding nursing skills, stating, "My name is (name), and I am good with (medications, trauma care, needles, or multitasking) because (state why)." The labels, "Super Drug Math Whiz, Super Coder, Super Poker, and Super Nurse" begin separating function from person. The nurses will share personal goals for the course, moving into a personal cognitive realm.
- **Instructional Strategy #1:** Large group: Review research study findings and literature supporting workshop content; define terms, review Day 1 learning objectives; participation, asking questions and giving feedback encouraged.
- **Learning Activity #1:** Large group: Reflecting research study participants who expressed different ways of learning, the activity will encourage self-discovery

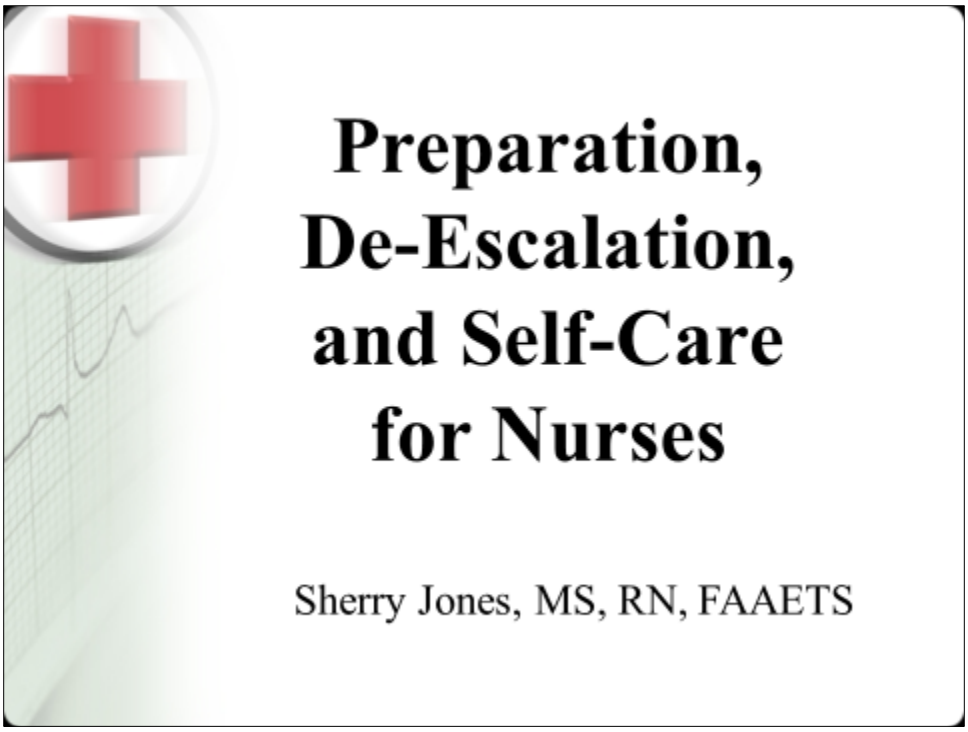
and increase awareness of how self/others learn. Participants split into groups of 4-5 based on the skill they chose in the icebreaker (each skill is a group).

- **Instructional Strategy #2:** Large group: All participants will discuss stress, its biopsychosocial sources and indicators, differentiating between acute and cumulative stress, outcomes of stress, signs and symptoms of OTS, and how home and work stressors interact and affect one another.
- **Learning Activity #2:** *Part 1:* Large group: All participants will use Appendix C evaluation tool to self-identify current life stressors. *Part 2:* In open discussion, participants may choose to share results and thoughts about home and work stressors, and how they overlap. Participants will be encouraged to recreate the list at 3-6 month intervals after employing coping strategies to see if there is a difference before and after the workshop. (Two-part activity)
- **Instructional Strategy #3:** Large group: All participants will discuss preparatory resilience, its military influences, self-inoculation training, and empowerment using knowledge as a strategy. Resilience as a preparatory strategy includes living a healthy lifestyle and recognizing individuals' resilience attributes.
- **Learning Activity #3:** *Part 1:* All participants will self-administer the evaluation tool to recognize resilience attributes. *Part 2:* Participants may choose to share select results or thoughts about self-evaluation measurement of resilience and how resilience may impact coping. Participants will be encouraged to repeat the test at 3-6 month intervals after employing coping strategies to reevaluate.
- **Instructional Strategy #4:** Large group: All participants will discuss how they

plan to prepare for exposures of CIS and OTS by increasing resilience in self, guiding others to strategies increasing resilience, and recognizing stress in coworkers that may indicate responses to OTS.

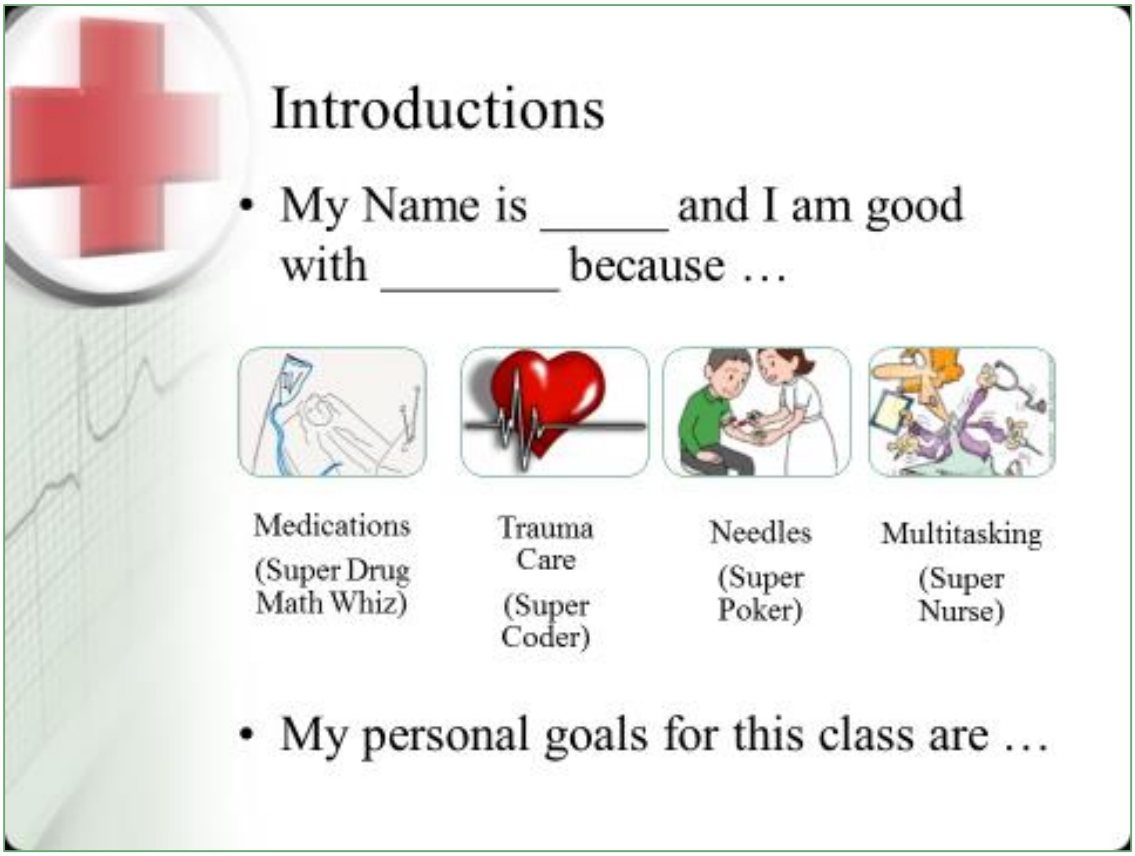
- **Learning Activity #4:** *Part 1:* In small groups of 4-5, create a resilience plan by collaborating with the group to write ideas intended to increase resilience in self and others, recognizing and responding to stress in others. *Part 2:* Participants will share results of learning activity with class.
- **Instructional Strategy #5:** Large group: All participants will discuss most commonly used coping methods by emergency responders, and practical strategies to mediate the effects of OTS exposures.
- **Learning Activity #5:** *Part 1:* In small groups of 4-5, participants will reflect on their last shift worked, share ideas and experiences, and write three positive things that went well on that day (prepare to explain why). One person from each group will act as recorder to write responses on a sticky-backed newsprint sheet. *Part 2:* Recorder or designate will report (and post) the collective list to the class.
- **Instructional Activity #6:** Large group: All participants will discuss positivity and reframing situations as part of an overall resilience and coping plan of action.
- **Review of Day 1:** All participants: Opportunity for Q&A and comments, review Day 1 goals and learning activities. Briefly discuss Day 2. Distribute evaluation forms, encourage their completion and remind nurses to sign CEU forms.

PowerPoint Presentation: **Introduction** and **Welcome**



Remind participants that this is a course based on what nurses have relayed during the project study research as what they feel they need to learn. Input is encouraged throughout the course as modifications will be made to include participants' contributions. Reevaluation and revision of the course and content will be ongoing to give the most effective, timely, and relevant material. The content spread over the 3-day period may be modified for *mini-trainings* and available to the nurses for shorter CEU presentations and in-services.

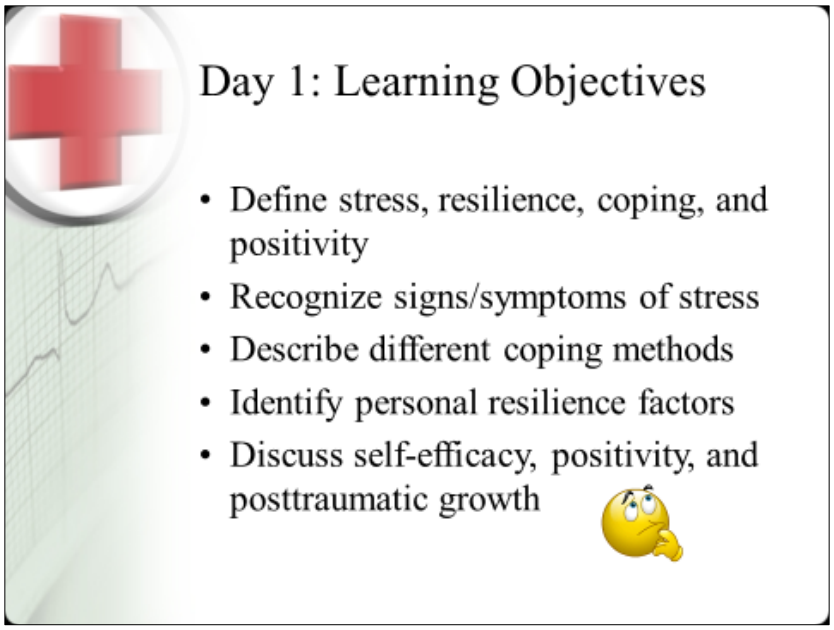
0800-0830: Welcome/**Icebreaker**: Entire Group



Remind nurses that we sometimes lose our *self* by self-identifying through a professional license, title, or skillset. Breaking through labels is part of learning how to work through traumatic exposures and taking care of ourselves. Begin the process of nurses thinking of this training as not a set of steps to take care of patients, equipment, meet competencies, or fulfill organizational obligations. If the nurses do not care for themselves, they will not be able to care for anyone else: *Put your own mask on first!*

0830-0900 IS #1: Objectives, Research/Literature Background: Entire Group

Objective	Discuss learning objectives for Day 1
	Participants will learn to define terms
	Discuss supporting literature
	Discuss research study findings

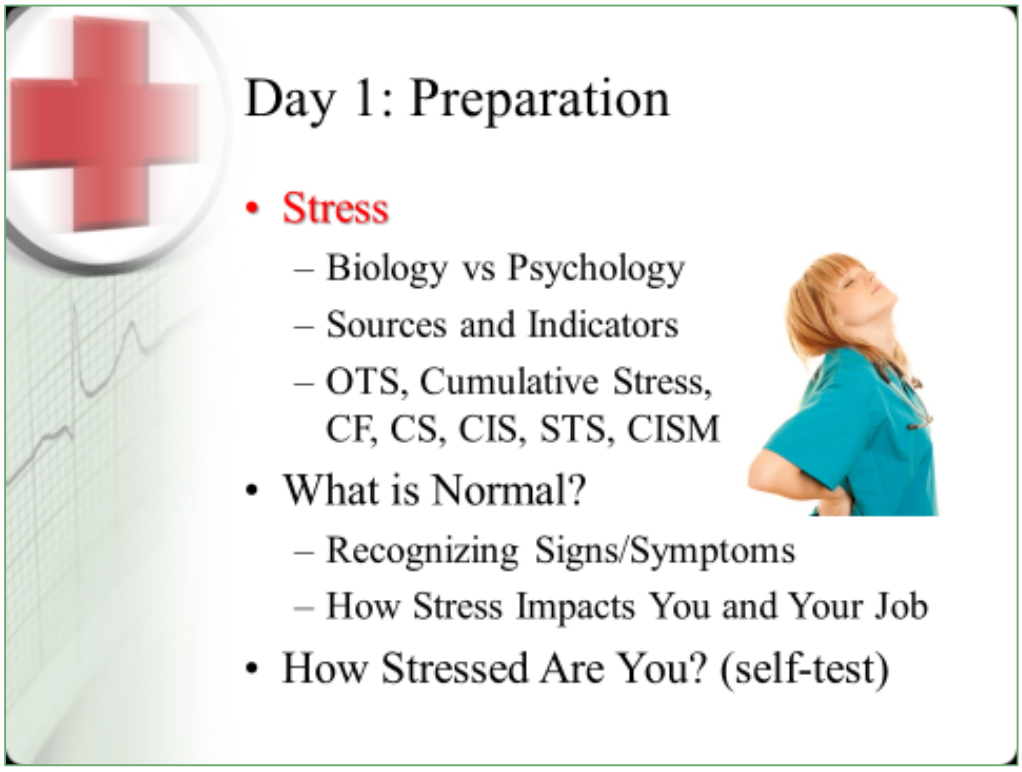


0900-0930 LA #1: Discuss Different Learning Styles: Entire Group

Objective	Discuss learning styles

0930-1015 IS #2: Preparation: Stress: Entire Group

Objective	Discuss stress, norms, types, and signs and symptoms of stress



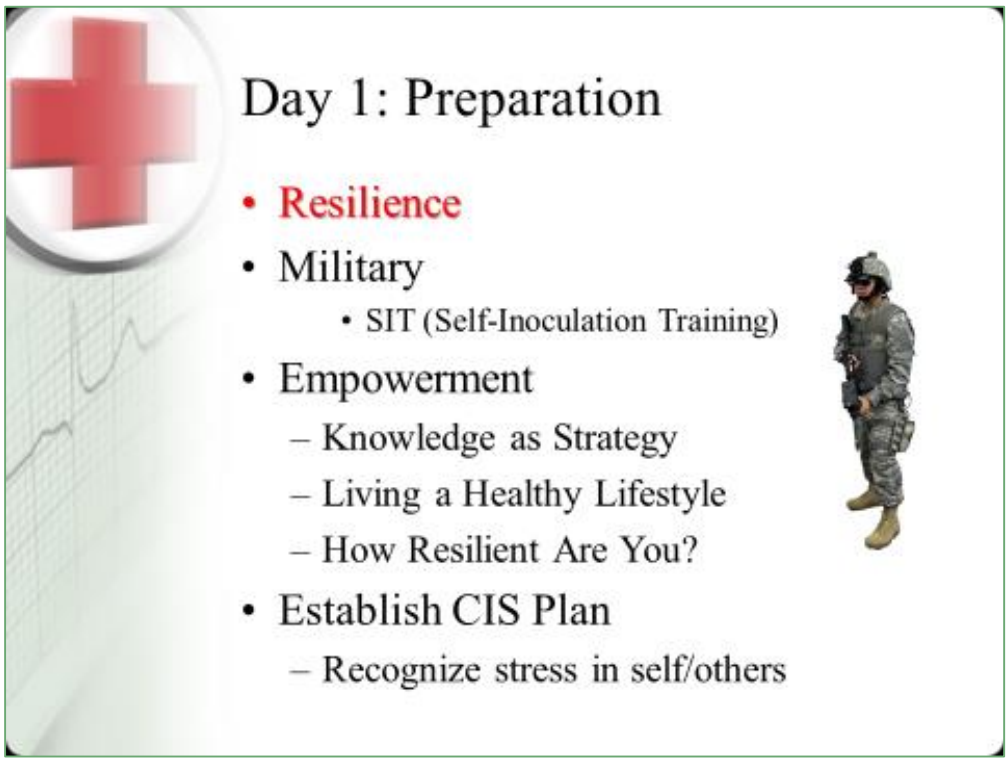
Participants are reminded that stress is individual, perceptual, varies with person, time, place, and situation. Understanding the expected responses to stress defuses their impact, and knowing when others may be responding to stress allows us to intervene in a healthier manner. Before we can help anyone, we have to be aware.

1030-1045 LA #2/Self-Test – Stress Evaluation: Entire Group

Objective (Appendix C)	Give examples of current work stressors that affect home
	Give examples of current home stressors that affect work
	Discuss results of inventory with class
	Discuss overlap of work/home stressors

1115-1200 IS #3: Preparation: Resilience: Entire Group

Objective	Discuss resilience, empowerment, wellness



Remind participants that resilience is a tool that can be enhanced through practice. Repeating the stress indicator self-evaluation and resilience self-evaluation tool at three and six-month intervals may guide participants to pay attention to their stress levels, resilience strengths and weaknesses, and the need for additional support.

1200-1215 LA #3: Self-Evaluation of Resilience: Entire Group

Objective (Appendix D)	Self-assess resiliency through evaluation
	Discuss results of resilience self-evaluation

1330-1345 IS #4: Preparation: Resilience: Entire Group

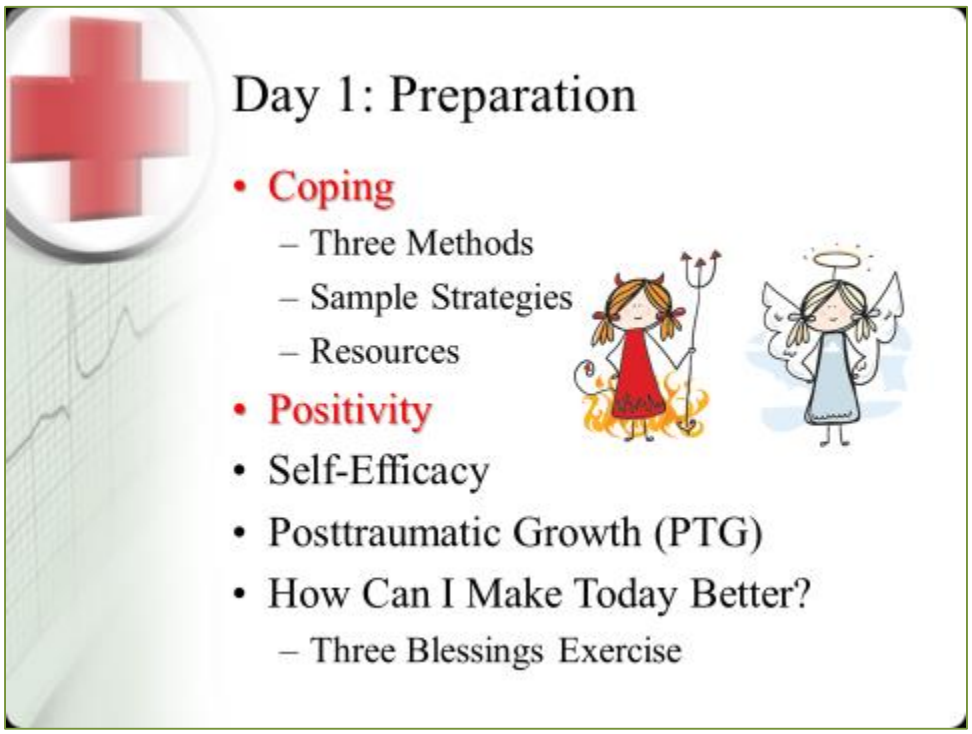
Objective	Discuss resilience, empowerment, wellness

1345-1400 LA #4: Establish a Resilience Plan**:** Small Groups (4-5 people)

Objective	Create a preparatory resilience plan
	Discuss plans developed by groups with class

1415-1500 IS #5: Preparation: Coping Methods and Strategies: Entire Group

Objective	Discuss coping methods
	Discuss practical strategies for coping



Developing effective coping strategies takes time especially when breaking old habits.

1515-1545 LA #5: Three Blessings Exercise: Small Groups (4-5 people)

Objective	Each person gives three examples of things that went well their last shift.
	Discuss results with class

Reframing remodels a negative situation into a positive, or *blessing*. Urge the class to continue this practice at home, actively rethinking situations to find what works well.

1545-1600 IS #6: Preparation: Positivity: Entire Group

Objective	Discuss positivity
	Discuss self-efficacy
	Discuss posttraumatic growth (PTG)

1600-1630: Entire Group

Objective	Review Day 1, evaluations, sign out

Day 1 Participant Evaluation Form

On a scale of 1-5, please rate the following:					
Program Effectiveness	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
The presentation material contributed to my learning.	❑	❑	❑	❑	❑
The information was presented at an appropriate learning level.	❑	❑	❑	❑	❑
The visual aids and handouts were satisfactory.	❑	❑	❑	❑	❑
The activities were effective.	❑	❑	❑	❑	❑
The presenter demonstrated knowledge of the subject material.	❑	❑	❑	❑	❑
The presentation met the stated objectives below (The participants will be able to):	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
Define stress, resilience, coping, and positivity	❑	❑	❑	❑	❑
Recognize signs and symptoms of stress	❑	❑	❑	❑	❑
Describe different coping methods	❑	❑	❑	❑	❑
Identify personal resilience factors	❑	❑	❑	❑	❑
Discuss self-efficacy, positivity, and posttraumatic growth	❑	❑	❑	❑	❑
Comments					
The best part of today was: The worst part of today was: Additional comments:					

Day 2 Schedule: Preparation, ***De-Escalation***, and Self-Care ***Strategies for Nurses***

Day 2	Instructional Strategies/Learning Activities	Time
0800-0830 **LA #1**	Welcome Back! Pass the Bedpan; overview objectives	**30 Minutes**
IS #1 **0830-0900**	Review Day 2 learning objectives, terms, site discuss organizational resources with site staff	**30 Minutes**
IS #2 **0900-0930**	Instructor led discussion: trauma setting de-escalation during OTS exposures	**30 Minutes**
IS #3 **0930-1015**	Instructor led discussion: mindfulness, humor, CB interventions, resources, walking away	**45Minutes**
1015-1030	**Morning break**	**15 Minutes**
LA #2 Part 1 of 2 **1030-1045**	Small groups: participants discuss mindfulness to de-escalate, walking away	**15 Minutes**
LA #2 Part 2 of 2 **1045-1115**	Participants present and discuss findings from each group to class	**30 Minutes**
IS #4 **1115-1145**	Instructor led discussion about peer support, motivating factors, benefits	**30Minutes**
IS #5 **1145-1215**	Instructor led discussion about mentoring, motivating factors, supportive resources	**30 Minutes**
1215-1300	**Lunch** – boxed meals provided	**45 Minutes**
LA #3 Part 1 of 2 **1300-1315**	Participants will break into small groups to develop examples of how they can support and mentor their peers	**15 Minutes**
LA #3 Part 2 of 2 **1315-1345**	Participants present and discuss findings from each group to class	**30 Minutes**
LA #4Part 1 of 2 **1345-1400**	Small group discussion about support resources, how to meet peer support and training needs within and outside organization	**15 Minutes**
LA #4 Part 2 of 2 **1400-1415**	Participants present and discuss findings from each group to class	**15 Minutes**
IS #6 **1415-1500**	Instructor led discussion about team cohesion, motivating factors	**45 Minutes**
1500-1515	**Afternoon Break**	**15 Minutes**
LA #5 Part 1 of 2 **1515-1530**	Small groups: develop list of ways in which to increase team cohesion in your ED	**15 Minutes**
LA #5 Part 2 of 2 **1530-1545**	Participants present and discuss findings from each group to class	**15 Minutes**
IS #7 **1545-1600**	Instructor led discussion: Positive communication	**15 Minutes**
1600-1630	Review of Day 2, Q/A, additional thoughts, overview Day 3, sign out	**30 Minutes**

Day 2: Instructor Guidelines

Preparation, ***De-Escalation***, and Self-Care ***Strategies for Nurses***

- Welcome participants to Day 2, re-introduce instructor and ancillary support staff.
- Review the workshop purpose, goals, and expectations
- Review ground rules (phones/electronics off, respect for all participants, lunches/refreshments supplied and on premises).
- Encourage participation; there will be breakout groups, we value everyone's input.
- Review facility (exits, bathrooms, etc.).
- Remind to sign in, sign CEU form, fill out evaluations at end of day.
- Review schedule for the day.
- **PowerPoint Presentation: Welcome Back/Icebreaker: Learning Activity #1:** Pass the Bedpan: All participants will pass a bedpan filled with treats and trinkets around the room. Encouraging discussion, those who choose to share thoughts after reflecting on Day 1 may take two treats. Those who want to pass may take one treat (maintaining the option of contributing later and getting a second treat).
- **Instructional Strategy #1:** Large group: Review of Day 2 learning objectives, participation, asking questions, giving feedback encouraged; define terms. Re-introduction of nursing education staff who can address resources available within their specific institution (objective #5), and how to access those resources.
- **Instructional Strategy #2:** Large group: All participants will discuss de-escalation in the trauma ED setting, what it means to the staff to incorporate

positive strategies during a trauma, and benefits/motivating factors for implementing real-time and positive de-escalation strategies.

- **Instructional Strategy #3:** Large group: All participants will discuss mindfulness, practical strategies, and how staying in the moment helps to focus on the present situation; motivating factors for including mindfulness strategies; appropriate humor as a de-escalation strategy, mindful of surroundings; real-time cognitive behavioral interventions, and available resources (chaplains, EAP) in urgent situations. Consider spiritual needs. All participants will have the opportunity to practice brief mindfulness strategies (like deep cleansing breaths, circle breathing). Discuss when and how to meet needs of removing self from stressors (walk away).
- **Learning Activity #2:** Part 1: Small groups: Participants discuss de-escalation strategies that have worked for them in the past, what they would like to try in the future, and assemble the best strategies on a sticky-back poster paper. Included are strategies to help nurses who need to leave the immediate area to de-escalate. Part 2: Representative of group posts list on the wall and discusses strategies that worked well and new mindfulness de-escalation strategies they would like to try.
- **Instructional Strategy #4:** All participants will discuss formal and informal peer support addressing one-on-one and group strategies, motivating factors for instituting a peer support initiative, maintaining individual support outside of formal programs, and the benefits of peer support.
- **Instructional Strategy #5:** All participants will discuss formal and informal

mentoring relationships as an educational and peer support method of de-escalation; motivating factors and benefits for including mentoring relationships beyond nursing orientation; and supportive resources available to staff during work hours to address assisted de-escalation and defusing interventions for staff support.

- **Learning Activity #3:** Small groups: Part 1: Participants will develop examples of how they can support and mentor their peers at work. Ideas will be written on a sticky-back poster paper by a recorder for the group. Part 2: Representative of each group posts their list on the wall and discusses their group's ideas for support and mentoring strategies.
- **Learning Activity #4:** Small groups: Part 1: Participants will discuss support resources, how to meet peer support and training needs sourcing within and outside of the organization. Assemble strategies written by the group recorder on a sticky-back poster paper. Part 2: Representative of group posts list on the wall and discusses strategies their group developed.
- **Instructional Strategy #6:** All participants will discuss team cohesion and motivating factors for using de-escalation strategies within a supportive team atmosphere to help work cohorts function in a more unified and supportive manner. Include discussion similar to pre-surgical time out where everyone stops to look around, see where they are at in the process, make sure everyone is on point, and see if there are any items (or people) requiring attention. Consider the phrase and supportive actions following, *how can I help*?

- **Learning Activity #5:** Small groups: Part 1: Participants will develop a list of ideas as to how they might increase team cohesion. A representative of the group will record the ideas on sticky-backed poster paper. Part 2: Representative of group posts list on the wall and discusses their list of strategies to increase ED team cohesion with class.
- **Instructional Strategy #7:** All participants will discuss positive communication as a strategy of de-escalating stressors. Discuss the benefits of not pursuing every discussion, attending to the mindfulness of letting go and other strategies to increase cohesion. Conversely, discuss the benefits and appropriate application of using courageous or crucial conversation as a de-escalation strategy that may permit ending situations instead of fueling small problems.
- **Review of Day 2:** All participants: Opportunity for Q&A and comments, review Day 1 goals and learning activities. Briefly discuss Day 2. Distribute evaluation forms, encourage their completion and remind nurses to sign CEU forms.

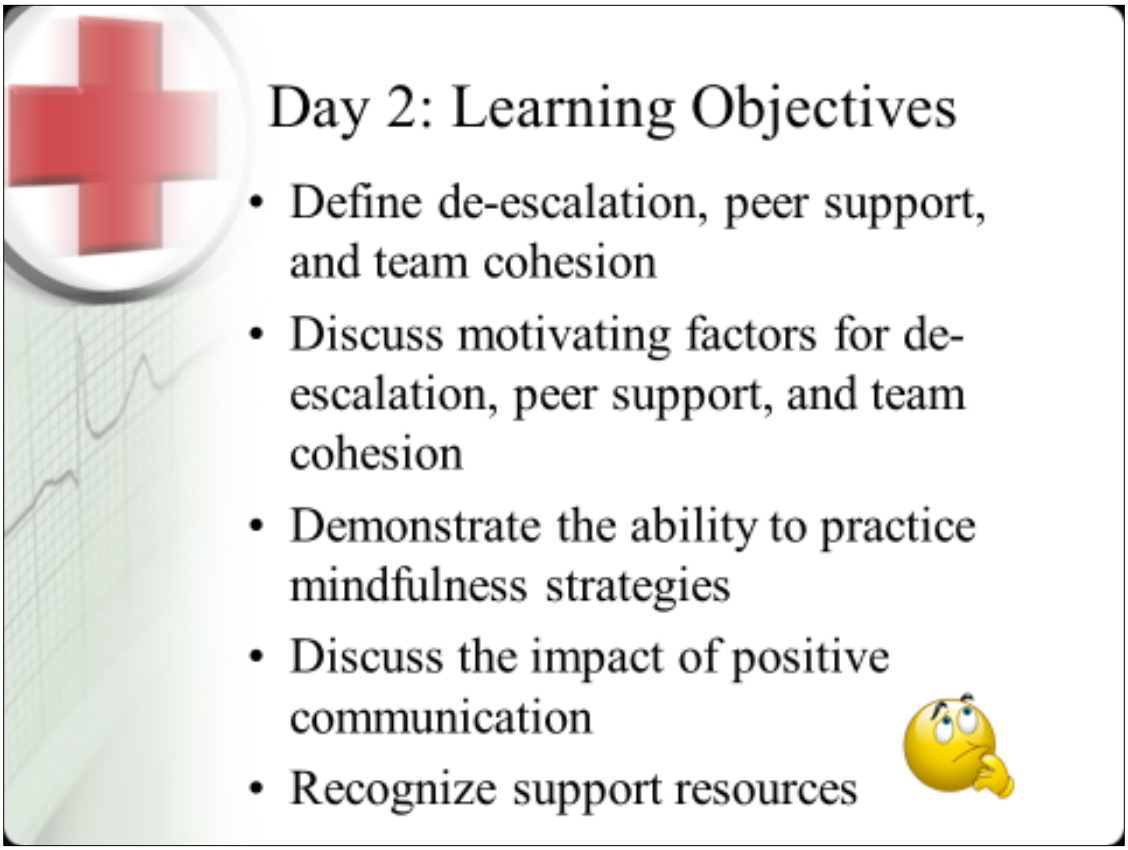
Welcome Back!

0800-0830 LA #1: Welcome/Icebreaker: Entire Group

Objective	Discuss participants' reflections from Day 1 during a fun activity

0830-0900 IS #1: Day 2 Learning Objectives: Entire Group

Objective	Discuss learning objectives for Day 2
	Participants will learn to define terms
	Discuss supporting literature
	Discuss research study findings

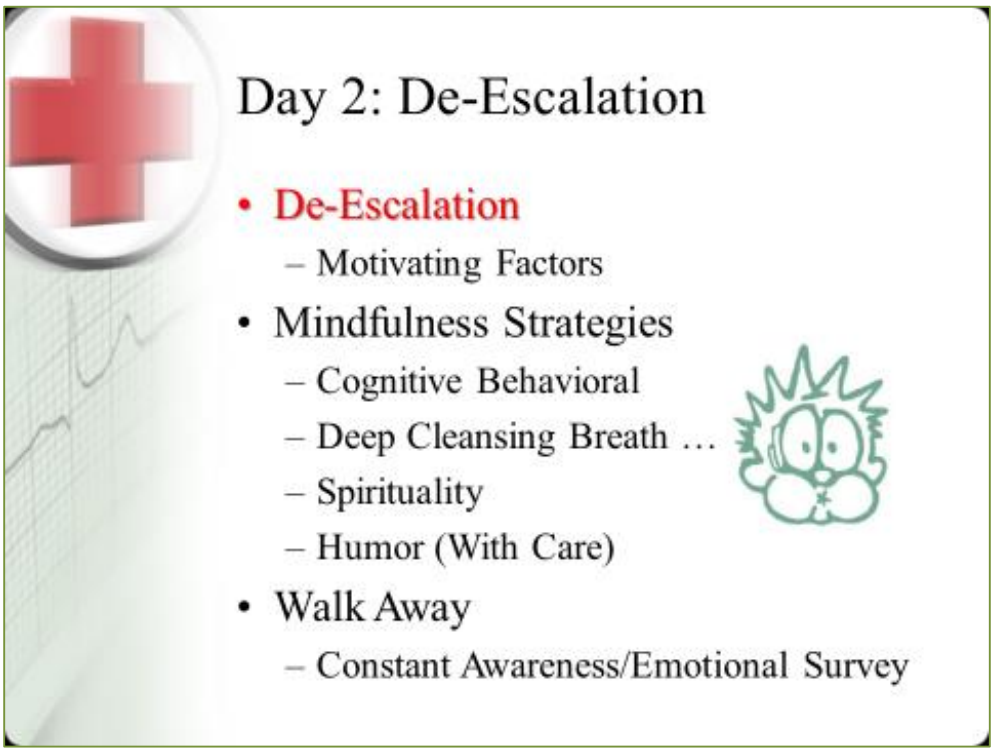


0900-0930 IS #2: Trauma De-Escalation: Entire Group

Objective	Discuss trauma de-escalation strategies
	Discuss motivating factors to employ strategies

0930-1015 IS #3: Mindfulness Strategies: Entire Group

Objective	Discuss mindfulness
	Participants will learn and practice mindfulness strategies
	Discuss humor and spirituality components of mindfulness
	Discuss need to step away from trauma



1030-1115 LA #2: Mindfulness Exercise: Small Groups

Objective	Discuss mindfulness strategies
	Develop a list of mindfulness de-escalation strategies
	Discuss strategies with class

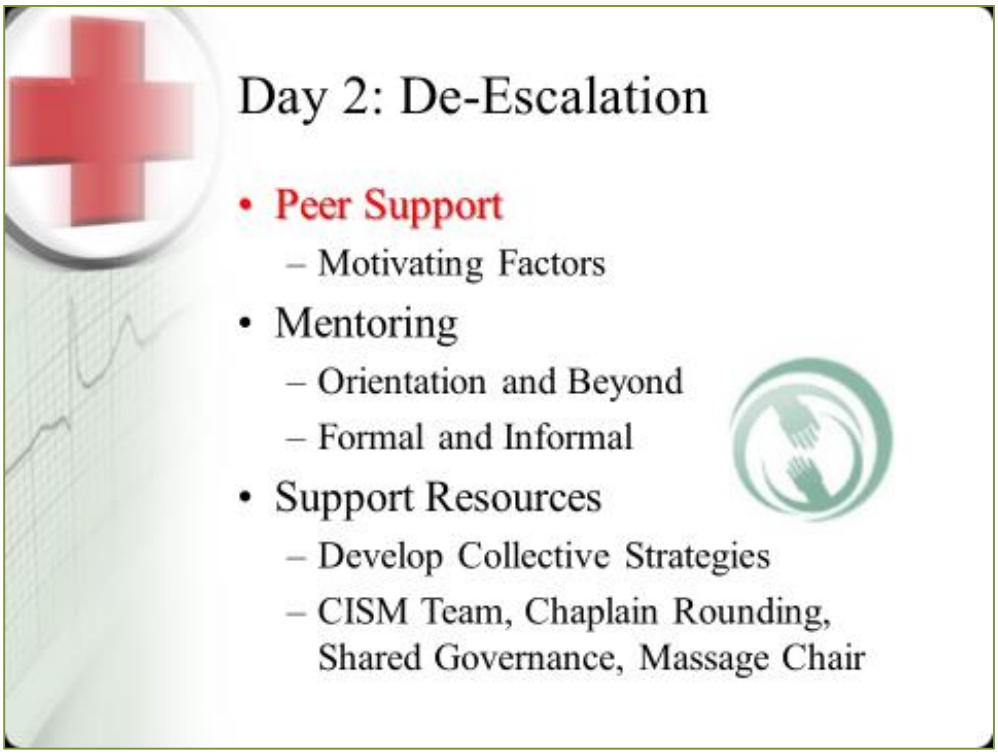
Not all strategies can wait until the trauma has passed; some strategies need to be immediate during the trauma to maintain cognitive equilibrium. Each persons' perceptions are individualized as to the impact of trauma and how to de-escalate from it.

1115-1145 IS #4: Peer Support: Entire Group

Objective	Discuss peer support strategies
	Discuss motivating factors for strategies
	Discuss benefits of peer support activities and programs for de-escalation

1145-1215 IS #5: Mentoring: Entire Group

Objective	Discuss mentoring relationships
	Discuss motivating factors of mentoring
	Discuss benefits of mentoring relationships for de-escalation strategies



1300-1345 LA #3: Peer Support: Small Groups

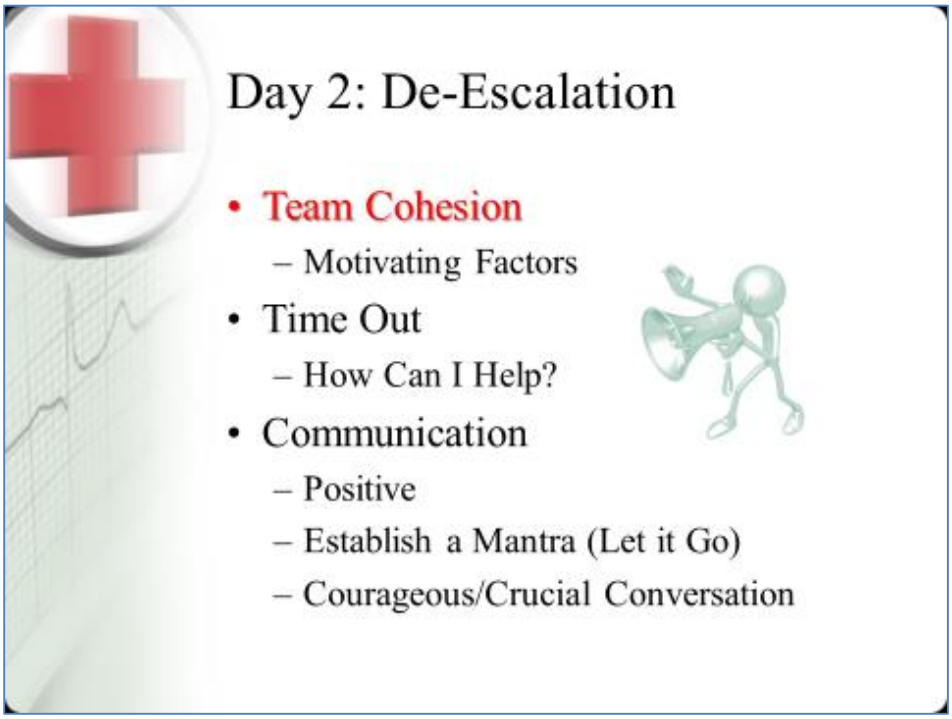
Objective	Give examples of how to support and mentor peers during work hours
	Discuss findings with class

1345-1415 LA #4: Support Resources: Small Groups

Objective	Develop list of possible peer support and training resources within and outside of nursing education
	Discuss findings with class

1415-1500 IS #6: Team Cohesion: Entire Group

Objective	Discuss team cohesion
	Discuss motivating factors of team cohesion on de-escalation strategy success



1515-1545 LA #5: Team Cohesion: Small Group

Objective	Develop list of strategy ideas to increase team cohesion
	Discuss findings with class

1545-1600 IS #7: Positive Communication: Entire Group

Objective	Discuss positive communication as a de-escalation strategy
	Participants will learn mindfulness strategies in communicating
	Participants will learn courageous or crucial conversation strategies in communicating as a de-escalating strategy

1600-1630: Entire Group

Objective	Review Day 2, fill out evaluations, sign out

Day 2 Participant Evaluation Form

On a scale of 1-5, please rate the following:					
Program Effectiveness	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
The presentation material contributed to my learning.	❑	❑	❑	❑	❑
The information was presented at an appropriate learning level.	❑	❑	❑	❑	❑
The visual aids and handouts were satisfactory.	❑	❑	❑	❑	❑
The activities were effective.	❑	❑	❑	❑	❑
The presenter demonstrated knowledge of the subject material.	❑	❑	❑	❑	❑
The presentation met the stated objectives below (The participants will be able to):	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
Define de-escalation, peer support, and team cohesion	❑	❑	❑	❑	❑
Discuss motivating factors for de-escalation, peer support, and team cohesion	❑	❑	❑	❑	❑
Demonstrate the ability to practice mindfulness strategies	❑	❑	❑	❑	❑
Discuss the impact of positive communication	❑	❑	❑	❑	❑
Recognize support resources	❑	❑	❑	❑	❑
Comments					
The best part of today was: The worst part of today was: Additional comments:					

Day 3 Schedule: Preparation, De-Escalation, and ***Self-Care Strategies for Nurses***

Day 3	Instructional Strategies/Learning Activities	Time
LA #1 Icebreaker 0800-0830	Welcome Back! Coffee Icebreaker; pass the urinal, tell one thing nobody knows about you	**30 Minutes**
IS #1 0830-0900	Review Day 3 learning objectives, terms, reflection on Day 2	**30 Minutes**
IS #2 0900-0930	Instructor led discussion on the importance of self-care, renewal, changing your list ranking	**30 Minutes**
LA #2 Part 1 of 2 0930-0945	Small groups discuss strategies/create affirmations getting out of nurse mode	**15 Minutes**
LA #2 Part 2 of 2 0945-1015	Participants present and discuss strategies and affirmations from each group to class	**30 Minutes**
1015-1030	**Morning break**	**15 Minutes**
LA #3 Part 1 of 2 1030-1045	Small groups develop self-care plan of action; collaborate, use social media, Google	**45 Minutes**
LA #3 Part 2 of 2 1045-1115	Participants present plans to class	**30 Minutes**
IS #3 1115-1145	Instructor led discussion on mindfulness and MBSR techniques	**30Minutes**
IS #5 1145-1215	Participants will practice MBSR techniques	**30 Minutes**
1215-1300	**Lunch** – boxed meals provided	**45 Minutes**
IS #4 1300-1315	Instructor led discussion about wellness, renewal, and positive reframing	**15 Minutes**
LA #4 Part 1 of 2 1315-1330	Small group discussion, wellness with intention (health and relaxation plans)	**15 Minutes**
LA #4Part 2 of 2 1330-1345	Participants present and discuss findings from each group to class	**15 Minutes**
IS #5 1345-1415	Instructor led discussion about biopsychosocial wellness practices; journaling	**30 Minutes**
LA #5 Part 1 of 2 1415-1445	All participants individually complete, score, and journal thoughts about the Life Stress Test (LST)	**30 Minutes**
LA #5 Part 2 of 2 1445-1500	Participants will voluntarily share thoughts about the LST and journal exercise after	**15 Minutes**
1500-1515	**Afternoon Break**	**15 Minutes**
LA #6 Part 1 of 2 1515-1545	Small groups: Develop a plan of action for preparation, de-escalation, and self-care	**30 Minutes**
LA #6 Part 2 of 2 1545-1615	Participants present and discuss findings from each group to class	**30 Minutes**
1615-1630	Final review, evaluations, sign out.	**15 Minutes**

Day 3: Instructor Guidelines

Preparation, De-Escalation, and ***Self-Care Strategies for Nurses***

- Welcome participants to Day 3, acknowledge ancillary support staff.
- Review the workshop purpose, goals, and expectations.
- Review ground rules (phones/electronics off, respect for all participants, lunches/refreshments supplied and on premises).
- Encourage participation; there will be breakout groups, we value everyone's input
- Review facility (exits, bathrooms, etc.).
- Remind to sign in, sign CEU form, fill out evaluations at end of day.
- Review schedule for the day.
- **Welcome/Icebreaker:** Activity is passing the urinal (like a talking stick) as each participant shares something about themselves that nobody else knows (I paint pet rocks, I was a Marine but wanted to do something easier so chose nursing, etc.).
- **Instructional Strategy #1:** Participants will review Day 3 learning objectives, terms, discuss thoughts about Day 2 (and Day 1) after reflecting.
- **Instructional Strategy #2:** Instructor will lead a discussion about the importance of health care specific to nurses, who care for others first and put themselves last. Discuss the biopsychosocial ramifications of running out of steam and never refueling. Discuss the need for renewal, findings through such models as the John's Hopkins Tripartite Model of Disaster Mental Health, etc. Nurses will be urged to consider the actual list of those for whom they give care and how they might perhaps move a little higher up on the list (from the last position).

- **Learning Activity #2:** Part 1: Small groups discuss methods for getting out of nurse mode and into mom-wife-student-person mode (using mindfulness to be aware of the present moment, making time for family, establishing a routine at home that has nothing to do with nursing, etc.). Recorders will notate the lists established on sticky-backed poster paper. Part 2: Participants will share results of learning activity with class.
- **Learning Activity #3:** Part 1: Small groups take responsibility for establishing a self-care research and development plan and outline steps they would take if giving the same instructions to a cohort, friend, family member or patient. Encourage use of social media, blogs, Google, and other online resources for finding simple strategies. Part 2: Recorder will share creative lists and plans devised during learning activity with class.
- **Instructional Strategy #3:** All participants will discuss an expanded version of mindfulness beyond the introduction presented in Day 2 of non-judgmental, living in the moment, take a deep breath, and move on strategies. Mindfulness Based Stress Reduction techniques will be reviewed, with resources given to expand on the basics covered in this workshop, to allow nurses to make those strategies part of their home repertoire for self-care.
- **Instructional Strategy #4.** All participants will practice MBSR strategies, such as circle breathing, deep cleansing breaths for acute response, guided imagery, relaxation techniques (cognitive-behavioral based strategies). Short explanations before and discussions after each strategy will help cement learning processes.

- **Instructional Strategy #5:** All participants will discuss wellness as a lifestyle, coping mechanism, preparatory educational practice, de-escalation strategy, and self-care tool. Included in the discussion are tools like cognitive reframing practices, positivity theory, self-efficacy and the power of believing in what can be accomplished. Included are the importance of diet, exercise, attending to a wellness plan, never giving up, the reality of small missteps, the forgiveness of the setting sun. Participants will discuss the possibilities of adding wellness strategies to their lifestyle as opposed to changing their lives to fit wellness.
- **Learning Activity #4:** Part 1: Small group discussion of wellness with intention. Participants will create lists of things they can do in daily life to facilitate wellness and relaxation plans, how to maneuver them into a busy nurses' schedule, how cooperatives of friends may assist in that effort. A recorder will write the list on sticky-backed poster paper for class display. Part 2: Recorder will present findings to the class in open discussion.
- **Instructional Strategy #6:** All participants will discuss the biopsychosocial aspects of wellness and the effect of intention and personality. Introverts may cope, recover, renew, refuel, and attack wellness differently. Someone who prefers to be on their own instead of going out to socialize after work at the local pub is not necessarily unfriendly or antisocial; they may need alone time. Extroverts, who gather energy from outside themselves, may not understand that preference and refuel themselves through the energy and company of others. Understanding the difference is important knowing how to support cohorts in

dealing with acute and cumulative stressors at work and after for self-care and wellness approaches. One of the strategies proposed will be journaling, with an explanation of how to approach that strategy, how it connects with wellness, and how it provides a record of growth or need for outside intervention.

- **Learning Activity #5:** Part 1: All participants will individually complete a Life Stress Test self-assessment and self-score the results. If participants complete the self-evaluation before the allotted time is passed, they will be encouraged to journal thoughts and feelings stirred by the evaluation and how those thoughts might relate to the material covered in the course. Part 2: Participants will voluntarily share thoughts and feelings about taking the Life Stress Test, the results obtained, and the journaling exercise afterward.
- **Learning Activity #6:** Part 1: Small groups: participants will develop a single plan of action from each group for preparation, de-escalation, and self-care strategies. A recorder will note the plan on a sticky-backed poster paper. Part 2: Recorders will share the plan of action with the class for discussion.
- **Review of Day 3:** All participants: Opportunity for Q&A, comments, review Day 3 goals and learning activities. Distribute evaluation forms, and remind nurses to sign CEU forms. Thank participants for their attentiveness, and contributions.

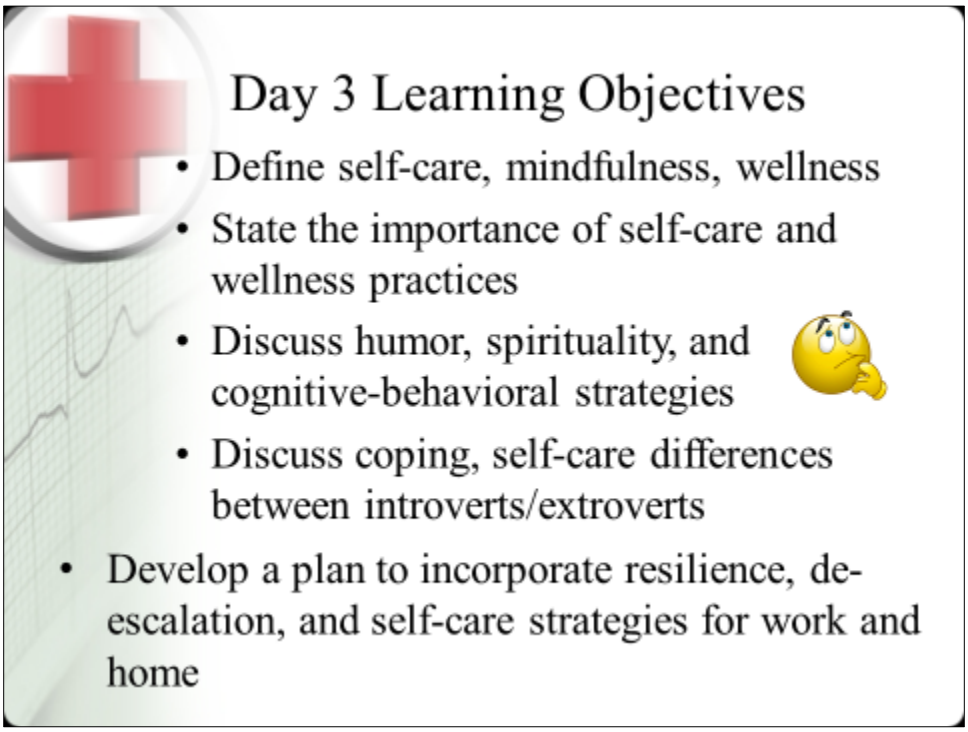
Welcome Back!

0800-0830 LA #1: Welcome/Icebreaker: Entire Group

Objective	Morning coffee and icebreaker: Pass the Urinal game

0830-0900 IS #1: Day 3 Learning Objectives: Entire Group

Objective	Discuss learning objectives for Day 3
	Participants will learn to define terms
	Discuss reflections from Day 2



Remind participants that the first day we established a base of knowledge about stress, resilience, and the importance of preparedness education for dealing with OTS. On the second day, we learned about how to get through the workday with real-time de-escalation strategies that serve to mitigate the effects of OTS, reduce anxiety, and help the team grow more supportive of one another in the shared environment and culture of emergency nurses. Day three means learning to focus on and take care of ourselves.

0900-0930 IS #2: Self-Care and Renewal: Entire Group

Objective	Discuss importance of self-care for nurses
	Understand biopsychosocial need for renewal
	Evaluate where 'self' ranks in priorities

0930-1015 LA #2: Strategies and Affirmations: Small Group

Objective	Discuss transitioning from nurse mode to home/person mode after work
	Develop list of strategies to accomplish the transition to home mode
	Discuss results of learning activity with class

1030-1115 LA #3: Self-Care Research and Development: Small Group

Objective	Discuss ways to research self-care information using social media, blogs, Google, LinkedIn, etc.
	Develop a list of steps for instructing others to research self-care strategies
	Discuss results of learning activity with class

Remind participants that they have the critical thinking skills and professional training necessary to add to their knowledge when formal courses are not available.

1115-1145 IS #3: Mindfulness and MBSR: Entire Group

Objective	Discuss expansion of MBSR strategies

1145-1215 IS #4: MBSR Techniques: Entire Group

Objective	Discuss MBSR techniques
	Understand how to practice MBSR techniques
	Execute MBSR techniques

Participants are reminded that the MBSR and cognitive-behavioral strategies are too numerous to cover in a short time, so they are encouraged to seek out classes, courses, groups, or training that offer those options. Other mindfulness practices that fall under the categories of self-care and wellness include such practices as Yoga and Tai Chi to name a few, where the energy is drawn into the individual instead of being pushed out as with conventional exercise.

1300-1315 IS #5: Wellness, Renewal, Positivity: Entire Group

Objective	Discuss wellness as a lifestyle
	Understand cognitive reframing
	Discuss positivity
	Discuss self-efficacy

1315-1330 LA #4: Wellness with Intention

Objective	Discuss health and wellness as a strategy
	Develop list of things to do daily to facilitate wellness
	Develop list of strategies to insert relaxation plans
	Discuss results of learning activity with class

1345-1415 IS #6: Wellness Practices and Journaling: Entire Group

Objective	Discuss biopsychosocial wellness
	Discuss incorporating social activities into plan
	Understand journaling as a strategy

1415-1445 LA #5: Life Stress Test Evaluation: Entire Group

Objective	Execute completion of self-test, Life Stress Test (LST)
	Complete self-score and analysis of LST
	Execute journaling practice reacting to LST
	Discuss thoughts about the LST and journaling with class

1515-1615 LA #6: Plan of Action: Small Groups

Objective	Discuss synthesizing preparation, de-escalation, and self-care strategies training
	Develop list of steps to implement plan of action synthesizing training in preparation, de-escalation, and self-care strategies
	Discuss established plan of action with class

1615-1630: Entire Group

Objective	Review Day 2, fill out evaluations, sign out

Day 3 Participant Evaluation Form

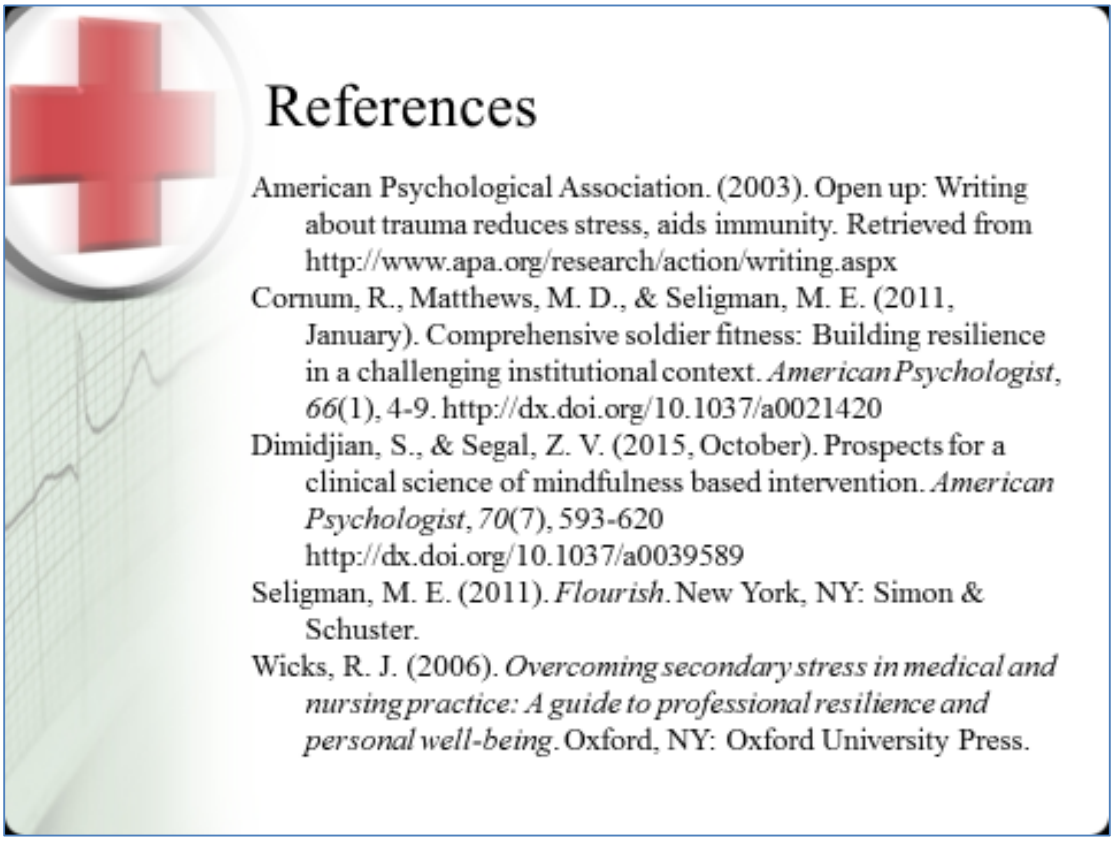
On a scale of 1-5, please rate the following:					
Program Effectiveness	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
The presentation material contributed to my learning.	❑	❑	❑	❑	❑
The information was presented at an appropriate learning level.	❑	❑	❑	❑	❑
The visual aids and handouts were satisfactory.	❑	❑	❑	❑	❑
The activities were effective.	❑	❑	❑	❑	❑
The presenter demonstrated knowledge of the subject material.	❑	❑	❑	❑	❑
The presentation met the stated objectives below (The participants will be able to):	**1-Strongly Disagree**	**2-Disagree**	**3-Neutral**	**4-Agree**	**5-Strongly Agree**
Define self-care, mindfulness, and wellness	❑	❑	❑	❑	❑
State the importance of self-care and wellness practices	❑	❑	❑	❑	❑
Discuss humor, spirituality, cognitive-behavioral strategies	❑	❑	❑	❑	❑
Discuss coping and self-care differences between introverts and extroverts	❑	❑	❑	❑	❑
Develop a plan to incorporate resilience, de-escalation, and self-care strategies for work and home	❑	❑	❑	❑	❑
Comments					
The best part of today was: The worst part of today was: Additional comments:					

Budget

Workshop Title: Preparation, De-Escalation, and Self-Care Strategies for Nurses
Training Duration: 3 days
Number of Participants: 20

Expense Items	***Anticipated Expenses**	**Unit Cost/Day**	**Total Budget Expense Per Item (3 Days)**
	Subsidized		
Marketing (Internal)	0	0	0
Materials: Handouts, pens, note pads	50.00/Day	2.50/Person/Day	150.00
Morning and Afternoon Refreshments	(80.00/Day)	4.00/Person/Day	(240.00)
Boxed Lunches	(140.00/Day)	7.00/Person/Day	(420.00)
Training Classrooms	0	0	0
Equipment	0	0	0
	Volunteers		
Instructor(s)	(500.00/Day)	(25.00/Person/Day)	(1500.00)
Administration	0	0	0
Classroom Assistants	0	0	0
Sub-Total	($770/Day)	($38.50/Person/Day)	$2310.00
		Sponsor Paid or Volunteered	-$2160.00
TOTAL			**$150.00**

**Parenthetical items represent cost when not supplied by venue or volunteers. Food items at hospital cost.*



References

American Psychological Association. (2003). Open up: Writing about trauma reduces stress, aids immunity. Retrieved from http://www.apa.org/research/action/writing.aspx

Cornum, R., Matthews, M. D., & Seligman, M. E. (2011, January). Comprehensive soldier fitness: Building resilience in a challenging institutional context. *American Psychologist*, *66*(1), 4-9. http://dx.doi.org/10.1037/a0021420

Dimidjian, S., & Segal, Z. V. (2015, October). Prospects for a clinical science of mindfulness based intervention. *American Psychologist*, *70*(7), 593-620 http://dx.doi.org/10.1037/a0039589

Seligman, M. E. (2011). *Flourish*. New York, NY: Simon & Schuster.

Wicks, R. J. (2006). *Overcoming secondary stress in medical and nursing practice: A guide to professional resilience and personal well-being*. Oxford, NY: Oxford University Press.

Appendix B: Interview Protocol

1) What courses or training have you taken in resilience or coping strategies?
   a) What resilience or coping strategies were recommended in the courses or training? Were these strategies helpful? If so, how? If not, what suggestions would you make to include these strategies in course work or training?
   b) What resilience or coping training or professional development was offered during your clinical experiences? Were the training or professional development helpful? If so, how? If not, what suggestions would you make to include these strategies during clinical experiences?

2) What makes working with trauma in the ED stressful?
   a) How do you define traumatic stress?
   b) What factors contribute to your traumatic stress?
   c) How do you measure your traumatic stress?
   d) How has traumatic stress affected your nursing performance?

3) What coping strategies have you used in the ED during traumatic stress exposures?
   a) Give me an example of the circumstances when you used them
   b) Please tell me about the outcome of using these coping strategies and whether they were helpful or a hindrance.
   c) How did you acquire these coping strategies?

4) How do you prepare for further exposure to occupational traumatic stress?
   a) Probing question: Please clarify…
   b) Follow-up question: Describe the factors that contribute to your preparation for further exposure to occupational traumatic stress.

5) What do you think makes an emergency nurse successful in coping with occupational exposure to trauma?
   a) Probing question: Please clarify…
   b) Follow-up question: What suggestions would you make for supporting emergency nurses to cope with occupational exposure to trauma?
   c) What training would help emergency nurses cope with occupational traumatic stress?

6) Thinking about occupational traumatic stress and the questions you have answered in this interview, is there anything you would like to add?

Appendix C: Stressors Evaluation

WHAT ARE MY STRESSORS?

Please take five minutes to list as many work-related and home-related stressors as you can. Try to focus on those work issues that may affect you at home, and home issues that may affect you at work. Remember that this list is for your personal use, and sharing during the group discussion is voluntary.

WORK	**HOME**

Appendix D: Self-Evaluation of Resilience

I have an attitude of _____

My thinking is _____

I get through tasks with a sense of _____

My stress-coping strategy is _____

I care for myself by _____

I set boundaries by _____

I surround myself with people who are _____

I nurture my awareness through _____

I intentionally avoid _____

When I need help, I reach out to _____

Mindfulness to me means _____

I find meaning in _____

I reframe into positivity by _____

I know how to get out of my head by _____

When I cannot find the answer or meaning to something, I _____

I invest my time and energy into _____

If the above is not working for me, or do not promote my wellness, I will

_____

I will revisit this list to reevaluate my resilience thoughts and strategies, remembering that *I am most resilient when* _____

Appendix E: Life Stress Test

As caregivers, we are often stressed and do not know why. Without realizing the effects that life circumstances have on us, we tend to sweep our feelings of frustration, sadness and turmoil under the rug. In the past 12 to 24 months, which of the following major life events have taken place in your life?

Mark down the points for each event that you have experienced this year. When you are done looking at the whole list, add up the points for each event, and check your score at the bottom.

_____ Death of spouse (100 points)

_____ Divorce (73 points)

_____ Marital separation, or from relationship partner (65 points)

_____ Jail Term (63 points)

_____ Death of close family member (63 points)

_____ Personal injury or illness (53 points)

_____ Marriage (50 points)

_____ Fired from work (47 points)

_____ Marital reconciliation (45 points)

_____ Retirement (45 points)

_____ Change in family member's health (44 points)

_____ Pregnancy (40 points)

_____ Sex difficulties (39 points)

_____ Addition to family (39 points)

_____ Business readjustment (39 points)

_____ Change in financial status (38 points)

_____ Death of close friend (37 points)

_____ Change to a different line of work (36 points)

_____ Change in number of marital arguments (35 points)

_____ Mortgage or loan over $30,000 (31 points)

_____ Foreclosure of mortgage or loan (30 points)

_____ Change in work responsibilities (29 points)

_____ Trouble with in-laws (29 points)

_____ Outstanding personal achievement (28 points)

_____ Spouse begins or stops work (26 points)

_____ Starting or finishing school (26 points)

_____ Change in living conditions (25 points)

_____ Revision of personal habits (24 points)

_____ Trouble with boss (23 points)

_____ Change in work hours, conditions (20 points)

_____ Change in residence (20 points)

_____ Change in schools (20 points)

_____ Change in recreational habits (19 points)

_____ Change in church activities (19 points)

_____ Change in social activities (18 points)

_____ Mortgage or loan under $20,000 (17 points)

_____ Change in sleeping habits (16 points)

_____ Change in number of family gatherings (15 points)

_____ Change in eating habits (15 points)

_____ Vacation (13 points)

_____ Christmas season (12 points)

_____ Minor violations of the law (11 points)

_____ **Your Total Score**

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale can predict the likelihood that you will fall victim to a stress-related illness. The illness could be mild (frequent tension headaches, acid indigestion, loss of sleep) to very serious illness like ulcers, cancer, migraines, etc.

LIFE STRESS SCORES

0-149: Low susceptibility to stress-related illness

150-299: Medium susceptibility to stress-related illness: Learn and practice relaxation and stress management skills and a healthy well lifestyle.

300 and over: High susceptibility to stress-related illness: Daily practice of relaxation skills is very important for your wellness. Take care of it now before a serious illness erupts or an affliction becomes worse.

Permission to reprint the Life Stress Test received from: Dr. Tim Lowenstein, P.O. Box 127, Port Angeles, WA 98362 http://www.stressmarket.com