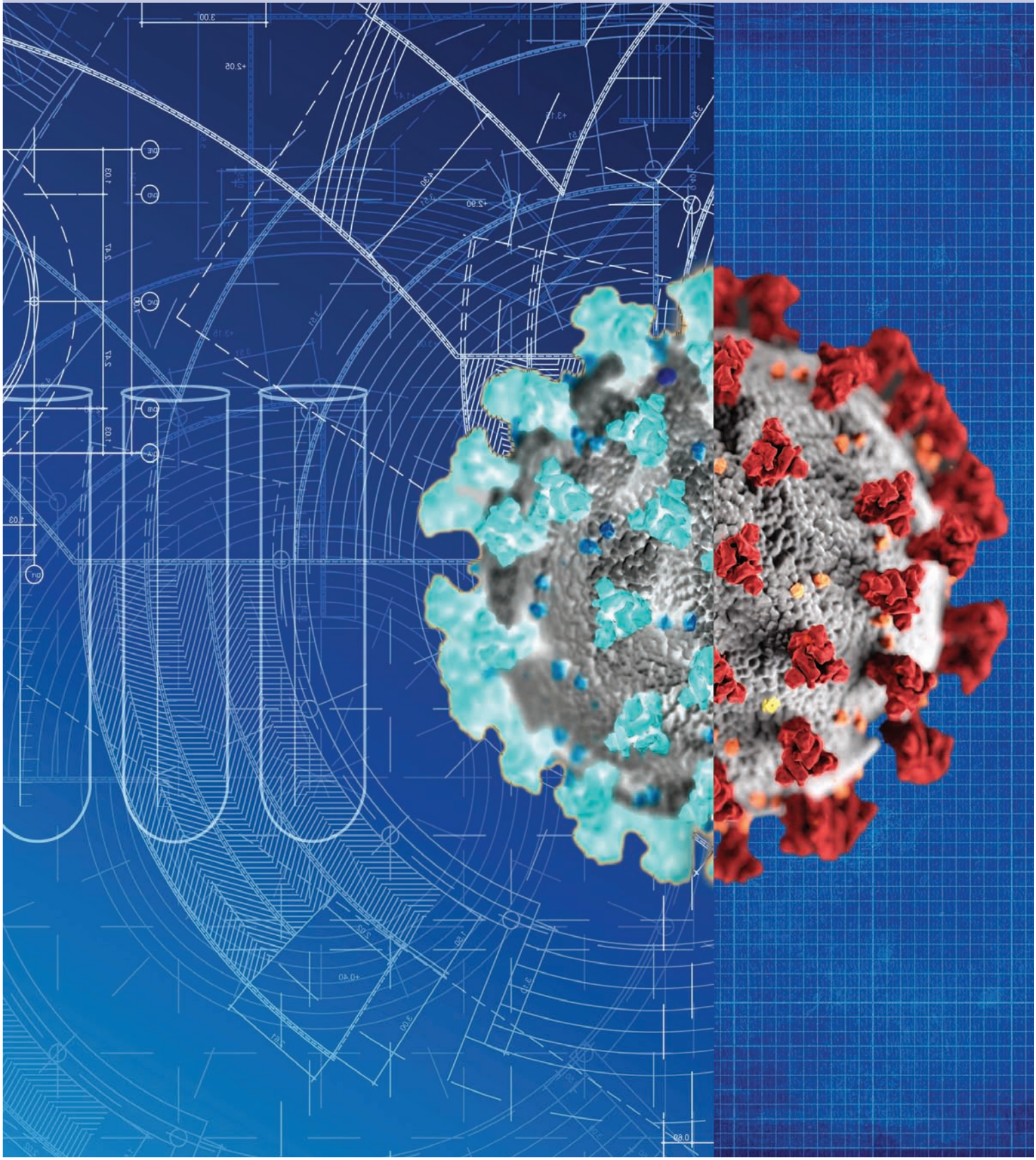

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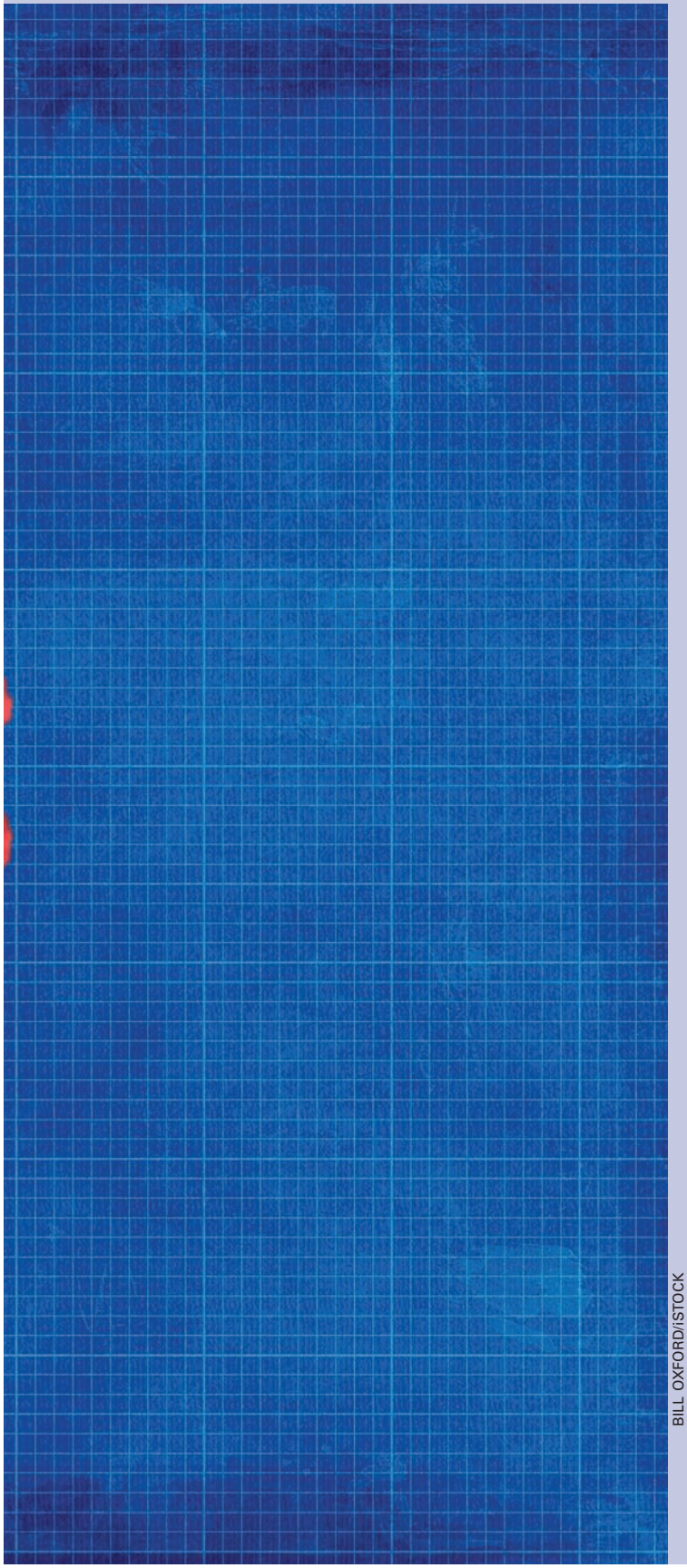

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An expanded institutional- and national-level blueprint to address nurse burnout and moral suffering amid the evolving pandemic

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In 2020, members of our team developed an institutional-level blueprint to minimize nursing burnout and moral distress, published in this journal as "A Blueprint for Leadership During COVID-19: Minimizing Burnout and Moral Distress Among the Nursing Workforce."[1] To sustain the nursing workforce, it's imperative to decipher between "unavoidable

occupational suffering (inherent to the [nurse's] role) and avoidable occupational suffering (systems failures that can be prevented)."[2] Although resilience capacity building is key to addressing the unavoidable suffering of clinical practice, avoidable suffering must be prevented and resolved at the organizational level. Here, we provide an expanded blueprint, with updates to our previous institutional recommendations accompanied by a national plan to address nurses' burnout and moral suffering.[1]

The problems started long before COVID-19

The common misconception that nurses are burned out and leaving their jobs because of COVID-19 mischaracterizes the problems nurses face. More accurately, the pandemic has exposed and amplified the longstanding occupational circumstances of nurses. Scientific consensus suggests that understaffing, poor work environments, and the lack of robust ethical frameworks are the primary contributors to the development of burnout and moral suffering among nurses.[1,3-5] Although moral suffering can contribute to the development of burnout, the two are distinct based on their differential causes and consequences. (See *Table 1.*)[4,6] There's agreement that the poor working conditions leading to burnout and moral distress were prevalent long before the pandemic started.[3,7-9]

Inadequate state-level leadership from some of our elected leaders has compounded negative working conditions for nurses through misguided policy action and glaring inaction. For instance, despite the thousands of people hospitalized with COVID-19 in Florida at the time of this writing, Florida's governor has attempted to uphold a ban on vaccine and mask mandates, contrary to over a century of empirical evidence supporting these effective public health interventions.[10] Similar choices of leaders across the country further jeopardize population health and place healthcare workers at great risk under the guise of protecting personal liberties.

Policymaking that lacks a scientific base, or worse, intentionally contravenes scientific knowledge, intensifies patterns of verbal and physical violence toward nurses.[11] Nurses who are victims of workplace violence don't have the same legal or policy-based protections that other service workers do, compounding nurses' feelings of betrayal by leaders and the public they're dedicated to serving.[12,13] These mental health costs are resulting in rising levels of depression, anxiety, posttraumatic stress disorder, and suicide among nurses.[14]

Complex problems require multilevel solutions

The US Department of Health and Human Services recently approved $103 million as part of the *American Rescue Plan* to strengthen resiliency and address burnout in the health workforce in the wake of COVID-19.[15] This call for research acknowledges that although efforts to address burnout are typically focused on individual-level solutions, these efforts won't be successful without strategic attention to organizational factors associated with poor working environments.[16] Structural changes are foundational to achieving any long-term benefits of cultivating individual resilience capacity.[17] The 2019 National Academy of Medicine *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* report also asserts that system-level change is imperative to enacting widespread workforce sustainability.[4]

Failures of health administrators and political leaders to create working conditions conducive to the delivery of safe care prevent nurses from performing with both the clinical acumen and ethical integrity for which they were trained. The pandemic has created a chronic crisis standard of care by exacerbating workloads and the ethical dilemmas that contribute to nurses' burnout and moral suffering.[5,18] To address these issues, organizational leaders tend to invest in stress management programs that place the burden of resilience capacity building on individuals rather than enhancing structural mechanisms to protect clinician well-being.

Although many organizations focus on resilience, the term is frequently misunderstood and misappropriated. Individuals must be empowered to engage in resilience capacity building at the system level rather than as an additional expectation of employment.[19] If changes to address nurses' well-being solely target changing the individual in the absence of supportive policy improvements, they're likely to backfire and further contribute to the demoralization of the workforce. Rather than accept-

Table 1: Differentiating between burnout and moral suffering

	Burnout	Moral suffering
Definition	• Burnout is a work-related condition characterized by a high degree of emotional exhaustion, cynicism, and lack of personal accomplishment in relation to one's work.[35]	• Moral suffering occurs on a continuum that encompasses harms caused by moral distress and moral injury.[66] • Moral distress is the anguish that occurs when clinicians feel their integrity is under threat as they know the morally right course of action but feel they can't take it.[1,67] • Left unattended, moral distress accumulates, creating moral residue and eventually escalating to moral injury, a more corrosive form of moral suffering that erodes a person's moral core, identity, and integrity.[68]
Causes	• Burnout is largely the result of a poor work environment, including insufficient staffing, inadequate resources and support, poor working relationships with administration and physicians, and management that isn't responsive or can't address nurses' needs or concerns.[3,21,69] • Nurses also often lack professional autonomy to change their working circumstances, which can lead to burnout.	• Moral suffering arises in response to circumstances that violate core beliefs, values, and expectations, which erodes moral well-being, capability, and integrity and causes persistent distress symptoms in response to betrayals by self or others, especially those in authority in high-stakes situations.[70-72]
Consequences	• Burnout not only leads to negative physical and mental health outcomes, but it's also predictive of organizational turnover, amounting to a significant financial burden with the average hospital losing between $3.6 and $6.5 million annually.[73-75] • Burnout is linked with significant risks to patient safety, including higher rates of medical errors, hospital-acquired infections, mortality and failure to rescue, and longer lengths of stay.[9,27,76]	• Moral distress can lead to feelings of powerlessness when voicing concerns about patient care.[77] Nurses experiencing moral distress often have feelings of regret, shame, guilt, and anger and may withdraw from others.[77] Sleep challenges, headache, depression, and anxiety may also result.[77,78] • Moral injury can degrade a person's moral identity, wholeness, and meaning in life temporarily or permanently.[71] • Moral suffering can also contribute to burnout.[4,6]

ing that organizations' nurse staffing levels, work environments, and protocols are the way they are, leaders must leverage the pandemic as an opportunity to reevaluate priorities moving forward.

2021 updates to institutional recommendations

Systematically improve the work environment. Magnet® recognition and Pathway to Excellence® designation are the only approaches shown to improve work environment features that affect both nursing and patient outcomes.[3,20] Having enough resources to deliver safe patient care, fostering positive working relationships with colleagues and administration, empowering management to be responsive to clinician concerns, and promoting nurse autonomy can alleviate burnout in any setting.[21] Research has shown that the improvements in nursing and patient outcomes resulting from increased nurse staffing aren't possible without supportive work environments.[22] See *Table 2* for specific recommendations on how to improve the organizational work environment, which are adapted from the *Keeping Patients Safe: Transforming the Work Environment of Nurses* report.[23]

Champion safe nurse staffing levels. Healthcare organizations have been chronically understaffed for years, forcing nurses across the continuum of care to work with more patients than

Table 2: Improving work environments

Legitimize nursing leadership role and authority. Nurse leaders at the top of administration and at every level of management have clear authority and involvement in decisions that impact patient care and the nursing workforce, facilitate communication between nurses and administration regarding work processes, and represent and advocate for nurses' concerns. Nurse leaders should be provided with the acquisition, management, and dissemination resources to properly support nurses delivering care.

Authorize nurses to manage staffing. Nurse leaders should be authorized and empowered to independently manage and control staffing based on safe standards. This includes the ability to regulate unit workflow and adjust staffing for different units based on patient volume, accounting for the burden of admissions, discharges, and "observation" or "less than full day" patients in addition to the regular patient census. Safe standards for minimum staffing levels should be state-regulated and overseen by an external body such as state boards of nursing outside of healthcare organizations.

Institute a well-being governing board. Governing boards with robust nursing representation should be implemented to focus on clinician physical, psychological, spiritual, and moral well-being.[32] Nonnurse leaders, particularly managers, administrators, and financial leaders, should identify how managerial, policy, and financial decisions affect the delivery of clinical care and contribute to or degrade well-being. All stakeholders should be educated on the relationship between administrative oversight, management practices, and budget allocations and the impact on clinician well-being. Senior leadership should be accountable for achieving benchmarks of clinician well-being that are as important as improved patient outcomes, productivity, and financial goals and demonstrate their commitment to achieving those outcomes by investing resources and funding to sustain progress and redress unintended consequences. Well-being doesn't solely fall under the purview of nurse leaders, but requires investment, partnership, and accountability with broader organizational leadership.

Prioritize nursing professional development. Nurses need a robust career pathway to sustain them in the profession. Investment in nursing professional development for all roles/specialties is evident when a portion of the organizational budget is allocated for sustained education and advancement of nursing within the organization. Examples include a robust nurse residency and preceptor program, annual individual development plans for each nurse, ongoing education for new technologies and materials, ethics and self-stewardship skills, and decision support for clinical care. Development efforts should include point-of-care nurses and midlevel managers, with special attention to clinical leaders transitioning into new roles. Scholarships for formal educational advancement with commensurate service once attained are vital in creating multidimensional and diverse career pathways that are inclusive of the many ways nurses practice.

Foster interdisciplinary relationships. Transdisciplinary training and education across health professionals, as well as a transparent dialogue about the barriers and facilitators to adopting a transdisciplinary working model and philosophy, are imperative.[79] Healthcare leaders can support collegial relationships through interdisciplinary rounding and shared continuing education models for all clinicians on a continuous basis. Aligning the well-being efforts of nurses and nonnurses will assist in fostering collective initiatives to sustain the broader health workforce and build a culture that supports the integrity and flourishing of everyone.

Create and monitor standards that protect well-being. Standards for well-being must be established and monitored and processes to address findings devised. Nurses should be protected from practices that promote excessive fatigue such as mandatory or voluntary overtime that amounts to more than 12 hours in a day or more than 60 hours in a 7-day week. With staffing minimums in place and support from organizational leadership, nurses should have the time to take breaks from delivering care throughout the day to take care of their physical needs and as a reprieve from the intensity of clinical care. Nurses should be encouraged to use their full vacation time and personal days annually. Managers should be trained in evidence-based, proactive assessment to detect mental health concerns or self-harm risks and make mental health services accessible and confidential. Routinely assess systemic contributions to degraded physical, psychological, and moral well-being with accountability for implementing timely and meaningful solutions.

Redesign workflow. Processes should be scrutinized and determined, if necessary, for the safe delivery of care. For example, because documentation presents a great burden to clinical nurses and has been linked with burnout, the focus should be on supporting nurses' workflow in real time.[80] Special attention should be given to time-intensive processes, such as admissions, medication administration, and other high-priority practices, by unit. Technology supporting documentation should be functional and easily accessible for nursing staff. Identify other systemic barriers to effective workflow that simultaneously degrade nurse well-being and integrity, such as lack of continuity of medical teams, ineffective communication, and conflict among clinical decision-makers.

Restructure as a "flat organization" to improve nurse autonomy. Decentralize decision-making processes and empower point-of-care nurses and those directly overseeing them to make changes to their workflow, creating a more horizontal (as opposed to hierarchical/vertical) leadership structure. A plan for larger organizational changes should be scheduled and implemented. Support for changes in practice should be provided.

Note: These recommendations are adapted from the *Keeping Patients Safe: Transforming the Work Environment of Nurses* report.[23]

what's safe and placing patients and nurses at risk for negative outcomes.[22,24-27] With staffing shortages drastically worsened by the pandemic, workload has heightened and nurse burnout has intensified.[28] In some cases, nurses are choosing to leave their organization or the nursing profession entirely.[29] This workforce turnover leads organizations to rely more frequently on pools of traveling nurses and, in some cases, necessitates bidding wars with nearby organizations for supplemental staff.[30,31]

The continued reliance on supplemental nurse staffing is encouraging a cycle of turnover among permanently employed nurses. Institutionally based nurses are frustrated when traveling nurses come in with record-breaking bonuses and an hourly rate triple (or more) to their own.[30] We encourage organizations to reevaluate their own staffing standards and demonstrate the value of longstanding employees by avoiding continued reliance on supplemental staffing agencies. Staffing improvements will likely need federal and state support.

Expand well-being to include moral well-being. We advocate for healthcare leaders to champion not only physical and mental health, but also moral well-being. As outlined in the *Future of Nursing 2020–2030* report, moral well-being includes the "development of innate capacities that enable humans to flourish…by managing the adaptive challenges of vulnerability, constraint, connection, and cooperation in an uncertain, risky environment."[32,33] Both individual and organizational investments are required for moral well-being to flourish.

Leaders can advocate for systems to support moral well-being by attending to nurses' concerns when their integrity is imperiled by systemic patterns in organizations, such as inadequate resources and ineffective collaboration with colleagues, patients, or leaders. Unit rounding, focus groups, and debriefings after distressing events should be deployed to better understand unit-specific needs and nurses' concerns. Individual strategies to support well-being and integrity, strategically coupled with the requisite system-level infrastructure to take advantage of available self-stewardship mechanisms during the workday, are vital.[34] Without the infrastructure in place to engage in self-stewardship, nurses know that taking a break from clinical care will only make their work even more difficult on their return and increase the strain on their similarly overburdened colleagues.

Leaders can demonstrate their commitment to well-being through engaging in regular assessment, strengthening confidential reporting systems, and ensuring accountability to redress factors that erode integrity. There are myriad ways to measure both burnout and the continuum of moral suffering and moral resilience.[18,35-38] However, measurement of moral suffering (moral distress or moral injury) and burnout only provide a partial picture of an individual nurse's experience. A more complete picture can be gained by routinely measuring well-being, moral resilience, and engagement while proactively identifying organizational patterns that contribute to both sides of the equation. Identification of the sources of distress needs to be aligned with system accountability to remediate those that are modifiable.

Create an ethics infrastructure. Organizations can demonstrate their commitment to upholding their espoused values by investing in resources and roles for clinical and organizational ethicists and creating routine monitoring and action to address ethical transgressions and contributors to degraded workforce integrity. A more robust ethics infrastructure is required so nurses don't have to be heroic to provide integrity-preserving, safe care. The false and harmful narrative of heroism prevents health workers from embracing their human limitations and identifying their own need for help or mental health services in the face of cumulative loss and systemic limitations that may inherently cause moral suffering.[39] Values such as respect, dignity, compassion, and equity should be extended not only to patients and their families, but also to the entire workforce. Most healthcare organizations have adopted a safety framework such as a Just Culture.[40] Such efforts need to be more closely aligned with an organizational ethical framework that makes explicit where threats or violations of values and integrity occur. External leadership accountability will be required to enforce standards and address such issues.

Deploy interdisciplinary groups in resource allocation efforts. Throughout the pandemic, interdisciplinary groups

were created to develop ethically grounded standards for resource allocation.[41-43] Their focus was primarily on how to fairly and equitably allocate medications, machines such as ventilators, blood products, and then later vaccines. Our attention to the allocation of supplies and resources must expand to include the allocation of staff as a scarce resource. Ventilators and hospital beds are meaningless without nurses to staff them. Despite this, organizations often silo responsibility of resource allocation to operations departments without sufficient investments in nurses to ensure success. Without interdisciplinary staff being involved in resource allocation, the operations department can't understand evolving point-of-care delivery needs and plan accordingly or anticipate the unintended consequences of decisions on the clinicians who are responsible for carrying them out. Proactive models of interdisciplinary planning are urgently needed now and in the future.

Rebuild trust through transparent communication and planning. Trust between organizational leadership and nurses was eroded during the pandemic, partially due to the evolving understanding of the virus that resulted in dissonant decision-making, frequent policy changes, and poor communication about changes. In some instances, nurses were advised to reuse personal protective equipment in ways that were contrary to prepandemic standards or were given conflicting advice about their risk of exposure and transmission to their families. Part of a good work environment is positive relationships between nurses, administrators, and managers.[21] These areas can be strengthened by improving communication, empathetically honoring nurses' experiences, and providing transparent explanations for the decisions that have been made. Transparent communication doesn't end with acknowledgment; it also requires accountability and change. Organizational leadership must work directly with nursing staff to devise, implement, and evaluate a comprehensive plan to prevent untenable working circumstances in the future.

Require vaccination and masking for staff. At the time of this writing, national vaccine mandates for all federal employees and employees of health facilities that accept Medicare and Medicaid have been announced.[44] However, future litigation may impact the timely adoption and implementation of such policies. As a model for optimal community care, all healthcare settings should require their staff to be vaccinated and fully masked. In the absence of consistent state-level leadership, local healthcare organizations serve as models to the community and encourage wider vaccine uptake. The American Academy of Nursing and the American Nurses Association, along with 50 other professional organizations, released a joint statement urging organizations to mandate vaccines for healthcare providers.[45] Similar to institutional requirements for vaccination against seasonal influenza, hepatitis B, and pertussis, the same strategy should be used for COVID-19 to protect not only staff, but also patients, vulnerable or immunocompromised individuals, and those unable to be vaccinated in the community.

Healthcare organizations should model evidence-based strategies aimed at reducing the spread and severity of COVID-19. This leadership has the potential to influence local communities because trusted healthcare providers may serve as change agents in vaccine-hesitant populations. By requiring staff to be vaccinated, a clear message is sent to staff and

Our attention to the allocation of supplies and resources must expand to include the allocation of staff as a scarce resource. Ventilators and hospital beds are meaningless without nurses to staff them.

patients alike that population health is valued and widespread vaccination is a primary means of achieving health. Nurses are facing a rising tide of moral distress resulting from the emerging discussions on the role of personal liberty in times of public health emergencies, specifically related to vaccine and mask acceptance at the individual level and disparities between institutional, local, and state policies. Organizational leaders must be clear about expectations and consequences for both lack of vaccination and failure to follow masking protocols among staff.

National recommendations for policy makers

Mandate safe nurse staffing levels. We recommend a national plan to implement mandated staffing ratios to protect nurses and their patients. Staffing ratios should be implemented at the state level with federal oversight and legislative support. Many states are currently using federal dollars to finance reactionary staffing needs that stem from states' chronic underinvestment in nurse staffing and failures to mandate public health strategies that reduce rates of hospitalization from COVID-19, such as vaccine and mask requirements.[30,46-49] Decades of past research and more recent evidence show that the staffing crisis isn't temporary or pandemic-specific.[7,8,22,24-27]

Critics say that staffing mandates interfere with nurse autonomy and managerial flexibility to staff based on real-time conditions. However, without staffing mandates, nurses and managers are still constrained by central budgetary decisions and have little autonomy in deciding staffing levels. Staffing mandates establish a minimum guardrail against assignments that are patently unsafe, and hospitals retain the flexibility to staff above those levels as patient acuity requires. For example, California mandated minimum staffing levels of no more than five patients to one nurse on medical-surgical units. Since implementation of this legislation in 2004, hospitals across California observed improvements in staffing levels, including safety net hospitals known for functioning on narrow financial margins.[50,51]

Another familiar refrain is the threat of a nursing shortage, taking responsibility away from institutional administration and placing it on higher education or framing it as a labor supply problem.[52] There isn't a shortage of nurses, but rather a deficit of adequately budgeted nursing positions creating vacancies that are often publicly mislabeled as shortages. The US has produced more new-to-practice nurses than ever before. In 2020, 177,407 US educated new nurses successfully passed the NCLEX compared with 71,475 in 2000.[53] However, there's also a maldistribution of nursing human resources that's influenced by poor working conditions and the inability of organizations to attract and retain nurses.[7,8,17,22,24-27] When hit with a patient surge, these already understaffed hospitals are poorly equipped to keep units open, becoming reliant on a pool of federally subsidized and expensive travel nurses. When it's difficult for organizations to fill positions or there's high turnover, the lens should be turned inward on the organization before gazing outward and mislabeling it at as a labor supply issue.

The other common argument is that staffing mandates will force hospital closure, denying access to patients in underserved areas. However, there was no evidence of hospital closure following implementation of safe staffing minimums in California.[51] In Queensland, Australia, the government mandates an average threshold where individual nurses can have more patients assigned to them as long as the overall average across the unit is within the legislated level.[54] Regardless of whether staffing mandates are state-sponsored, minimum staffing standards are nevertheless necessary given the persistence of unsafe staffing and the subsequent harms. Minimum staffing policies must be combined with work environment improvements to get the maximum benefit of the investment in more nurses.

Require improvements to healthcare work environments. We recommend that states require improvements to healthcare work environments in alignment with the *Future of Nursing 2020–2030* report.[32] The working conditions that facilitate safe, quality patient care are the same that support clinician well-being.[9] To monitor the effectiveness of work environment changes, burnout, moral distress, turnover, and their corollaries should be routinely evaluated. States can follow the European Union-led

Magnet4Europe protocol as an example of a state-sponsored effort to systematically improve hospital work environments.[55] Additionally, policy makers should pass the Workplace Violence Prevention for Health Care and Social Workers Act to address violence committed against health workers and ensure safe work environments.[56]

Implement the Nurse Licensure Compact (NLC). During the pandemic, many governors used emergency authority to temporarily lift state regulations around nurse licensure so nurses in surrounding states could cross state lines and help during pandemic surges.[57] We recommend national adoption of the National Council of State Boards of Nursing's NLC to facilitate effective workforce mobility. Consistent legislation across all states allows nurses to efficiently cross state borders to provide care where it's needed, relieve brief localized nursing shortages, and better prepare for mass disasters and future pandemics.[58] Currently, 38 states have enacted the NLC.[59] In alignment with the *Future of Nursing 2020–2030* report, there must be a "bold and expansive effort…to fully support nurses in becoming prepared for disaster and public health emergency response" through a "national strategic plan."[32]

Publicly report nursing workforce resources. Information on nursing resources, such as staffing, skill mix, and work environment, should be made publicly available so patients can choose where they get their healthcare based on nursing-sensitive features shown to affect outcomes. These data may be presented on the Medicare Hospital Compare website just like other key patient safety and quality indicators that are important for the public to know.[60] There have been bills proposed previously along these lines.[61]

Investigate why nurses aren't using existing resources and develop commensurate and strategic responses. Over the last year, numerous mental health resources have been created for nurses to support their well-being.[62,63] Most healthcare systems haven't created viable mechanisms to assist nurses in taking advantage of these resources, particularly during their workday. It's possible that shame or stigma associated with using mental health resources plays a role in underutilization. Additional issues persist around licensure and whether mental health diagnoses affect nurses' ability to obtain or retain their nursing license despite calls for the removal of these barriers.[64] Perhaps nurses simply don't have the bandwidth to use these resources outside of work. Research is needed to fully understand the factors that enable nurses to use existing resources and the barriers that undermine their use. Organizations must recalibrate the expectation that the onus for well-being resides exclusively on individual nurses.

Healthcare organizations can demonstrate their commitment to nurse well-being by shifting their focus to dismantling system impediments to meet nurses' needs to provide high-quality care while also creating work environments that don't require heroic sacrifices. Policy makers can implement best practices to prevent suicide and improve mental health among health professionals by supporting relevant legislation, such as the Dr. Lorna Breen Health Care Provider Protection Act.[65]

Now and in the future

COVID-19 has exposed longstanding organizational failures associated with burnout and moral suffering. Our institutional and national responses shouldn't be limited to COVID-19-specific factors, but rather focused on improving nurses' working conditions now and into the future. If durable changes aren't made, patient outcomes will continue to suffer long after the pandemic ends and the nursing workforce will continue to experience mental and emotional harms through the health system's next crisis. NM

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