Fall 12-11-2020

Three Good Things to Extinguish Caregiver Burnout

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NURS 653: Internship

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Fall 2020

Abstract

Caregiver burnout is a widespread issue in healthcare and institutions should be increasingly concerned about burnout because of the significant impact on quality of patient care, employee health, and financial stability. Many interventions and studies regarding burnout are focused on improving systems issues or removing negative stressors on caregivers. Although such interventions may be necessary to attempt, comprehensive systems-wide changes can be cumbersome and expensive, while removing negative stressors may be an unrealistic goal in a fast-paced, demanding healthcare environment. The Three Good Things method is an evidence-based, effective, simple, low-cost intervention to improve feelings of caregiver burnout in which caregivers write down or share three good things they saw or experienced that day. The idea behind this is to identify and reinforce positive emotions instead of trying to eliminate negative emotions, which can be much more complex. This project aims to create a plan to implement the Three Good Things intervention on a hospital microsystem to see how this stress relief exercise affects and improves reported caregiver burnout compared to current practices, or lack thereof, over a one to two-month period. It is projected that implementing this method at a local San Francisco hospital, which will be referred to as the Hospital, will decrease nursing related burnout and emphasize positive emotions. Changes in burnout are to be reported through the Mini Z burnout survey and staff interviews. Long term benefits of this practice could include reduced spending on nurse turnover and decreased adverse events in patient care.

Keywords: burnout, three good things, positive emotions

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> If you have ever seen a building that has been burned out, you know it's a devastating sight. What had once been a throbbing, vital structure is now deserted. Where there had once been activity, there are now only crumbling reminders of energy and life. Some bricks or concrete may be left; some outline of windows. Indeed, the outer shell may seem almost intact. Only if you venture inside will you be struck by the full force of the desolation. (Freudenberger & Richelson, 1980)

This quote opens the book, Burn-Out: The High Cost of High Achievement (1980), written by clinical psychologist Dr. Herbert Freudenberger, who coined the term burnout in regard to caregivers. While researching and practicing in New York City in the 1970s, Freudenberger regularly volunteered at a drug clinic. Noting the correlation between personalities, physical degradation, and mental states of the drug addicts and the exhausted, overworked caregivers, he made the comparison. This harrowing visual described in the quote above is a darkly accurate representation of many healthcare workers dealing with long, stressful hours in the clinical setting. Those struggling with its effects can be withered husks of their former selves. Or they do their best to put up a façade of strength and a countenance of fortitude to hide or distract from the numbed exhaustion inside.

In general, burnout is often defined as a syndrome characterized by “exhaustion resulting from excessive demands on energy, strength, or resources in the workplace…and a set of symptoms including malaise, fatigue, frustration, cynicism, and perceived inefficacy” (Reith, 2018). Caregivers that are burnt out show physical signs as well as emotional and psychological ones. They may be emotionally labile and easily triggered into being irritated, angry, or sad. They may be forgetful, distracted, or apathetic, all of which can affect job performance. Social

psychologist Christina Maslach, who's prominent research career has focused on burnout over the past several decades, likens it to a drained battery (Maslach, 1982). The person may look the same on the outside, but they simply are depleted and have no energy left to give.

Maslach (1982) defined three major aspects of burnout syndrome: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. Emotional exhaustion is when people extend themselves too far to the point where they are emotionally overwhelmed, listless, and find themselves incapable of giving any more of their care or time to others; depersonalization is when healthcare professionals view patients as objects and lose the empathetic human factor of care, often as a defense mechanism against emotional distress; and reduced feeling of personal accomplishment is a marked lack of self-efficacy and self-confidence, leading to general feelings of inability to perform at work (Lee et al., 2016). Of these three, emotional exhaustion is the primary element and main predictor of work- and care-related negative outcomes (Maslach et al., 2001). Through her continued research, Maslach and her colleagues developed the Maslach Burnout Inventory (MBI), which is a tool used to measure the three main dimensions of burnout. The 22 item tool is made up of nine items for emotional exhaustion, five items for depersonalization, and eight items for personal accomplishment, where each item asks nurses and caregivers to rate their feelings about the items on a scale from 1-7, based on if they never have those feelings or have those feelings daily (Poghosyan et al., 2009). Among researchers today, the MBI is the most widely utilized tool to quantify and measure burnout, and many studies show that the literature supports its effectiveness (Poghosyan et al., 2009). Since its inception and initial intention for healthcare workers, versions of the MBI have been updated and expanded for other fields such as police, military, and education.

Burnout is a rampantly pervasive issue in the United States among caregivers and healthcare personnel. Among registered nurses, some studies say the incidence of burnout is as high as 70% (Bakhamis et al., 2019). Other studies show the rate of burnout to be more in the 35%-45% range, but enough to be considered a public health crisis (Hylton Rushton & Pappas, 2020). Discrepancies between studies may show varying rates of burnout among different groups of healthcare workers, but the main point remains the same: caregiver burnout is a hugely prevalent problem and it has many detrimental repercussions.

Many issues can arise from caregiver burnout. Emotional distress and exhaustion can lead to psychological issues or destructive behaviors for caregivers. These employees may be more prone to making mistakes which can lead to increased negative outcomes in a facility, which can in turn have detrimental financial, logistical, legal, or systemic effects (Reith, 2018).

Problem

Nursing burnout has long been an issue in healthcare, and the Hospital is no different. They have struggled with this for a long time, but it has all been significantly exacerbated by the COVID-19 pandemic, which began in early 2020. Discussions with the Chief Nursing Officer (CNO), have shed further light on the subject and the state of nurses and staff at the Hospital during these challenging times. According to the CNO, since the beginning of the COVID-19 pandemic, there has been an increased number of sick calls throughout the hospital, and a marked increase in staff members taking a Leave of Absence. All of this intensifies the issue by putting added pressure on the remaining staff left behind or trying to pick up the slack of those that are out. If staff members have to work double shifts, overtime, or extra days, this increases the stress and anxiety level, which could lead to exhaustion and a higher rate of burnout. This also puts a financial stress on the Hospital, as the additional expense to compensate the

remaining staff for overtime pay can add to the existing logistical stress of coordinating sufficient care with less personnel.

This issue of increased sick calls and overtime is not confined to just one unit, but a pervasive issue throughout the hospital; with the most stressed units, emotionally and logistically, being the Emergency Department and Medical Imaging. Every patient that comes into the Emergency Department is assumed to be COVID positive and is treated as such. The employees wear personal protective equipment, which they say can be uncomfortable and hot when worn for long periods of time. Staff in Medical Imaging and Radiology have expressed concern and feel vulnerable because patients may have to take their masks off to get proper, safe imaging, which leaves the staff feeling uncomfortably exposed.

The staff is also normally quite close and social, and they often eat together in the break room, coordinate potlucks, and celebrate birthdays. These social activities increase camaraderie and community, bring the team closer together, and can help boost overall morale. Because of the pandemic however, social interactions and meal sharing are eliminated, which can be a detriment to spirit and emotional well-being of staff. The CNO shared all of this in light of caregiver burnout, and how the need for focusing on ways to reduce burnout and improve staff morale is vital right now.

Literature Review

The question driving the research for this project was: How does implementing the Three Good Things practice compared to other practices, affect reported caregiver burnout and mental state? Key search words included burnout, three good things, and positive emotions, which narrowed the search results to more relevant articles.

By 2030, the World Health Organization forecasts a shortage of 18 million healthcare workers across the world (World Health Organization [WHO], 2020). Burnout can be a contributing factor to high healthcare employee turnover rates and can negatively feed into the growing shortage of caregivers, which makes it all the more important to address.

Nurse Burnout

Burnout in the nurse population can have negative effects on patient outcomes. Nurses often have the highest amount of patient contact and care in a hospital, therefore any lapse in work effectiveness can have some of the most direct impact on patient care and results. If a nurse is severely stressed and fatigued, their executive functions, attention, and memory may be negatively impaired (Deligkaris et al., 2014). If a caregiver is emotionally exhausted, a core tenet of burnout, they are fatigued and can have significant difficulty managing the demands of their position. As such, "emotional exhaustion could thus exert its negative effect on patient safety via a lack of physical and cognitive ability to perform one's duties" (Welp et al., 2015). This diminished physical and cognitive level makes caregivers more prone to committing errors, which could in turn lead to adverse events. Therefore, "the effect of burnout affecting patient safety via adverse events leading to increased mortality and length of stay would thus indicate a serious threat to patients" (Welp et al., 2015).

Nurse burnout is linked to higher rates of common hospital acquired infections. Negative mental demands such as constant interruptions, divided attention, and feeling rushed are linked to increased feelings of burnout (Holden et al., 2010). These distractions and stressors are more common in facilities where nurses have to care for more patients, as opposed to facilities where nurses care for fewer patients and can take their time to be more accurate. Studies have shown that there is a statistically significant association between nurse staffing and healthcare

associated infections. There is a higher rate of infections seen in hospitals where nurses have to care for more patients, which is attributed in part to higher nurse burnout related to these higher patient caseloads (Cimiotti et al., 2012). When comparing nurse workload and data across 161 hospitals, Cimiotti et al. (2012) found that "every 10% increase in burned-out nurses in a hospital increased the rate of urinary tract infections by nearly 1 per 1,000 patients and the rate of surgical site infections by more than 2 per 1,000 patients." When a nurse is burnt out and exhausted, they can be more negligent and more prone to skipping or forgetting proper hand hygiene or other infection precautions, lending to the relationship between burnout and hospital associated infections (Cimiotti et al., 2012).

Infections can have physically harmful effects on patients of course, as well as costly financial effects on facilities. As such, it would behoove any hospital or healthcare facility to look into reducing burnout among their nursing staff, as doing so could improve the mental and emotional state of the nurses, save the hospital money, and improve patient outcomes.

Systems Issues of Burnout

With nurses making up the majority of caregivers at a hospital, it is simple enough to draw the conclusion that if there are issues with their level of care or workflow, patient and systems outcomes suffer. These are just negative results of sequelae of initial instances caused by burnout, but there are significant costs to healthcare facilities from burnout itself.

The conclusion that burnout leads to greater rates of job turnover in nurses is fairly ubiquitous in the literature. Turnover can lead to disruption of care, decreased efficiency, and logistical difficulties for a hospital or healthcare facility. However, what can be shocking, is the financial costs incurred by the facility due to turnover itself. Turnover for registered nurses costs

anywhere from $44,380-$63,400 per nurse in the United States, and at a turnover rate as high as 16.5%, this can cost large hospitals millions of dollars each year (Yarbrough et al., 2017).

Reducing burnout is most definitely in a facility's best interest and it would be the role of leadership to figure out how to best take care of their employees and put practices in place to help staff well-being. Burnout is more often the result of systems shortfalls than it is the result of individual caregiver issues. As such, literature reviews and meta-analyses demonstrate that systems-wide, organizational interventions are more successful at effectively reducing caregiver burnout than individual-focused interventions (Olson et al., 2019). Nurses benefit from management support. Hunsaker et al. (2015) found that lower or insufficient manager support of emergency department nurses led to higher levels of compassion fatigue and burnout, while nurses or departments that reported high levels of management support and positive involvement reported higher levels of compassion satisfaction.

Three Good Things

The method to be implemented in this project, with the intended effect of addressing staff's mental health and reducing feelings of burnout, is the Three Good Things concept. This concept is a psychotherapy technique that has been around for the past 20 years, based on the research and work by Dr. Bryan Sexton of Duke University. The idea is that each night a person writes down Three Good Things they saw, heard, did, or experienced that day, and in doing so they reinforce positive emotions. Each good thing could be small or large, abstract or concrete. This is done for 15 days and the effects are then evaluated on burnout (emotional exhaustion), depression, problems with work-life balance, and happiness.

The Three Good Things technique has been implemented in numerous studies to improve self-efficacy and psychological well-being in different population groups. A notable study done

by Sexton and Adair (2019), had 228 healthcare workers participate in a 15-day long Three Good Things intervention to see if there was a change in efficacy based on the emotional exhaustion subset of the MBI, and changes in depressive symptoms, subjective happiness, and work-life balance based on validated measurement tools for each of those, respectively. The results showed that the participants exhibited "significant improvement from baseline in emotional exhaustion, depression symptoms and happiness at 1 month, 6 months, and 12 months, and in work-life balance at 1 month and 6 months" (Sexton & Adair, 2019).

A randomized controlled study implemented Three Good Things via an app in their facility, with an intervention group and a control group without the intervention, and found that the intervention group had statistically significant post-intervention scores for self-efficacy and job performance (Guo et al., 2020). A similar study recruited 87 nurses with reported burnout to participate in the Three Good Things intervention for six months, and concluded that even recording good things just twice a week led to lowered exhaustion scores (Luo et al., 2019).

The psychological research behind this is thorough and well-documented. The core of the Three Good Things idea is centered around the benefits of positive emotions. When one experiences positive emotions, they are shown to have a better ability to recover from emotional upheavals (Tugade & Frederickson, 2004). Positive emotions, much like the benefits of meditation or optimism exercises, can help bolster personal emotional stores like motivation for personal growth, social bonds, and intellectual skills; as well as physical benefits of undoing negative cardiovascular effects of emotional upheaval, stress, or trauma and return to baseline cardiovascular levels (Frederickson et al., 2000). As opposed to negative emotions and stress, positive emotions can actually help recharge a person's ability to self-regulate when they are feeling exhausted or depleted emotionally and physically (Tice et al., 2004).

Dr. Sexton's research and methods are focused more on the lack of positive emotions in people experiencing burnout, than on trying to find ways to eliminate negative emotions like other methods to reduce burnout. People who are experiencing burnout are more likely to focus on negative emotions and stimuli, even when they may logically know that focusing on positive stimuli would be more beneficial (Bianchi & Laurent, 2015). Similar to depression, this has the tendency to be a cyclic, self-sabotaging process. Sexton's work intends to disrupt this fixed pattern of mental self-flagellation with conscious, deliberate, self-regulatory positive thoughts. It is a mental recalibration of sorts. Sexton and Adair (2019) suggests that the Three Good Things method works in two possible ways. First, when a person writes down or logs their Three Good Things, "there is savoring of positive emotion, whereby participants re-experience the positive emotions that accompanied the good thing that happened to them, perhaps also with a broader appreciation for that experience and what it involved" (Sexton & Adair, 2019). Secondly, when a person knows they are going to log their Three Good Things later that evening, they become more conscious of good things that happen throughout the day and are more cognizant of positive things around them that they may have previously overlooked when in a more negative emotion focused mindset (Sexton & Adair, 2019).

In the setting of a demanding and stressful hospital caregiver role as a nurse, reinforcing positive emotions could be the difference between burnout and maintaining a fulfilling, emotionally stable career and life. The Three Good Things method is a great way to do so within a hospital system or unit. It is simple to understand and easy to implement, taking only a couple minutes to complete at the end of a shift or end of the day. It doesn't require elaborate, time-consuming, and expensive training or processes to implement, costing the facility little or no extra money. It can be done on paper or a web-based format. Being simple to deploy, easy to

grasp, cheap to do, and effective, makes Three Good Things an attractive tool for facilities and burnt out caregivers.

Rationale

Caregiver burnout has been a problem facing healthcare for a long time, well before COVID-19. The CNO of the Hospital states that team morale has digressed and stress levels have increased since the start of the pandemic. The emotional state of the nurses at the Hospital, along with information in the literature, have been the main factors considered for this project. Another impetus guiding this project and how it could be effectively implemented is the population setting: the nurses at the Hospital. With these caregivers in mind, a Transformational Leadership model and Knowles' Adult Learning Theory made up the conceptual framework for this project.

Transformational Leadership Model

The Transformational Leadership theory, developed by Bernard Bass (1985), is a leadership method that focuses on building trusting, empathetic, respectful relationships between leader and followers. Instead of other leadership models that are more authoritarian or transactional with no interpersonal relationship, the Transformational Leadership style intends to establish trust and admiration of the leader as he/she works to transform or motivate their followers to achieve their maximum personal and team potential, while working towards a common goal. Bass described four main foundational components of Transformational Leadership that a leader needs to uphold in their relationships with their followers or employees: individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence (Bass, 1985).

Transformational leadership can be especially desirable in healthcare and has been shown to lead to employee and systems benefits. With the goal of establishing trusting, caring relationships with their employees, the transformational leader mirrors those goals of the caregiver-to-patient relationship. This has particular relevance to this project because this leadership style has been shown to be helpful in regard to burnout. In a literature review on how leadership styles affect burnout, Kelly and Hearld (2020) found that "Transformational Leadership was negatively associated with emotional exhaustion and depersonalization, and positively associated with personal accomplishment." This demonstrates that there is a strong percentage of literature that has found benefits of Transformational Leadership for the three main factors of burnout according to the MBI. If Transformational Leadership goes up, emotional exhaustion and depersonalization go down, and personal accomplishment goes up. Interestingly enough, this article also noted that several of the studies they examined showed a strong positive correlation between Transactional Leadership and emotional exhaustion (Kelly & Hearld, 2020). The authors did note that it was difficult to determine direct causation in this instance, but that the majority of literature they reviewed did show strong correlation.

The literature supporting Transformational Leadership is pertinent because any new method or protocol to be implemented with the intention of reducing caregiver burnout will need to have strong leadership to push it forward. If a leader is well-respected and embodies Transformational Leadership qualities, employees may be more likely to effectively adopt the new protocol and change may be more likely to occur.

Knowles' Adult Learning Theory

The main population in this project is the adult caregiver, so it makes logical sense to focus on how adults learn and adopt new skills or habits. This theory posits that adults need to be

a large, direct factor in their own instruction and learning process; they need to be involved in both the plan of their teaching, and the retrospective evaluation of the teaching process. Experience is key, and adults draw on previous life experiences and knowledge to augment their learning and growth. This includes mistakes, which can provide a foundational basis in adult learning. The theory also states that adults will be more engaged and motivated to learn if there is a clear, immediate application to their present, whether it be their job or personal life (Knowles, 1984).

Adult learners tend to be driven by intrinsic motivation as opposed to external forces, they prefer self-directed learning, and they need to know why they are learning something. The reasoning why and the immediate relevance are key factors for engaging adults. The caregivers at this facility can understand the concept of burnout and that there are practices they can implement to improve their stress levels and mental health. They can think back on a time they were stressed or overwhelmed and did some sort of relaxing activity to calm and center themselves. With intrinsic, experiential evidence to support the extrinsic instructions being given to them, adults are more motivated to adopt a change or learn a new skill. This could prove to be beneficial when trying to implement a change.

Project Aim

This project focuses on the caregiving staff at the Hospital, mainly nurses. The specific PICOT question to be answered is: In the staff population at the Hospital, how does implementing the Three Good Things practice compared to current practices, (no specific reported practices), affect reported caregiver burnout and mental state within a 30-day period? The goal is to survey the staff before and after the intervention to see if the practice had any effects on their views of work, their burnout levels, or their emotional state. The intervention

includes educating the staff on the theory behind Three Good Things and its benefits, then describing the process of writing down Three Good Things they saw, heard, or experienced at work that day, and pinning them up on the board in the breakroom before they leave.

The hope with this method is that the process of centering, introspection, and focusing on positive, good things that happened during the shift will have positive effects on outlook, work satisfaction, and detrimental feelings of burnout. All staff will increase their awareness of burnout and the collective need to implement practices to limit burnout and compassion fatigue, realizing that it is a collaborative micro- and macrosystem effort to work towards improvement.

This project initially intended to carry out the implementation plan and evaluate the Three Good Things method as it relates to nurse burnout on the unit. However, due to difficulties related to the COVID-19 pandemic and time constraints, it was ultimately decided to progress as a theoretical plan. The background, literature review, and overall aim still stand, but the methods and intervention will be the proposed plan with projected processes and results. The hope is that this fully laid out project and evidence-based plan can be picked up by future groups to implement at the Hospital or other facility, or be built upon successfully.

Methods

An interdisciplinary approach will be utilized, connecting several levels of involvement at the microsystem level. Graduate nursing student interns, staff nurses, unit nurse leaders, and senior management will work together. Collaborative effort and open communication will be necessary to achieve the collectively beneficial goal of improving caregiver burnout. The Hospital is small, with an intimate leadership group and about 80 nurses on staff. The benefit of this is more streamlined communication and simpler, swifter implementation.

Context

In January 2020, the Hospital began preparing for COVID-19. The hospital took on more patients from the local county general hospital to accommodate their expected rise in patient days. While logistical precautions were made to combat the challenges faced by COVID-19 and its transmission, little was done to increase support for hospital workers. As a result, caregiver burnout has worsened over the course of the pandemic. There has been an increase in nurses calling out sick and an increased number of people taking a longer-term Leave of Absence. This puts more pressure on the remaining nurses to pick up the slack and cover for their fellow staff members who are not there. This also puts a financial burden on the Hospital by having to pay increased overtime pay or hire and train new staff (see Appendix A). Caregiver burnout in healthcare settings has long been a detrimental and complex issue. The COVID-19 pandemic has only exacerbated this long-standing, systemic issue, highlighting the necessity for increased efforts and measures to address caregiver burnout. Stakeholders want their staff to be as healthy as possible because they know that can lead to better care and outcomes.

Intervention

The microsystem will be assessed and the unit that will implement the change will be chosen. This can be done through discussions with the CNO or unit champion via Zoom or in-person meetings. In early conversations, the CNO suggested to first try out the intervention with the Emergency Department nurses, because they are the frontline and potentially more stressed than less acute units. Qualitative data will be collected through in-person or Zoom interviews with nursing staff members, as well as any staff satisfaction survey data available, and exit interview information if possible. Quantitative data may include analyzing hospital information on caregiver retention rates, turnover rates, and length of employment, if available. All data collected will need to be evaluated to form a needs assessment for this population. This will then

be used to determine an appropriate intervention to decrease hospital worker burnout: the Three Good Things method.

The implementation plan will include setting up and conducting a staff training for the exercise for a pilot group. This can be done either in person or electronically if preferred. Since the initial implementation is only one unit, with about seven nurses, it can be determined that doing this via Zoom, over the phone, or making a detailed PowerPoint presentation on the method and plan and sending it to the initial test nurses could be sufficient. This is also optimal if in-person meetings are discouraged due to COVID-19 restrictions. This will not impede the plan or proposed implementation because the Three Good Things rationale and method is straightforward and easy to understand. The ideal goal is to make a corkboard in the break room for the nurses to pin their Three Good Things written down on a note at the end of each shift. This plan can also be implemented electronically via an app or any variety of sharing services; whichever is determined to be less time consuming and the least expensive for the Hospital.

Surveys will be conducted before and after the intervention to determine if Hospital caregivers believed the intervention to be helpful and sustainable. The nursing process and a CNL framework will be used throughout this project to focus on systems-level quality improvement that can have logistical, social, financial, and professional benefits.

Intervention Evaluation

The evaluation of the intervention and its effectiveness will be based on survey data and firsthand interviews with staff. The Three Good Things method will be implemented and then subsequently evaluated. The staff will be educated on the benefits and background of the intervention, and then instructed on how it will be deployed in the Emergency Department. The pre- and post-intervention surveys are to be distributed in the breakroom. The staff will be

notified to take the quick surveys and of the necessity to do so. Completed surveys are to be placed in a drop box in the breakroom. Stressing to staff that the surveys are anonymous and for the intention of systems and community improvement, will help ensure truthful, honest answers without fear of consequences. Reminders will be placed in and around community areas on the unit to help improve staff participation in the intervention. Unit leaders will also be asked to mention the Three Good Things method and management intention to adhere to the recommendations during their beginning and end of shift huddles with staff.

Tools

The Mini Z Burnout Survey (see Appendix B) will be used as a simple, low-cost method to survey the staff before and after the intervention to gauge results. The Maslach Burnout Inventory is also available to use to measure burnout and its associated symptoms in detail, as previously discussed. However, it does seem to be a paid service and would have to be considered in the facility's budget, so its use can be evaluated in future projects. The Mini Z Burnout survey was deemed sufficient for the purposes of this project because it is easy to distribute and is free for the Hospital.

Note on Inclusion

Through assessment of the facility, units, and staff, and conversations with managers, it was deemed necessary to make the intervention as inclusive as possible. The Hospital is in a multiethnic area, so the tools and words on the corkboards and any education material are to be displayed in English, Mandarin, Cantonese, and Spanish to make it as accessible as possible for the whole staff community.

Measures

The Mini Z Burnout tool is a quick survey to assess burnout, job related stress, and job satisfaction. It asks questions based on common causes of stress and burnout such as teamwork, values alignment with leadership, documentation time pressure, and issues related to Electronic Medical Record (Linzer et al., 2016). There are ten questions, scaled from 1-5, and one free response type question at the end. Pre-intervention and post-intervention survey data will be collected and evaluated to see if satisfaction, stress, and burnout scores improved.

Results

To gauge staff morale and satisfaction, the Mini Z Burnout tool was distributed. For these pre-intervention surveys, 17 staff members filled out the tool, consisting of 16 nurses and one technician. Although it was not a comprehensive survey of the staff and statistical analysis is not in the scope of this project, general trends can be drawn from the results. Of the staff members who answered Question 3 on the survey, half of them circled: “I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion.” Question 1 of the survey asks if the responder is overall satisfied with their current job, and the staff’s average answer was “Neutral”, on a scale between “Strongly Disagree” and “Strongly Agree.” There were also several staff members who answered with a 4 or 5 on Question 6 saying the work environment is hectic and chaotic. Most answers trended toward positive or neutral responses to the survey questions. Some of the free response answers about work stresses and what can be done to improve them include: “Just give us the right staffing,” “More staff,” and “Make the EHR system faster, takes too long to load between patients.” See Table 1 for full survey results.

Data from a 2018 internal patient safety and employee satisfaction survey distributed by the Hospital, also showed some similar trends in staff sentiment. This was shared by the CNO of the Hospital and it consisted of 125 staff members. Some of the free response feedback included

complaints about issues around staffing, communication, and hesitation or concern about reporting errors or coming to management with concerns and complaints. Some caregivers said they don't feel listened to or comfortable to come to management or HR for help.

It is anticipated that post-intervention survey results will show less staff members reporting feelings of burnout and overall more positive satisfaction scores. The Three Good Things intervention would also be expected to reduce the number of staff concerns and complaints in regard to stress level, emotional exhaustion, and team cohesion.

Implementation Plan

The implementation plan will need to begin with a microsystem assessment of the chosen unit to determine the needs and desired changes. Using the aforementioned aim statement and PICOT question as guides, a meeting will need to be set up with the stakeholders and unit champions for the proposed project. Kotter's (1996) first step in his eight-step change model should be kept in mind here and creating a sense of urgency for the change will be crucial in the initial meeting with important staff personnel. After getting stakeholders on board with the intended change, a cost-benefit analysis (refer to Appendix A as a proposed guide), SWOT analysis (refer to Appendix C as a proposed guide), and implementation plan will also need to be completed before meeting with unit staff again to discuss the intervention and proposed project timeline. By week eight of the semester, roughly two months in, the plan should be set and ready to implement. Participating staff on the unit will be educated on the background and benefits of Three Good Things, as well as the intervention instructions. Per conversations with the CNO, it was recommended to keep a poster board up in the breakroom with the background info, benefits, and intended plan for the project throughout the length of the intervention. The Three Good Things method will be carried out on a corkboard in the staff lounge or breakroom, and

staff will pin their notes with their good things onto the board to be displayed for others to see. Anonymity can be maintained if staff wish to do so.

Evaluation of the intervention will be conducted via staff interviews, meetings with leadership, and post-intervention survey data. Exit interviews and meetings with stakeholders will be conducted to discuss efficacy, areas for improvement, and next steps for future related projects. Refer to the Gantt Chart in Appendix D for more detailed steps.

Discussion

The key findings that this project hopes to find are reduced feelings of burnout among the staff, less emotional exhaustion, and greater sense of personal satisfaction at work. Evaluation of effectiveness will include gauging overall staff compliance, overall staff feelings and review of process, and looking for more positive responses on the Mini Z Burnout survey questions after the Three Good Things intervention. Not only is the hope to improve each individual caregiver's morale and burnout symptoms, but also to provide positive reminders to staff and improve team cohesiveness and spirit as a whole. The intention of posting Three Good Things on a communal board is to boost team camaraderie that is lacking right now due to COVID-19 and reduced socialization, with the hope that a publicly viewed board can augment the team experience and enhance awareness of good things on the unit even in difficult times. The systems benefits of Three Good Things can improve patient care, reduce negative outcomes, and save the Hospital money in the long term, as previously discussed. This is all in line with the initial aim of the project and is a driving factor in why the Hospital's stakeholders are interested in pursuing this method.

From the survey results data collected, there is a clear need for this project. General trends in the Mini Z Burnout pre-intervention survey results show feelings of burnout, emotional

fatigue, and issues with understaffing. It was interesting to see that this correlated to sentiments and observations shared by the CNO in initial interviews about the general exhaustion and staff feelings of being overwhelmed related to increased sick calls and Leaves of Absence due to COVID-19. Furthermore, it was also fascinating to note that the 2018 patient safety and staff satisfaction survey showed feelings of fatigue, concerns about staffing, and issues with communication well before the COVID-19 pandemic. It is worth noting that most answers on all surveys trended towards positive responses and views of the facility. However, the fact that there are trends of burnout, clear neutrality in overall job satisfaction, and staffing concerns lends more credibility to the reasoning behind working to improve staff burnout and the need for practices like Three Good Things to focus on emotionally supporting nursing staff.

One expected hurdle to overcome for successful implementation would include making sure the staff fully understands the benefits and reasoning behind Three Good Things. This paired with the possible perceived lack of concrete incentives could affect staff adherence. Another difficulty that could affect staff buy-in is that it adds another thing to their to-do list, which is especially difficult in a stressful pandemic. Refer to the SWOT Analysis in Appendix C for more details.

Conclusion

The usefulness and feasibility of the Three Good Things method has become apparent over the course of this project. The evidence in the literature supports that burnout and emotional exhaustion can lead to negative patient outcomes, increased hospital costs, and harmful personal effects on caregivers. Literature also demonstrates that the Three Good Things practice can reduce feelings of burnout in caregivers. This is a sustainable effort because leadership and stakeholders were quickly on board and were eager to implement whatever measures they could

to help out their beleaguered staff in these trying times. To help give this project the best chance of successful completion, communication between all involved parties will be key and restrictions around COVID-19 will need to be navigated. Identifying unit champions early on will also be an imperative step in the process.

Future plans could see the project tweaked slightly. The ideal implementation method for this project is the written format of good things on a communal board in the breakroom, but a verbal Three Good Things method during huddles could work for an even quicker, less expensive implementation if charge nurses can champion. An app or electronic platform to share Three Good Things with fellow staff members is also an alternative option. Nurses make up the majority of caregiver staff, making them the logical choice to begin with for this method. Further exploration into physician and management level staff burnout could also be beneficial for future projects. Both of these are populations highly susceptible to burnout and emotional exhaustion, and their roles directly affect patient outcomes and systems performance.

References

Bakhamis, L., Paul, D. P., Smith, H., & Coustasse, A. (2019). Still an epidemic: The burnout syndrome in hospital registered nurses. *The Health Care Manager, 38*(1), 3-10. https://doi.org/10.1097/HCM.0000000000000243

Bass, B. M. (1985). *Leadership and performance.* N.Y. Free Press.

Bianchi, R., & Laurent, E. (2015). Emotional information processing in depression and burnout: an eye-tracking study. *European Archives of Psychiatry and Clinical Neuroscience, 265*(1), 27–34. https://doi.org/10.1007/s00406-014-0549-x

Cimiotti, J. P., Aiken, L. H., Sloane, D. M., & Wu, E. S. (2012). Nurse staffing, burnout, and health care–associated infection. *American Journal of Infection Control, 40*(6), 486–490. https://doi.org/10.1016/j.ajic.2012.02.029

Deligkaris, P., Panagopoulou, E., Montgomery, A. J., & Masoura, E. (2014) Job burnout and cognitive functioning: A systematic review. *Work & Stress, 28*(2), 107-123. https://doi.org/10.1080/02678373.2014.909545

Fredrickson, B. L., Mancuso, R. A., Branigan, C., & Tugade, M. M. (2000). The Undoing Effect of Positive Emotions. *Motivation and Emotion, 24*(4), 237–258. https://doi.org/10.1023/a:1010796329158

Freudenberger, H. J., & Richelson, G. (1980). *Burn-out: The high cost of high achievement*. Anchor Press.

Guo, Y.-F., Lam, L., Plummer, V., Cross, W., & Zhang, J.-P. (2020). A WeChat-based “Three Good Things” positive psychotherapy for the improvement of job performance and self-efficacy in nurses with burnout symptoms: A randomized controlled trial. *Journal of Nursing Management, 28*(3), 480–487. https://doi.org/10.1111/jonm.12927

Holden, R. J., Patel, N. R., Scanlon, M. C., Shalaby, T. M., Arnold, J. M., & Karsh, B. T. (2010). Effects of mental demands during dispensing on perceived medication safety and employee well-being: A study of workload in pediatric hospital pharmacies. *Research in Social & Administrative Pharmacy, 6*(4), 293–306. https://doi.org/10.1016/j.sapharm.2009.10.001

Hunsaker, S., Chen, H. C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. Journal of Nursing Scholarship: *An Official Publication of Sigma Theta Tau International Honor Society of Nursing, 47*(2), 186–194. https://doi.org/10.1111/jnu.12122

Hylton Rushton, C., & Pappas, S. (2020). Systems to address burnout and support well-being: Implications for intensive care unit nurses. *AACN Advanced Critical Care, 31*(2), 141–145. https://doi.org/10.4037/aacnacc2020771

Kelly, R. J., & Hearld, L. R. (2020). Burnout and leadership style in behavioral health care: A literature review. *Journal of Behavioral Health Services & Research*. https://doi.org/10.1007/s11414-019-09679-z

Knowles, M. (1984). *The adult learner: A neglected species (3rd Ed.)*. Houston: Gulf Publishing.

Kotter, J. P. (1996). *Leading change.* Boston, Mass: Harvard Business School Press.

Lee, H. F., Kuo, C. C., Chien, T. W., & Wang, Y. R. (2016). A meta-analysis of the effects of coping strategies on reducing nurse burnout. *Applied Nursing Research, 31*(1), 100-110. https://doi.org/10.1016/j.apnr.2016.01.001

Linzer, M., Poplau, S., Babbott, S., Collins, T., Guzman-Corrales, L., Menk, J., Murphy, M. L.,

& Ovington, K. (2016). Worklife and wellness in academic general internal medicine: Results from a national survey. *Journal of General Internal Medicine, 31*(9), 1004–1010. https://doi.org/10.1007/s11606-016-3720-4

Luo, Y. H., Li, H., Plummer, V., Cross, W. M., Lam, L., Guo Y. F., Yin, Y. Z., & Zhang, J. P. (2019). An evaluation of a positive psychological intervention to reduce burnout among nurses. *Archives of Psychiatric Nursing, 33*(6), 186-191. https://doi.org/10.1016/j.apnu.2019.08.004

Maslach, C. (1982). *Burnout: The cost of caring*. Prentice-Hall.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*(1), 397-422. https://doi.org/10.1146/annurev.psych.52.1.397

NSI Nursing Solutions (2020). NSI national healthcare retention & RN staffing report. Retrieved from https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

Olson, K., Marchalik, D., Farley, H., Dean, S. M., Lawrence, E. C., Hamidi, M. S., Rowe, S., McCool, J. M., O'Donovan, C. A., Micek, M. A., & Stewart, M. T. (2019). Organizational strategies to reduce physician burnout an improve professional fulfillment. *Current Problems in Pediatric and Adolescent Health Care, 49*(12). https://doi.org/10.1016/j.cppeds.2019.100664

PayScale. (2020, September). *Average registered nurse hourly pay in San Francisco, California*. https://www.payscale.com/research/US/Job=Registered_Nurse_(RN)/Hourly_Rate/4b73951d/San-Francisco-CA

Poghosyan, L., Aiken, L. H., & Sloane, D. M. (2009). Factor structure of the Maslach burnout

inventory: An analysis of data from large scale cross-sectional surveys of nurses from eight countries. *International Journal of Nursing Studies, 46*(7), 894–902. https://doi.org/10.1016/j.ijnurstu.2009.03.004

Reith, T. P. (2018). Burnout in United States healthcare professionals: A narrative review. *Cureus, 10*(12). https://doi.org/10.7759/cureus.3681

Sexton, J. B., & Adair, K. C. (2019). Forty-five good things: a prospective pilot study of the Three Good Things well-being intervention in the USA for healthcare worker emotional exhaustion, depression, work-life balance and happiness. *British Medical Journal: Open, 9*(3). https://doi.org/10.1136/bmjopen-2018-022695

Tice, D. M., Baumeister, R. F., Shmueli, D., & Muraven, M. (2004). Restoring the self: Positive affect helps improve self-regulation following ego depletion. *Journal of Experimental Social Psychology, 43*(3), 379-384. https://doi.org/10.1016/j.jesp.2006.05.007

Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology, 86*(2), 320–333. https://doi.org/10.1037/0022-3514.86.2.320

Welp, A., Meier, L. L., & Manser, T. (2015). Emotional exhaustion and workload predict clinician-rated and objective patient safety. *Frontiers in psychology, 5*(1573). https://doi.org/10.3389/fpsyg.2014.01573

World Health Organization. (2020). *Health workforce.* World health organization international. https://www.who.int/health-topics/health-workforce#tab=tab_1

Yarbrough, S., Martin, P., Alfred, D., & McNeill, C. (2017). Professional values, job satisfaction, career development, and intent to stay. *Nursing Ethics, 24*(6), 675–685. https://doi.org/10.1177/0969733015623098

Table 1

Staff Mini Z Burnout Survey Results

Staff Survey	Role	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
1	RN	4	3	B	3	4	3	4	4	3	4
2	RN	4	3	n/a	4	4	3	4	4	n/a	n/a
3	RN	4	3	B	4	3	3	4	3	4	4
4	RN	4	3	B	3	3	5	4	5	3	3
5	RN	1	1	B	2	2	4	3	5	3	3
6	RN	5	5	B	4	4	3	5	5	3	3
7	RN	4	4	n/a	3	3	3	4	5	5	5
8	RN	4	3	n/a	4	3	3	4	4	5	n/a
9	RN	3	3	n/a	3	3	3	4	3	4	3
10	RN	3	3	C	1	2	5	3	3	n/a	3
11	RN	2	4	C	1	2	4	3	2	5	4
12	RN	2	2	C	3	2	4	2	2	n/a	3
13	RN	2	4	C	3	3	3	3	4	3	3
14	RN	3	3	B	3	3	3	4	4	4	4
15	RN	4	4	n/a	4	4	3	4	3	5	3
16	RN	3	3	C	2	2	3	2	4	2	3
17	Tech	4	3	n/a	3	3	3	4	4	5	3
Average score		3.29	3.18	B or C	2.94	2.94	3.41	3.59	3.76	3.86	3.4

Note. This table shows the responses circled by staff members at the Hospital to the survey questions shown below in Appendix B. “Q1” refers to Question 1 of the survey, “Q2” refers to Question 2, and so on. Responses were compiled and averaged to show the mean response on the bottom row.

Appendix A

Cost Benefit Analysis

Benefits			
Item	Number	Savings	Total savings
Reduced Hospital Acquired Infection (Urinary Tract Infection) (Cimiotti et al, 2012)	Infection rate 8.6/1000 65 bed hospital: 0.559	$749/per UTI	$ 418.6
Reduced Surgical site infection (Cimiotti et al, 2012)	Infection rate 4.2/1000 65 bed hospital: 0.273	$11,087/ per SSI	$3026.7
Reduced nurse turnover rate (NSI, 2020)	Turnover rate in hospitals <200 beds= 18.8% ~14 nurses per year	Average cost of nursing turnover= $44,400	$44,400 - 639,360
Total savings		$ > 47,845.3	
Costs			
Item	Number	Cost	
Nursing time Average RN San Francisco pay $52.20/hr (Payscale, 2020)	45 minutes for 10 nurses, each with 3 patients	$1,174.5	

Miscellaneous supplies		$54
Total Cost		$1228.5
Total Net Savings		Greater than $46,616.80

Appendix B

Mini Z Burnout Survey

Answer the following questions as truthfully as possible to determine your workplace stress levels and how they measure up against others in your field. There are two sections of questions in this survey about your experience with burnout and your practice environment. When you have completed the survey, return it to the person who requested that you complete it or submit it to stepsforward@ama-assn.org. We will follow up with you to give you your results. Thank you.

Name:	**Role:**
Team/department:	**Date of survey:**

For questions 1-10, please choose the answer that best describes your experience with burnout. Please circle your answers.

1. Overall, I am satisfied with my current job:	1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
2. I feel a great deal of stress because of my job:	1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree

3. Using your own definition of "burnout," please circle one of the answers below:

   a. I enjoy my work. I have no symptoms of burnout.
   b. I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
   c. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.
   d. The symptoms of burnout that I am experiencing won't go away. I think about work frustrations a lot.
   e. I feel completely burned out. I am at the point where I may need to seek help.

4. My control over my workload is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal

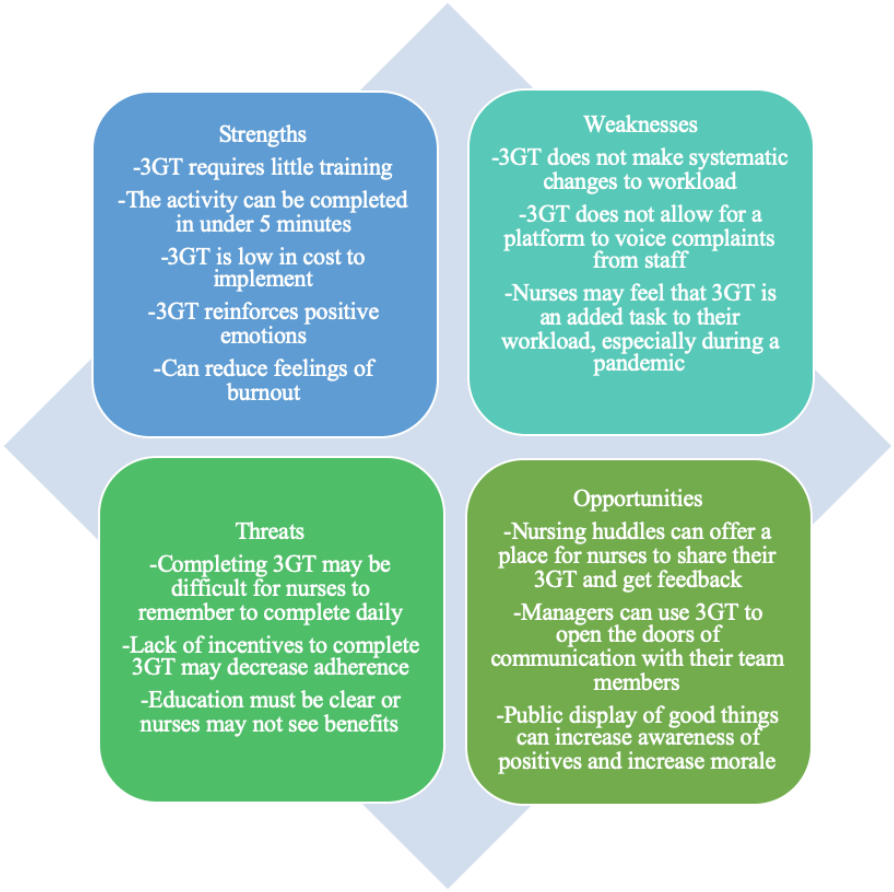
5. Sufficiency of time for documentation is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal
6. Which number best describes the atmosphere in your primary work area?	1 Calm	2	3 Busy, but reasonable	4	5 Hectic, chaotic
7. My professional values are well aligned with those of my department leaders:	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
8. The degree to which my care team works efficiently together is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal

9. The amount of time I spend on the electronic health record (HER) at home is:	1 Excessive	2 Moderately high	3 Satisfactory	4 Modest	5 Minimal/none
10. My proficiency with HER use is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal

11. Tell us more about your stresses and what we can do to minimize them (optional):

Appendix C

SWOT Analysis: Three Good Things (3GT)



Appendix D

Caregiver Burnout Project Proposed Gantt Chart

Task	Plan Start	Plan Duration
Meet with team/choose topic	1	1
Improvement theme /Aim statement	1	2
Meet preceptor and discuss plan	1	2
Microsystem/Needs Assessment	2	3
Develop PICOT statement/question	3	3
Initial Literature Review and EBP	3	4
Present plan to preceptor	4	4
Identify stakeholders and unit champion	4	4
Statement of determination/annotated	5	5
Business case/Cost benefit analysis	6	6
SWOT Analysis	7	7
Develop implementation plan w/ preceptor	8	8
Education/info session on Three Good Things w/ staff on	8	9
Distribute Mini Z Burnout survey to staff	8	9
Implement Three Good Things on unit	9	12
Stop in for huddles and education as needed	9	12
Meetings w/ preceptor weekly for updates	9	12
Interview staff about process	9	12
Interview staff about results and response of caregivers	11	12
Gauge staff compliance	12	12
Interview staff and distribute surveys to measure	12	13
Exit interview and debrief with stakeholders and preceptor	14	15
Thank staff and participants	14	15
Present poster, project, results to staff if desired	15	15
Work on paper throughout, follow rubric and instructor	1	16