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Charting the Path to National Recognition: A Medical-Surgical Microsystem Audit for Nurse Burnout

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**Charting the Path to National Recognition: A Medical-Surgical Microsystem Audit for
Nurse Burnout**

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Abstract

Problem Background: Clinical nurse burnout poses significant challenges, impacting patient outcomes and staff retention throughout the healthcare system. The American Medical Association's Joy in Medicine Program provides a framework for best practice to reduce workplace burnout. The aims of this project were to conduct a unit audit for burnout; identify and provide recommendations to leadership which would align unit practices with Joy in Medicine standards; and assess leadership for knowledge and competency of burnout reduction strategies.

Methods: The nursing leadership team completed an audit of current practices around burnout reduction. Participants received a one-hour educational in-service to discuss audit findings, provided recommendations to align the unit with Joy in Medicine Bronze level criteria and completed a composite survey evaluating knowledge and competency of burnout, personal experiences of professional burnout, and self-efficacy related to undertaking a burnout quality improvement project within 6-12 months of completion of this project.

Results: Knowledge of burnout increased from minimal/moderate to significant after the educational in-service and feelings of burnout within their work environment decreased. There were individual differences in self-rated self-efficacy scores, but all three participants had increased confidence to undertake a burnout-related QI project within 6 to 12 months.

Discussion: The Clinical Nurse Leader role can be effective in collaborating with nursing leadership to improve burnout reduction efforts within a clinical microsystem. Providing education and support to nursing leadership can improve feelings of self-efficacy and encourage change and adoption of best practices. Continuous assessment is needed to understand influencing factors for nurse burnout.

Table of Contents

Introduction	5
Problem	5
Available Knowledge.....	7
Rationale	10
Specific Aims.....	14
Methods	14
Context	14
Interventions.....	16
Study of the Interventions	20
Measures.....	21
Results	25
Discussion	37
Key Findings	37
Interpretation	41
Limitations	44
Conclusions	45
References	48
Appendix	57
Appendix A	57

Appendix B70

Appendix C83

Appendix D.....85

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Introduction

Problem Description

Requests for specific action to effectively address ‘Health Worker Burnout’ are highlighted in the US Surgeon General’s Advisory on Burnout (2022). Prioritization of healthcare workers’ mental health emerged from its focus during the COVID-19 pandemic. Job satisfaction, intent to leave the profession, and nursing turnover are related to patient and staff safety. Decreased staffing can lead to increased medication errors, feelings of fatigue in staff, and patient complaints (Garcia, et al. 2019). Nursing personnel, central to the delivery of direct patient care, reported working under more stressful conditions than before the crisis (Aiken, et al., 2022).

The American Nurses Foundation’s (ANF) Year 2 survey of pandemic-induced impact on nursing revealed how trends (e.g., understaffing, organizational approaches to financial strain, and incidences of workplace violence) influenced nurses’ participation in the field (ANF, 2022). Burnout strains the healthcare system through its adverse impact on economic feasibility of organizations (i.e., increased costs related to staff turnover, funding resource and travel staff to maintain safe staffing levels, etc.), and the health outcomes of patients and healthcare staff alike. Validated measurement tools have been developed and utilized to assess for influencing factors for burnout; however, they are more widely studied in the U.S. Physician population, not specific to nursing staff (Dyrebye, et al, 2018).

Examining available knowledge of health worker burnout suggests that while structural and leadership components can be strengthened within an institution, incorporating specific

activities to improve staff well-being are positive indicators for effective burnout reduction in staff (American Medical Association, 2023; Perlo, et. al., 2017; US Surgeon General, 2022). Examples of structural changes - system-level approaches to support staff well-being - could include regular assessment of core burnout contributors in a healthcare setting, improving ease of use with electronic health records, and institutional commitment to employee wellness. The Institute for Healthcare Improvement (IHI) supports a participatory, co-creative process to examine barriers to staffs' experience of a meaningful, safe, and enjoyable workplace (Perlo, et. al., 2017). Nursing staff and leadership should work together to find solutions to burnout because the professional relationship is reciprocal - nursing staff are needed to provide patient care and leadership provides stability and financial means for staff.

Effective measurement of burnout should be a priority of nursing leadership throughout the healthcare system. If employed strategically, the Clinical Nurse Leader (CNL) role can serve as an effective partner to relevant internal and external stakeholders within a healthcare setting to assist with systematic assessment of a facility's engagement in burnout reduction efforts through Quality Improvement (QI) approaches. A 2022 survey conducted by the University of Pennsylvania School of Nursing's Center for Health Outcomes and Policy Research (CHOPR) noted an increase in feelings of high burnout in medical-surgical nurses, who often practice in hospitals that could be subject to chronic understaffing or other factors that negatively influence clinical practice safety (Aiken, et. al., 2022). Systematic assessment (through surveys, interviews, or audits) can be a pathway to explore institutional transformation towards achieving national recognition, such as achieving Magnet status, which is awarded to facilities with robust work environments for their nursing staff (Adler-Milstein, et. al. 2020; Kutney-Lee, et. al., 2015; Okanlawon, 2015; Rotenstein, Sinsky, & Cassel, 2021). This project sought to adapt the

evaluation criteria for bronze level achievement within the American Medical Association's (AMA) Joy in Medicine Health Systems Recognition Program and evaluate a medical-surgical clinical microsystem against this standard of practice. To align a nursing microsystem with the standards of the Joy in Medicine Program, adaptation was required as the program was initially developed to assess physician satisfaction with employment.

Available Knowledge

Research suggests that professional burnout is multifactorial; contributors to the phenomena are related to organizational factors that can affect various aspects of employees' experience in the workplace. At 54%, nearly half of nurses and physicians report symptoms of burnout (National Academy of Medicine, 2022). Many studies on professional burnout in healthcare are physician-focused (Lyndon, 2015). However, there is a growing body of knowledge related to nurse burnout and turnover prevention efforts, particularly after the labor strain experienced by nursing staff throughout the COVID-19 pandemic (Berg, 2022; Phillips, 2020; Yellowlees & Rea, 2022).

Physician and nursing practice are interconnected. Many of the techniques put forth to combat physician burnout could be adapted to address the same issue in the nursing population. Both physicians and nurses express lack of meaning with work and negative health impacts as it relates to burnout (National Academy of Medicine, 2022; Sikka, et. al., 2015). Medical-Surgical nurses make up nearly half of hospital staff providing direct patient care, with noted increases in experiences of high levels of burnout and intent to leave their current position since the start of the pandemic (Aitken, et. al., 2023; Davis, 2023; Phillips, 2020).

Healthcare leadership has an obligation to address professional burnout, particularly due to the negative effects of professional burnout on patient safety (Yellowlees & Lea, 2022) and quality care delivery (Sikka, et. al., 2015). The Quadruple Aim in Healthcare, a framework for patient safety and quality improvement set forth by the Institute for Healthcare Improvement (IHI), lists the fourth aim as “Joy in work” although institutions may characterize their fourth aim based on preference (Feeley, 2017; Sikka, et. al., 2015). Exhaustion (emotional and physical), chronic understaffing of facilities, and lack of authentic leadership create stressful work environments for nurses (Maqbali, 2015; Salyers, et. al., 2017; Sikka, Morath & Leape, 2015; Yellowlees & Rea, 2022). Decreased support in the workplace can lead to increased instances of medication errors, workplace injuries, turnover rates, and overall increased costs of care for lengthened stays for adverse events such as patient falls or hospital-acquired infections (Yellowlees & Rea, 2022; Salyers, et. al., 2017). Workplace wellness programs are a recognized solution to address burnout (Onkalawon, 2015) but organizational readiness, as well as priorities of the nursing population as it relates to job satisfaction, should be assessed first for effective development, and regularly monitored after implementation (Boyd, 2021; Hannon, et. al., 2017; Maqbali, 2015; National Academy of Medicine, 2022; Pulchalski, Ritchie, & Strauss, 2019).

The COVID-19 pandemic has created more urgency to address employee health and wellness (National Academy of Medicine, 2022; The Joint Commission, 2019; US Surgeon General, 2022). Project development and implementation should be grounded in best practice and have a clear aim with a measurable outcome (Beaudin & Pelletier, 2018; Spath, 2021). Akin with the US Surgeon General’s national call for action against burnout, the National Academy of Medicine (NAM) issued the ‘National Plan for Health Workforce Well-Being’ in the same year. Priority Area 1 of the NAM plan seeks to, “Create and Sustain Positive Work Learning

Environments and Culture”; with Goal Four of the Priority Area as: “Leadership recognizes negative impacts of health worker burnout and fosters a culture of well-being” (NAM, 2022, p. 15). Action Item 4a, which correlates with the Priority Area goal suggests organizations to, “Use data to develop strategies that will continually improve well-being and decrease health worker burnout and distress” (National Academy of Medicine, 2022, Page 15). The AMA’s Joy in Medicine Health System Recognition Program was developed in 2019 to acknowledge facilities engaging in high-level practices for burnout reduction and provide a framework to be employed by other healthcare institutions who seek similar outcomes (AMA, 2021).

As of October 2022, 71 hospitals across the US are recognized from Bronze to Gold status (AMA, 2023) within the Joy in Medicine Program. Recognition status can be an indicator for positive patient and staff outcomes related to burnout reduction activities. Magnet Hospitals, who receive formal recognition for their excellence in exceptional nursing care, are associated with positive outcomes related to both nursing and patient outcomes (Kutney-Lee, et. al., 2015). Lower incidences of both preventable surgical complications and overall patient mortality are more pronounced in Magnet vs. non-Magnet hospitals and nurses experience more positive perceptions of their workplace in domains of job satisfaction, intent to leave, etc. (Kutney-Lee, et. al., 2015). Similarly, institutions that achieve Joy in Medicine Recognition are noted to employ best-practices for approaches to burnout reduction and prevention.

Entry level recognition for Joy in Medicine begins at the ‘Bronze’ level. At all levels, recognition is assessed with six key features for organizational commitment: *(1) Assessment (2) Commitment (3) Efficiency of Practice Environment (4) Leadership (5) Teamwork and (6) Support* (AMA, 2023). The frequency and type of activities related to burnout reduction distinguish the three levels (Bronze, Silver, and Gold). Summarily, Bronze criteria would require

a baseline burnout assessment performed utilizing a validated tool within the last 3 years, established systems to support employee well-being, and active inquiry with staff about barriers to an optimized experience (AMA, 2023). Given the increased awareness of professional burnout, turbidity of the practice area, and segmentation of ongoing burnout prevention efforts, the project leader utilized the bronze criteria eligibility for the Joy in Medicine Program to perform a baseline audit of the clinical microsystem in a rural hospital in the Northeast. Completion of the audit can be considered an introductory approach to assessing organizational readiness for change towards a more comprehensive, transformative approach to institutional burnout prevention efforts.

Rationale

Conservation of Resources (COR) Theory and Nurse Burnout

The Conservation of Resources (COR) theory guided the approach and interventions for this quality improvement project. COR theory was developed in the late 1980s by Hobfoll (1989) to better describe the relationship between individuals' desire to derive value from their participation in a system and to maintain wellbeing within their external environment. Hobfoll's theory asserts that stress is environmental, a response to a set of imposed circumstances, as opposed to a unidimensional "nature of the stimulus" as it was understood at the time (Hobfoll, 1989, p. 514). As a newer approach to understanding stress at the time, COR theory established a relationship between the stress response and external circumstances, proposing that individuals seek to mitigate stress through protection and rationing of resources to aid in their resiliency and cognitive processing of the stimulus (Hobfoll, 1989).

COR theory purports four types of main resources are available to any individual: *Object resources, conditions, personal characteristics, and energies* – when any of these resources are threatened, an individual will reasonably try to minimize their loss, with the hope of decreasing overall stress (Hobfoll, 1989). COR theory also provides a framework for appraisal of resources, clarifying the significance of what a resource means for an individual and how to maximize the “net gain” of resources in an environment, which would positively support an individual’s resilience and coping (Hobfoll, 1989). Given this project’s focus on improving understanding of the microsystem’s approach to burnout reduction, COR theory was appropriate to evaluate real or perceived stressors, as well as resource threats experienced by nursing staff and leadership alike.

Prapanjaroensin, et. al. (2017) argued the theory’s utility to demonstrate the relationship between nurse burnout and patient safety. During key activities, such as medication administration or patient handling, nurses’ experience of stress in the workplace can adversely impact patient outcomes (e.g., increased medication errors or patient injuries). The authors referenced an article that links two categories of burnout – emotional exhaustion (EE) and depersonalization (DP) - with falls, medication errors, and patient complaints (Prapanjaroensin, et. al., 2017). Healthcare workers typically experience burnout as an occupational-related phenomena; COR theory enhances the ability to assess how nurses’ access to resources can strengthen or mitigate their stress response (Prapanjaroensin, et. al., 2017).

Object Resources

Food, clothing, and shelter are examples of basic essential needs. Real or perceived threats to losing said resources can result in emotional or mental distress. Nurses exchange their labor to extract these resources. Prapanjaroensin, et. al. (2017) noted the dearth of literature

exploring this relationship. However, the relationship should be noted to better define COR theory's utility in explaining nurse burnout.

Kayre-Kwan, et. al. (2021) expounds upon nurses' experiences during the COVID-19 pandemic framed by Maslow's Hierarchy of Needs. Nurses require psychological and physical safety to carry out their necessary work activities. Kayre-Kwan, et. al. (2021) purported that the pandemic challenged the previously held belief that nurses' basic needs could be easily maintained. With unanticipated school closures, staff reductions, and increases in job demands all impacting the daily lives of healthcare workers, one can understand how object resources are central to understanding nurse burnout.

Condition Resources

Hobfoll (1989) described *condition resources* as those that are sought after by an individual based on value – mentioning “marriage, tenure, and seniority” as three examples (Hobfoll, 1989, p. 517). Prapanjaroensin, et. al. (2017) noted findings that married nurses tend to perceive higher levels of personal accomplishment through work as compared to their unmarried counterparts.

Job satisfaction, staff turnover rates, and work engagement can all be indicators of nurse burnout and should be regularly assessed for root causes (AMA, 2023). Phillips (2020) found that 43% of Medical-Surgical nurses in their study indicated intent-to-leave, with 52% of respondents planning to do so within 12 months. Nursing turnover can result from weakened resources, resulting in implications on recruitment, training, and retention of staff (Phillips, 2020).

Personal Characteristic Resources

Prapanjaroensin, et. al. (2017) describes resilience and coping mechanisms as vital personal characteristic resources in nursing. Garcia, et. al. (2019) found associations between a positive workplace culture and higher capacity for staff to combat workplace stress with patient centrality in care (i.e., “patient-centered care”). The authors suggest that professionals who can practice in an environment that affirm their productivity and satisfaction have lower exposure to burnout (Garcia, et.). al., 2019). Linton and Koonmen (2020) discuss self-care as an ethical obligation for nurses. The authors reference the American Nurses Association’s (ANA) Health Risk Appraisal, that found over 68% of nurses would place their patients’ well-being before their own. Nurses, aided by their professional leadership, should explore mechanisms to address their holistic needs as is required by the ANA Ethical Standard of *duty to self* (Linton & Koonmen, 2020). Through tending to individual needs, nurses can achieve self-actualization (as described by Maslow’s Hierarchy of Needs) through finding meaning and joy in effective nursing care combined with improved work-life balance (Linton & Koonmen, 2020).

Energy Resources

Time, money, and knowledge are examples of energy resources (Hobfoll, 1989; Prapanjaroensin, et. al., 2017). The US Surgeon General strongly urges hospital leadership to consider efforts to reduce the administrative burden for healthcare workers and protect staff time through institutional policies (US Surgeon General, 2022). The Institute for Healthcare Improvement recommends a co-creative process for tackling burnout and cultivating joy in the workplace (Perlo, et. al., 2017). Healthcare leadership should consider how work activities can negatively impact staff as implementation of interventions can increase stress or fatigue if added to overall level of staff activity (Perlo, et. al., 2017). Regular assessment of staff burnout could provide baseline information to drive substantive improvement in unit or system-level operations

that impact the overall quality of work experienced by staff (Perlo, et. al., 2017; US Surgeon General, 2022).

Specific Aims

1. To complete an audit of the Medical-Surgical clinical microsystem of the appointed hospital, evaluating the 6 key areas outlined by the Joy in Medicine Health System Recognition Program to determine eligibility for bronze level status, by February 2024.
2. Provide the Medical-Surgical unit with evidenced-based recommendations that align the unit with the Joy in Medicine Program bronze standards by March 2024.
3. Evaluate leadership knowledge of burnout reduction efforts and confidence to implement unit-wide changes through conducting a pre- and post-audit survey by March 2024.

Methods

Context

The project took place on a 41-bed adult Medical-Surgical unit at a hospital in Northeast Vermont. The unit is described as ‘Medicine-Telemetry’ with specialty care focused on patients with tracheostomies or ventilation needs. Project champions included a project sponsor and nursing unit leadership. The nursing leadership team consisted of a Nurse Manager, Assistant Nurse Manager, Nurse Educator, and Clinical Nurse Leader. The unit also utilizes a collaborative leadership structure that consists of interdisciplinary team members (Physician, Quality Improvement representative, and the unit nursing leadership team) that meet once weekly to discuss pertinent safety and patient outcome trends. Nursing staff includes full and part-time Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Licensed Nurse Aides (LNAs). Shifts are typically 12 hours and should include a 30-minute break and two 15-minute breaks or

a 15-minute break for every 4 hours worked. Standalone shifts are available for staff in 4-, 8-, or 12-hour increments past their 3 scheduled weekly 12-hour shifts.

There are two nursing stations at either end of the unit where nursing staff can chart and monitor patients if needed. The unit is equipped with 5 large rooms, oriented more central to the two nursing stations, that have electronic lift machines to assist with patient mobility. There is a small multipurpose room provided on-unit so staff can complete scheduled breaks and take lunch, with a larger breakroom available within about 1-2 minutes walking distance off-unit. At the time of this project, the unit was staffed with 84 individuals with either part-time or full-time positions. Part-time status is defined as less than 72 hours worked weekly, and full-time status as 72 hours or more weekly. About 30% of staff were part-time and 70% full-time.

Nurses used a buddy nursing system to manage clinical workflow, patient care, and take scheduled breaks. In the buddy system, nursing staff (typically two RNs to one Licensed Nursing Assistant (LNA)) are assigned patients in a similar hallway on the unit to encourage adequate coverage for scheduled breaks and assistance with patient mobility needs. Nursing “buddies” are also notified if the patient’s primary nurse is not available to ensure patient safety and continuity of care.

Unit staffing is driven by patient census and safety considerations. Typically, per shift, the unit is staffed with a Charge Nurse, 9 staff nurses, and 4 LNAs, one of which acts as the unit clerk during the weekdays. Safety huddle occurred at the beginning of the shift, on b day and night shift, with all staff present to discuss pertinent patient safety risks and staffing plans. The hospital is a unionized facility recognized by the National Labor Relations Board (NLRB). There were no ongoing burnout assessments being undertaken within the unit, although a network-wide employee satisfaction survey was completed within the last calendar year.

Interventions

Aim 1: Complete an audit of the Medical- Surgical Clinical Microsystem

The nursing leadership team completed an audit of the medical-surgical unit to evaluate the six key areas outlined by the Joy in Medicine Health System Recognition Program to determine eligibility for bronze level status by February 2024. The six areas are: (1) Assessment (2) Commitment (3) Efficiency of Practice Environment (4) Leadership Workplace (5) Teamwork and (6) Support and are reflected in table 1 below (AMA, 2023).

Table 1

Joy in Medicine Bronze Criteria and Audit Data Required

Joy in Medicine Criteria	Data Required	Response
Assessment	Please list the last dated burnout assessment within last 3 calendar years <i>Examples:</i> <i>Maslach Burnout Inventory</i> <i>Copenhagen Burnout Inventory</i> <i>Mini-Z Assessment</i>	

<p>Commitment</p>	<p>If conducted, were burnout assessments offered to all levels of staff?</p> <p>To your knowledge, does your unit or organization have a formally established role or position dedicated to staff wellbeing?</p>	
<p>Efficiency of the Practice Environment</p>	<p>Please list the last date of a conducted EHR time audit.</p> <p>If conducted, were results from the audit shared with unit leadership?</p>	
<p>Leadership</p>	<p>Please inform if your unit has engaged in any leadership listening campaigns within the last 3 calendar years.</p>	

<p>Teamwork</p>	<p>Please list the last date of a conducted team safety assessment.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> • <i>TeamSTEPPS</i> • <i>Safety Attitudes Questionnaire (SAQ),</i> <i>or</i> • <i>AMA Organizational Biopsy Tool</i> 	
<p>Support</p>	<p>Please list if your unit or organization has an established peer support program (e.g., EAP).</p> <p>Please list if your unit or organization engages in de-stigmatization of mental health and substance use disorders in their credentialing and application processes.</p>	

Note. This table was created to represent the six criteria evaluated for bronze recognition status in the Joy in Medicine Program. Adapted from “Joy in Medicine 2024 Program Guidelines” (pp. 6-14), 2023, American Medical Association.

“Assessment” required data related to the unit’s last assessment of burnout, utilizing a validated tool, within the last three calendar years. The date of last assessment and type of tool

used were asked to be reported. “Commitment” captured activities related to leadership and organizational structures that support staff in combatting burnout. Information related to the existence of a designated staff member or role dedicated to burnout reduction and the estimated annual costs related to burnout was reported. “Efficiency of Practice Environment” captured how the clinical workflow impacts staffs’ work balance, specifically time spent on documentation or other necessary tasks. This category also describes the rationale for the unit’s approach to measuring work balance. “Leadership” is described as a direct approach (i.e., a listening campaign) to uncover and gather more information on unrecognized sources of burnout. Key insights from the campaign that depict takeaways from leadership engagement were asked to be listed. “Teamwork” includes information about the utilization of a validated tool to measure group dynamics, such as a TeamSTEPPS assessment, Safety Attitudes Questionnaire (SAQ), or American Medical Association (AMA) Organizational Biopsy Tool. The project leader inquired about the last date of a Teamwork assessment. “Support” involved a brief description of the unit’s current attitudes and culture towards mental health and burnout for staff.

Aim 2: Provide the Medical-Surgical Nursing Leadership team with evidence-based recommendations to align the unit with the Joy in Medicine Program standards.

Data collection and audit conduction were completed by the end of January 2024. Relevant findings about ongoing or gaps in unit activities were evaluated and documented by mid-February 2024. Evidenced-based strategies were generated by the project lead and presented to unit leadership during a one-hour educational in-service. These recommendations were developed to be culturally appropriate for the unit’s clinical environment.

Aim 3: Evaluate leadership knowledge of burnout reduction efforts and confidence to implement unit-wide changes.

A pre- and post-audit survey were disseminated to unit leadership before and after the presentation of evidence-based recommendations which assessed the unit's nursing leadership team's knowledge and confidence to address burnout prevention and reduction.

Study of the Intervention

To determine the effectiveness of utilizing the CNL role in collaboration with nursing leadership to develop a burnout reduction strategy for staff, a Plan-Do-Study-Act (PDSA) style approach to internal communication checks was utilized. The PDSA cycle supports the 2014 Quadruple Aim for Healthcare (Feeley, 2017; Sikka, et. al., 2015) by evaluating the leadership team's perceptions and attitudes on using a collaborative, audit-style approach to burnout. Nundy, et al. (2022), while referencing Dr. Thomas Bodenheimer, author of the fourth aim (i.e., improving burnout and fostering joy in the workplace), assert that if one successfully addresses one of the other aims, while failing to address burnout or contributing to it, can only consider the triumphs a "hollow victory" (p. 521) as quality improvement would not be sustainable long-term without appropriate buy-in and continuity measures.

Process measures were monitored by the project leader through tracking open-ended feedback ("check ins") from nursing leadership during audit activities. The nursing leadership team were provided with two check-in opportunities during the project. Operationally, 'check-ins' are defined as opportunities to provide open-ended feedback to the project leader. Check-ins were used in lieu of a traditional 'Listening Campaign' to gain specific feedback from project stakeholders to identify opportunities for quality improvement, as well as real-time project facilitators and barriers. The first check occurred in mid-February 2024, after the audit process was completed, and the second after the evidenced-based practice recommendations were generated in late-February 2024. The feedback was collected and analyzed for keyword themes

(e.g., helpful vs overwhelming, enlightening vs confusing) related to effectiveness or non-effectiveness of the project approach.

Balancing measures were assessed through the open-ended feedback process, directly inquiring about the auditing process and any unintended impacts participation may have caused on nursing leadership's clinical workflow (e.g., decreases in ability to provide staff education, lessened patient care time, etc.). Open-ended feedback, and use of the pre- and post-intervention surveys, informed the collection of suggestions for appropriate adjustments to the CNL-involved approach in future iterations of the survey, following the Plan-Do-Study-Act (PDSA) model and IHI Framework for Improving Joy in Work. Continuous assessment (at least annually) of unit activities related to the six key criteria would be necessary to evaluate effectiveness of the audit and the collaborative recommendation-generation process.

Measures

Both quantitative and qualitative measures were used to assess the project's impact and scope. Evaluations were limited to the nursing leadership team due to the project's focus on system-level support for nursing staff for burnout reduction, particularly leadership confidence to implement personalized recommendations and strategies for the unit.

Assessment of knowledge and confidence of nursing leadership to address staff burnout were gathered through a pre- and post-project intervention survey (see Appendices A and B). Investigation for use of an existing tool to study relevant measures related to leadership confidence and knowledge of burnout was conducted; however, a validated tool that captured all measures of interest was not found. A composite survey was developed independently by the project leader with some adaption from the Kirkpatrick Model of Training Evaluation, Mini Z

Administrator and Leaders survey instrument, and General Self-Efficacy Scale (GSE) (Linzer et al, 2023; Kirkpatrick & Kirkpatrick, 2007; Rouleau, et al, 2019; Schwarzer & Jerusalem, 1995). The survey included 31 questions – a mixture of multiple choice, open-ended free text, and Likert-scaled responses - regarding satisfaction/usefulness of the audit process and assessment of knowledge regarding recognizing and addressing staff wide burnout. Respondents were blinded to the specific names of each survey utilized to comprise the final copy as to not bias their responses. Responses to the ‘Kirkpatrick Model of Training Evaluation’ section were documented from ‘Minimal’ to ‘Significant’ to measure knowledge and competency of nurse leaders to clinical and staff burnout. A mixture of ‘Strongly Disagree’ to ‘Agree’ ratings and scaled responses to self-rate clinical and administrative work areas were utilized from the Mini Z Leader and Administrator tool, which directly mirrored the paper/pen copy of the survey. Similarly, the original scaling for the GSE survey was utilized: ‘Not true at all’ to ‘Exactly true’ to rate the leadership team’s sense of confidence to enact change in their current position.

The Joy in Medicine Program was designed to recognize high-performing organizations and guide more effective approaches to burnout reduction (AMA, 2023). Outcome measures were assessed by nursing leadership responses to the confidence and knowledge (worsened, improved, or unchanged).

Analysis

Demographic Data

Demographic data was collected to maintain the reliability and validity of the use of the Mini-Z Administrators and Leaders tool. The original survey included an optional demographic data page for collection. Modifications were made to ‘Gender’ and ‘Race’ to have more inclusive

answer selections choices for respondents. This included adding ‘Select all that apply’, ‘Prefer not to share’ and including Gender X as answer options. Respondents were inquired on their number of years within the organization, information which could help draw inferences on their confidence level to undertake a burnout QI project in relation to their professional experience and self-assessed ratings of general self-efficacy.

Burnout Assessments

Three survey tools were utilized to create the composite pre-intervention survey. For each question, data was reported as response divided by total number of respondents. The Mini-Z Administrators and Leaders survey tool included an optional open-ended question for respondents to share free word text about additional stressors or contributors to burnout. That question was analyzed for use of keywords related to clinical nurse burnout. An independent, open-ended survey was conducted, manually reviewed, and analyzed for keyword theme analysis.

To evaluate effectiveness of the CNL-led approach, pre- and post-intervention survey results were analyzed for changes in response. To directly compare pre- and post-intervention results, respondents were asked to enter a three-digit code in their post-assessment.

Educational In-Service for Burnout Audit Results

Respondents’ satisfaction with a CNL-led collaborative approach was analyzed through direct comparison of pre and post results of the composite survey. Particularly, questions that represent the Kirkpatrick Model for Training Evaluation and Schwarzer & Jerusalem General Self-Efficacy Scale (GSE) were evaluated for changes in knowledge and satisfaction with

content shared during the educational in-service day as well as changes in confidence related to self-rating scores with the GSE.

Survey Timing

The pre-intervention survey was administered in mid-January, prior to any specific education or training on clinical nurse burnout. The first open-ended feedback survey was administered in early February, after completion of the pre-intervention survey and microsystem audit. This survey analyzed the nursing leadership team's experience with completing the chart audit by keyword theme analysis. Evidenced-based recommendations generated by the audit responses were shared during a one-hour in-person educational in-service in late February. The second open-ended feedback survey took place after the educational in-service mid-March. Results were shared with the nursing leadership team in a final written report in mid-March for review and continuity planning for the team by way of the P-D-S-A cycle.

Ethical Considerations

An Institutional Review Board (IRB) assessment was completed prior to the project's onset to determine the need for IRB board review and was exempt. Anonymity was prioritized as the respondent pool comprised only the nursing leadership team, not a large pool of respondents (i.e., entire nursing staff population or multiple nursing leadership teams within the organization). The demographic section of the survey was made optional for respondents. Reliability and validity of responses were founded on respondents providing true and honest answers to survey questions. Prior to beginning project activities and survey completion, multiple disclaimers were provided to the nursing leadership team (in-person and written) to assure that the purposes of the project were Quality Improvement in nature, and that

confidentiality would be ensured. Participants were also assured that project participation is non-punitive because their responses regarding their workplace experience would only be used for the project, not to influence their daily work experiences.

Results

Results from the pre- and post-intervention survey are discussed in relationship to this project's specific aims below. A timeline of interventions, explanation of necessary modifications to project interventions, contextual elements that impacted the project, and a summary of collected demographic data are shared for review below:

Timeline of Interventions

Orientation (Fall 2023)	Short meeting with nursing leadership team to orient project leader to microsystem.
Pre-Intervention Survey (Jan 2024)	Assessed knowledge of burnout, perceptions of burnout in current microsystem, current self-efficacy.
Unit Audit (Jan - Feb 2024)	Utilized Joy in Medicine Bronze criteria to assess clinical microsystem. Completed by nursing leadership team.
Open-Ended Feedback #1 (Feb 2024)	Online survey disseminated to project participants. Open text feedback related to experiences completing audit and survey. Two weeks to complete.
Educational In-Service (Early March 2024)	One-hour presentation with group feedback on audit and pre-intervention survey results.
Open-Ended Feedback #2 (Early March 2024)	Open text feedback on educational in-service. Embedded in Post-intervention survey #2.
Post-intervention Survey (Mid-March 2024)	Assessed knowledge of burnout, perceptions of burnout in current microsystem, current self-efficacy after educational-in service. Two week to complete.

Modifications to Interventions

The original intervention for this project was to collaboratively develop recommendations to align the unit to Joy in Medicine bronze level recognition status with the nursing leadership

team. Given the time constraints, a modification was made to have the project leader review respondents' audit and survey data and subsequently develop a list of practice recommendations to share with the leadership team during an educational in-service instead of having leadership review recommendations independently and then hold an educational in-service.

Project participants expressed an interest in having individualized reports of their survey response with pre- and post-intervention data, so an additional modification was made to generate individual survey reports for each team member as well as a summary of project findings and recommendations for the team's future use.

Contextual Elements

Time played a crucial role in the undertaking of interventions for this project. The nursing leadership team expressed high interest in the project but also indicated time constraints related to participation. Email communication and scheduled in-person visits were utilized to facilitate project interventions. The project leader was not a staff member at the participating hospital or unit, so several pre-meetings were scheduled at the onset of the project to acclimate the project leader to the participants' clinical microsystem.

Demographic Data

To maintain a level of confidentiality within the small, intimate group that comprises the nursing leadership team, reporting demographic data was left optional for respondents. In the pre-intervention survey, 2/3 respondents reported data related to their (1) number of years at the organization, (2) gender, and (3) Race/Ethnicity. The average number of years at the

organization between the two respondents was 12.5 years. One participant identified as female and one participant male. One participant identified as Black and one participant White.

Post-intervention, there was a 100% response rate to all demographic data fields (3/3 respondents). Two of the three respondents identified as White and female; one respondent identified as Black and male. The average number of years at the organization between the three respondents was 13 years (10 years, 14 years, and 15 years averaged between 3 respondents).

Aim 1: Complete an audit of the Medical- Surgical Clinical Microsystem

Unit Audit for Burnout

At the onset of the project, the nursing leadership team was provided a shared, editable Word document that housed the audit chart to evaluate their clinical microsystem compared to the Joy in Medicine Bronze level criteria. These six criteria are (1) *Assessment* (2) *Commitment* (3) *Efficiency of the Practice Environment* (4) *Leadership* (5) *Teamwork* and (6) *Support*.

Participants had about three weeks to complete the survey and were asked to provide as much information as possible regarding current organizational and unit-based approaches to burnout, as laid out in the bronze level criteria descriptions. The team ultimately had one nursing leadership team member complete the chart with input from other team members for time purposes.

‘Assessment’ relates to routine assessment of burnout utilizing an evidenced-based tool. At the time of the project, the team indicated that no formal assessments were being conducted, but that it was common practice to rely on self-reports from employees. The team indicated that only one staff member had explicitly reported feeling burnout within the past 12 months.

‘Commitment’ refers to the organization’s dedicated efforts to burnout reduction. The unit did not have a specific team or staff member dedicated to well-being (e.g., Chief Wellness Officer), but utilization of a specific role of that nature is typically undertaken by the larger organization as to not overburden unit leadership amidst their many clinical and administrative responsibilities. The nursing leadership team reported that employees are encouraged to participate in wellness offerings provided through the larger organization, and mentioned they inform onboarding employees of the existing financial reimbursement program for wellness activities available to staff.

‘Efficiency of Practice Environment’ is related to regular assessment of clinical processes that impact staff experience. Specifically, documentation requirements, types of electronic health systems utilized, and adequate resources to complete necessary tasks are evaluated. Standardized tools (e.g., electronic health record (EHR) audit log) and processes (e.g., ‘Getting Rid of Stupid Stuff (GROSS) exist to assist said effort. Team members reported that they were not aware of the last specific EHR time audit that was completed on-unit.

‘Leadership’ refers to specific actions undertaken by the organization to engage staff and hold space for their experiences. The Joy in Medicine guidelines reference listening campaigns (specific, dedicated time to allow staff to share concerns, interests, facilitators, and barriers with leaders) as required for bronze level recognition. While the nursing leadership team reported that they do not hold listening sessions, they keep an “open door” policy for staff to share their thoughts with them. The team also utilized annual staff evaluations as an opportunity to confer with people individually and provide them an opportunity to share concerns. Informal gatherings are offered to new staff when they join the unit for their first 12 months, but it is regarded as a regularly held wellness event for the entire staff population.

‘Teamwork’ requires regular assessment of team dynamics utilizing evidenced-based tools. Established tools include the Safety Attitudes Questionnaire, Team STEPPS, or AMA Organizational Biopsy Tool. Results would be shared with organizational leaders and invested stakeholders. The nursing leadership team reported that they had no current structure in place to support said process.

Lastly, ‘Support’ relates to an organization’s existing processes for assisting staff in achieving and maintaining wellness. In their current state, the nursing team reported encouraging staff to use the hospital’s Employee Assistance Program – an anonymous service that provides wellness resources and social support to employees – when needed.

Aim 2: Provide the Medical-Surgical Nursing Leadership team with evidence-based recommendations to align the unit with the Joy in Medicine Program standards.

Educational In-Service

A one-hour educational in-service was scheduled to review the general results of the survey and burnout audit responses with the team. An inquiry was sent out via email to coordinate meeting scheduling. The project leader and team met on the unit; refreshments were provided to the participants as the meeting took place midday. A PowerPoint presentation was developed to streamline communication of the results and make the visual data points meaningful to the team.

The presentation began with a short video that describes and defines burnout. The project leader reiterated the timeliness, relevance, and aims of the project. Over approximately 30-minutes, the project leader explored recommendations to align the unit with Joy in Medicine Bronze criteria standards. See the chart below:

Criteria Area	Current Process	Practice Recommendation
Assessment	<ul style="list-style-type: none"> • Self-reports from employees 	<ul style="list-style-type: none"> • Conduct a baseline assessment. • Regularly assess. • Use existing tools/surveys MBI, Mini-Z, or Copenhagen • Implement exit surveys
Commitment	<ul style="list-style-type: none"> • Encouragement to staff to complete assessment • Financial reimbursement for participation in select wellness activities 	<ul style="list-style-type: none"> • Continue encouragement. • Explore UVMMC's resources. • Advocate for a Chief Wellness Officer
Efficiency of the Practice Environment	<ul style="list-style-type: none"> • Unsure of last EMR audit 	<ul style="list-style-type: none"> • Casual rounds IT Rounds • Conduct a baseline audit. • GROSS ('Getting Rid of Stupid Stuff')
Leadership	<ul style="list-style-type: none"> • Annual Evaluations • Informal office meetings • Check-ins with new staff 	<ul style="list-style-type: none"> • Develop a mission and vision statement for wellness. • Informal "townhalls" • Balanced scorecards
Teamwork	<ul style="list-style-type: none"> • None in place currently 	<ul style="list-style-type: none"> • Attend a conference on burnout. • Safety Attitudes Questionnaire (SAQ) or TeamSTEPPS Assessment
Support	<ul style="list-style-type: none"> • Utilization of EAP 	<ul style="list-style-type: none"> • Wellness station • Reviewing recruitment process • Establish a peer support system

Note. This table was generated to depict the recommendations for practice as it related to the six criteria evaluated for bronze recognition status in the Joy in Medicine Program. Adapted from "Joy in Medicine 2024 Program Guidelines" (pp. 6-14), 2023, American Medical Association.

Aim 3: Evaluate leadership knowledge of burnout reduction efforts and confidence to implement unit-wide changes.

Discussion of results is divided into three sections to demarcate which questions assessed this project's three aims. Respondents were provided with a link to the survey via email and had two weeks to complete the survey. Questions 1-7 assessed the nursing leadership team's competency around topics related to clinical nurse burnout prior to the educational in-service provided by the project leader. Questions 8-22 assessed the team's experience of their clinical environment and professional burnout experiences in the unit's current state. Questions 22-31 directly inquired on respondent's self-rating their perceptions of self-efficacy.

Pre-Intervention Survey

Q1-7 (Assessing Competency on Burnout)

This section of the survey was developed utilizing the Kirkpatrick Model for Training Evaluation. Respondents were asked to rate their general knowledge around topics related to burnout. Additionally, participants were inquired about their knowledge of their organization's practices and procedures related to burnout. Responses could be rated from 'Minimal' to 'Significant'. The goal was to understand participants' knowledge and comfort with tackling burnout in its current state on their unit. There was 100% response rate for 'Minimal' knowledge and competency around topics related to burnout (i.e., "My knowledge of evidenced-based burnout reduction techniques is: "My understanding of my unit/facility's approach to burnout and burnout reduction is:"). Nurse leaders are expected to effectively demonstrate an organization's support to staff through their leadership process, so having a well-established knowledge of nurse burnout and resiliency strategies is critical to being effective in the role.

However, it cannot be understated that the onus is ultimately on the healthcare organization to ensure there are multiple measures in place to ensure that the system can promote and support resilience in their nursing staff.

Q 8-22 (Assessing Clinical Environment and Professional Experiences of Burnout)

The second section of the survey utilized the Mini-Z Assessment for Leaders and Administrators. No questions were altered or adapted for this section. Per the instructions of the Mini-Z, scoring instructions were not included with the selection choices. Questions were Likert-scaled. The first two questions were scaled from ‘Strongly Disagree’ to ‘Strongly Agree’ in relation to stress and satisfaction with current work conditions. The third question asks respondents to self-rate burnout ranged from ‘I enjoy my work. I have no symptoms of burnout.’ to ‘I feel completely burned out. I am at the point where I may need to seek help.’; and the remaining questions were scored from ‘Poor’ to ‘Optimal’ and explored respondents’ feelings about the adequacy of their clinical environment to support completion of required work-related tasks.

Q23-31 (Assessing Self Perceptions of Self-Efficacy)

Like Section 2, the final section was comprised of the original, unchanged questions utilized in the General Self-Efficacy Scale (GSE). Respondents are asked to self-rate their feelings of self-efficacy in relationship to the prompts (e.g., Question 4: “I am confident that I could deal efficiently with unexpected events.”). Self-rated responses have four choices, ranging from ‘Not true at all’ to ‘Exactly True’. Each response is ascribed a numerical value from 1-4; with 10 questions for the scale, respondents can score up to 40 total points, with scores closest to 40 indicating increased feelings of self-efficacy.

Open-ended Feedback Survey #1

The first round of feedback was elicited to understand participants' perceptions of the project in relationship to completion of the pre-intervention survey and burnout audit. One participant stated, "The time taken off administrative duties cannot equate to the value of the project which will be made available for us." indicating their appreciation for focus being placed on a timely, relevant matter for all levels of nursing. The other participants found value in the process too, affirming their investment in the project. No participants specifically referenced the use of a CNL-collaborative approach in the first round of feedback.

Post-Intervention Survey

The same survey was administered after completing a one-hour educational in-service with the nursing leadership team, during which their individual and team report was discussed.

Q1-7 (Assessing Competency on Burnout)

All three participants moved from 'Minimal' or 'Moderate' to 'Moderate' or 'Significant' for knowledge and competence on clinical burnout and evidenced-based reduction techniques. Post educational in-service, 66% of participants had changes from 'Minimal' or 'Moderate' to 'Moderate' or 'Significant' in their scores for the 7th question: "My overall satisfaction with how burnout is being addressed on unit (in its current state) is:". The third participant was unchanged for said question and for their scores for self-reported knowledge and competency of burnout. This participant saw more significant changes in questions inquiring on their understanding organizational approaches to burnout and confidence to implement a burnout QI project.

Q 8-22 (Assessing Clinical Environment and Professional Experiences of Burnout)

Post-educational in-service, changes were noted in all three participants' self-report of their clinical environment. 100% (3/3) of participants reported changes in their perception of their microsystem as 'hectic' or 'busy' to more 'stressful, but manageable'. Specifically, Questions 16 and 17 inquire "Which number best describes your clinical work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic)" and "Which number best describes your administrative work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic) respectively. It is unclear why these changes occurred. Clinical and administrative duties could have naturally waned, or it could be indicative that the leadership team found the in-service informative enough that their perceptions of burnout shifted.

The participant with the least number of years within the organization had the highest personal rating of burnout in Question 10 "Using your own definition of "burnout", please choose one of the answers below:" which corroborates with the previous notation that nurses with more experience tend to self-reports increased feelings of resilience. The other two participants rated their work-related stress as more manageable pre and post intervention rating the same question. 100% (3/3) of participants rated themselves more aligned with organizational values post-intervention. This rating was significant because professional alignment is a positive indicator for experiencing joy in the workplace and a sign of positive coping when resilience is required.

Q23-31 (Assessing Self Perceptions of Self-Efficacy)

Participant 1 was unchanged with a pre- and post-intervention rating at 29/40. Participant 2 had little change with a pre-intervention rating of 30/40 and 31/40 rating post-intervention. Participant 3 had the most significant change with a pre-intervention rating of 19/40 pre-intervention to 30/40 post-intervention. The first participant, who had the least number of years

in the organization, was unchanged for self-efficacy rating, whereas the other two participants did note a change. Again, it is unclear why the one participant had such a significant increase in self-efficacy, but they did also have a change in their knowledge and competency of burnout in section 1, which could indicate that improving resources around education and training on the topic could improve motivation of leadership to pursue specific QI projects.

At the end of the educational in-service, participants were asked to rate themselves 0-10 (0 being completely unlikely and 10 being confident and motivated) how likely they would pursue a burnout QI project within 6 to 12 months. Responses ranged from as low as a 2 to as high as a 6 pre-intervention. Post-intervention, all participants rated themselves at around a 7 to 8/10 likelihood to pursue a QI project within 6 months. The participant who initially rated their response as a 2 said that time sensitivity was a factor because they wanted to pursue the project when they had fewer competing priorities, which is understandable given the already turbulent clinical environment that is the norm for Medical-Surgical microsystems. The other two participants expressed similar concerns for time sensitivity, wanting more knowledge and training around specific burnout topics, and organizational support to see the project through.

Open-ended Feedback Survey #2

Overall, feedback was positive in the second feedback survey. Surprisingly, even with the constraint of time, team members reported that they would have liked to have an even more collaboration with the project leader in the CNL role. They described how more frequent meetings, in-person and remote, would have kept them more closely informed of project happenings, as the project group was only able to meet in-person three times over about three months. Project participants did acknowledge the short timeline of this project but were interested in pursuing more planning around a larger project down the line, time-permitting.

Unintended Consequences

The project leader and nursing leadership team engaged in open discussion of the project process and its impacts at the end of the educational in-service presentation. One team member described the feeling of being monitored with a “bird’s eye view” throughout the project, as the interventions focused on the leadership team’s experiences (team members were used to surveys being implemented in all-staff or all-organization) and the surveys were sent out via Blind Carbon Copy (BCC), to ensure confidentiality within the small group of participants. Another participant described that they thought the survey was being shared with all nursing staff due to utilization of the BCC feature. Their anxiety was assuaged after the project's results were shared because it assured them that the project intended to strengthen their ability as nurse leaders to enact change around the topic of burnout within the nursing experience.

Additionally, all three participants described some confusion with the project aims until the educational in-service was completed. Namely, project participants described wanting even more engagement from the project leader by way of a more in-depth primer of the project prior to its onset and more frequent updates on the project either in-person or via video conference. This seemed to be a misperception of time by the project leader. Namely, in the spirit of reducing burnout, updates were provided via email and kept succinct to not draw leadership away from their daily clinical and administrative responsibilities.

Missing Data

Not all participants entered feedback in the first online survey. This feedback was collected in person during the educational in-service and the second online survey had an open-

text response for respondents to provide their second round of feedback, so they did not need to complete an additional survey.

One question was accidentally omitted from the Mini-Z Administrators and Leaders assessment which inquired on participant's intent to leave within the next 12 months. This question, although noticed to be missing, remained purposefully omitted because of the small, intimate nature of the group. The aim of the project was to explore the team's clinical microsystem and providing that level of information to the group could erode trust in their well-established team dynamics. Owners of the Mini-Z tool approved any needed changes to the question set for this project prior to onset.

Discussion

Key Findings

Overall, the goals of this quality improvement project were to: audit the microsystem against Joy in Medicine Bronze Recognition standards, provide unit leadership with recommendation and strategies to align their unit with Joy in Medicine standards, and assess unit leadership's competence of and confidence around clinical nurse burnout reduction. Changes were noted in two participants' self-rated self-efficacy scores pre and post intervention, notating increased feelings of confidence around clinical nurse burnout and reduction techniques. Unintentionally, all three participants noted a decrease in feelings of clinical and administrative burnout. Additionally, participants described better overall understanding of clinical nurse burnout, its implications, and felt motivated to explore a burnout QI project in the future. Considering those factors, all three specific project aims were achieved.

Examining the number of years at an organization was meaningful as research notes that experience can be a key factor in fostering resilience in nurses and empowering them during challenging times (Joint Commission, 2019). The nurse leaders who participated in this study work on a busy Medical-Surgical unit that services complex patients, so both clinical competency and interpersonal skills are required to provide high quality care to patients and high-quality leadership practices to nursing staff. Assessment of levels of education would be of interest for future iterations of this work as to examine the effects of education on quality, style, and individualized approach to nursing leadership.

For the bronze level (lowest entry) recognition, an organization would have to assess their staff for burnout utilizing a validated tool at least annually and disseminating those results to participants and key stakeholders. Examples of these tools include the Maslach Burnout Inventory (the 'gold standard' for assessing burnout in healthcare workers), Mini-Z Assessment, or Copenhagen Burnout Inventory. The 22-item MBI-Human Services Survey (MBI-HSS) is the most psychometrically sound tool to reliably assess burnout in U.S. physicians along with associated interventions or outcomes (Dyrbye, et al., 2018), but is proprietary and requires copyright permissions and payment to be utilized. The cost to administer the survey may be a barrier for use by organizations, despite its high reliability and validity for assessing burnout measures. The Mini-Z and Copenhagen tools have no associated fee and are broadly applicable to physicians and other healthcare providers, but again, their construct validity is based mostly on U.S. Physicians, not specifically for nurses (Dyrbye, et al., 2018). However, this should not deter its use for assessing burnout measures, especially with its accessibility as no-cost and reliability in a similar professional demographic and population.

. The National Academy of Medicine's (NAM) 'National Plan for health workforce well-being' describes a variety of strategies that can be employed to cultivate and promote resiliency throughout an organization. In Priority Area 1 of the plan ("Create and sustain positive work and environments and culture") to 'advance organizational commitment', one recommended strategy is to adopt a unique position dedicated to staff wellness to demonstrate an organization's dedication to addressing burnout and providing staff with meaningful resources to promote resilience and health during turbulent times (NAM, 2024).

Many nurses report clinical documentation as a barrier to joy in the workplace because it takes time away from patient care and it is not always clear the rationale behind documentation requirements (Stites, 2023). Organizations should be mindful of what documentation requirements they ascribe to staff and should assess how those requirements impact on the staff's daily activities or ability to leave work on time.

The utilization of 'listening campaigns', the practice of bringing together employees to discuss facilitators and barriers experienced in daily workflow and systemic influences, is common among U.S. physicians (Richard & Lowndes, 2022) and certainly can be adapted for use in the nursing population by nursing leadership.

The foundation of healthcare is teamwork in that high quality care consists of team members of various disciplinary backgrounds and centers on the patient/population/community receiving care. The National Academy of Medicine's Resource Compendium for Healthcare Worker Well-Being details a variety of resources that can be adopted by different level organizations to begin regular assessment of team dynamics (NAM, 2023).

The NAM Resource Compendium lists “The Well-being Playbook: A Guide for Hospital Leaders and Health Systems Leaders” as a resource for management to brainstorm interventions that promote resilience, health, and joy in the workplace (American Hospital Association, 2019). One case study referenced in the toolkit describes the approach to improving physician wellness at Wellspan York Hospital of York, Pennsylvania. Hospital leadership disseminated a survey and hosted a retreat to engage staff and inquire how the hospital system could improve the lives of the physicians. Results from the survey spurred interventions such as creation of a protected lounge with meditation zones, valet parking, and a fitness center. The result: increased satisfaction scores of physicians and decreased turnover (American Hospital Association, 2018).

Additional themes of interest were explored by the project leader post-intervention:

Adapting Physician-Based Criteria for Nursing Practice

The Joy in Medicine program was developed by the American Medical Association and its standards are related to recognized strategies related to physician burnout. As such, its use had to be adapted for utilization to assess nursing leadership in this project. The project leader found that process to be relatively simple as the US physician population and US nursing population share similarities in their clinical and administrative duties and have similar ethical obligations for care of others and themselves. Additionally, the criteria set forth in the Joy in Medicine program standards are organizational practices, so they can apply to both nursing and physician and nursing populations. The project leader found it appropriate to adapt the criteria for the clinical microsystem audit. Further research could be explored on the criteria for practices in Magnet status hospitals that achieve recognition through the quality of their nursing care and compare that to the Joy in Medicine Program. Comparing the two criteria of the programs would

delineate similarities and differences between achieving recognition status that could be utilized for reiterations of a clinical microsystem audit.

Use of the Clinical Nurse Leader Role

The Clinical Nurse Leader role is relatively new, both in its definition and application. Members of the nursing leadership team were generally familiar with the Clinical Nurse Leader role, as they have one employed on unit. As previously stated, project participants found use of the role in this project as more “supervisory” than collaborative, but because of the design of the project, not the role itself. Team members shared that they were open to utilizing a CNL role and were interested in more visibility and collaboration with the CNL throughout the project. This could be considered a positive finding because their response speaks to the use of the CNL and its ability to improve engagement and stakeholder buy-in by project participants.

Interpretation

Demographic Data

Basic demographic information was collected in the pre and post surveys. There were no identifiable correlations between the number of years within the organization and self-rating clinical and administrative burnout and confidence to enact change around burnout on the unit. Future iterations of this work should be expanded to collect information on education levels, turnover and retention of leadership and staff, and years in a leadership position. Expanding this project throughout a hospital system would also assist in collecting more data to statistically examine for correlations between years of experience and perceptions of burnout. Examining the onboarding and orientation process of the organization could also provide insight into the

alignment of staff with the organization's mission and values. Alignment with an organization cannot be understated in employees' experiences of joy and meaning within their workplace.

Pre-Intervention Data

As this was the first project of this manner conducted on the unit, pre-intervention data can serve as a baseline for participants' experiences of burnout. All three participants rated their knowledge of burnout as 'Minimal' at the onset of the project. Nursing leadership effectively represents the larger organization within a specific microsystem. As such, nurse leaders should be encouraged and supported by their organizations to pursue continuing education around a subject that directly impacts recruitment and retention of staff. If not sponsored by the organization itself within its leadership community, opportunities to pursue continuing education related to burnout reduction should be reimbursed or compensated to incentivize improved competence and confidence around the subject.

Section 2 of the survey utilized the Mini-Z Administrators and Leaders. All three participants rated their clinical and administrative environments as at least 'busy' utilizing Likert scaling. Given more time, there could have been more exploration into what specific duties were influencing their perceptions of a busy work environment, as those identified concerns could be considered when developing improvement practices or interventions.

Self-efficacy was measured to assess how education on the topic of burnout and auditing of the microsystem would impact leaders' willingness to implement reduction measures within 6-12 months. The Surgeon General's Advisory on Healthcare Worker burnout makes it clear that if little to no action is taken, the general population is at risk of losing nurses (US Surgeon General, 2022). A 1995 version of the General Self-Efficacy Scale (GSE) was administered to

participants. Upon further research, the project leader found an updated 8-item GSE developed in 2001, that would decrease the number of questions participants were asked to answer (Chen, 2001).

Post-Intervention Data

Participants knowledge of clinical nurse burnout and related reduction efforts improved by their self-rated scores. All three participants moved from 'Minimal' understanding to 'Moderate' or 'Significant' understanding. Increased knowledge includes understanding signs and symptoms experienced individually as well as the ability to identify those signs in other staff or team members. A primer on nurse burnout could be included during the orientation process for both nursing staff and leadership, so that all populations have equitable access to resources that promote burnout reduction. Organizational change also requires stakeholder buy-in, so participants must understand the rationale behind the impact of burnout to enact change around the phenomenon.

Perceptions of project participant's work environment changed from a more stressful purview to more manageable post-intervention. While there were differences in scoring for alignment with organizational values with each participant, all three did note a decrease in their clinical and administrative environment from 'busy' or 'hectic' to 'manageable' and 'good'. Continuous assessment of burnout measures would be required to assess effectiveness of reduction measures over time and could reveal unique factors that contribute to perceptions and experiences within their microsystem.

Changes in self-efficacy scoring were noted in two participants. There was no change in scoring (no increase or decrease) in one participant. The participant with no change in scoring of

self-efficacy did have a change in scoring their ability to undertake burnout QI project from a 2 to 3/10 pre-intervention to 8/10 post-intervention. Participants said that time, and access to resources, would be both the biggest facilitators and barriers to starting a new burnout project on-unit. They shared that they found the work extremely meaningful, but they wanted to be able to give a project of this nature more time and attention, so that they could see the efforts through over time, instead of starting and stopping when competing priorities arise.

Outcomes

More research is required to explore the impact and scope of clinical nurse burnout post COVID-19. The pandemic highlighted the experiences of mental health and wellness in healthcare workers, but many interventions are based on the U.S. physician population. French (2022) studied the effect of directly providing nurse managers with resources around burnout reduction and its impact on management effectiveness and job satisfaction. French's study was more widely implemented as the project was undertaken at a larger scale (i.e., implemented in multiple manager groups throughout a hospital system during an annual nursing strategic retreat and monitored over time); yet yielded no statistically significant results of burnout reduction post-intervention. However, the project outlines a robust approach to implementing similar quality improvement measures within a large health system.

Information related to recruitment, retention, and turnover was not studied in this project. To assess the cost-benefit analysis of burnout reduction, evaluating the cost of staff turnover in relation to the cost of new staff orientation and onboarding could be explored further in future iterations of the work. The goal of modern healthcare is to strive for value-based, patient-centered care so measurement practices would have to be established first to understand the financial impact or scope of burnout on healthcare organizations.

Limitations

The main limitation for this project is the lack of statistical analysis for the pre and post intervention survey data. After the educational-in service, the project leader was able to meet with the university's statistician for advisement on how to appropriately analyze collected results. The statistician advised that while a Wilcoxon signed rank test or a paired T test would be relevant tests to conduct, data collection for the project needed to be implemented on a larger scale, (i.e., running the project with multiple unit managers or unit leadership throughout the hospital organization).

Additionally, this project is not generalizable in that there was only an n of 1 because the unit leadership team is related within a small group. This project could easily be recreated on a larger, organizational scale. A larger project would also support an organization's pursuit of recognition by the Joy in Medicine Program and, thus, hopefully have farther reaching effects with assessing burnout in multiple healthcare disciplines within a healthcare organization. Future projects should also consider the type or level of healthcare facility wherein which the project is implemented. This project was undertaken at a university hospital that has made previous attempts to achieve Magnet status, but results could differ in a less acute setting or long-term care facility.

Time was a significant limit for this project. Participants and the project leader only had about three months to complete project objectives, in addition to any outside obligations. The audit and survey both required time for participants to complete them, away from necessary clinical and administrative tasks, which could be a significant task in an already strained department or organization. In the future, organizational support could be furthered through the incorporation of such a project or education within employee or leadership onboarding, facility-

wide education and training on burnout, and/or utilization of an employee or leadership retreat to tackle this issue.

Conclusions

Overall, the specific aims for this project were met through successfuly conduction of a clinical microsystem audit for burnout in a Medical-Surgical setting, providing recommendations to the nursing leadership team to align unit practices with Joy in Medicine Broze level criteria standards, and assessing unit leadership for burnout reduction strategies as well as confidence and confidence. Project participants had increased knowledge and competency of clinical nurse burnout as well as burnout reduction techniques after project interventions. Participants also had increased confidence to undertake a quality improvement project related to burnout on their unit within 12 months of the completion of this project. Activities related to the project were appreciated by the nursing leadership team and they indicated interest in utilizing strategies in their future practice.

Implications for Nursing Practice

The Joy in Medicine Health Systems Recognition Program was developed to acknowledge healthcare systems that engage in high level practices for burnout reduction. This project explored the framework of adapting a physician-based program to a nurse-based setting. Further exploration of how to adapt physician-based burnout strategies to nursing should be explored in the future. Encouragement to explore burnout reduction and providing or sponsoring training in nursing leadership would help advance this goal.

This project also explored utilizing the Clinical Nurse Leader role to collaborate with nursing leadership to address nurse burnout. Wider utilization of the Clinical Nurse Leader role

could be explored with future iterations of the work with a larger project, or a project facilitated in different healthcare settings. Professional nurses are encouraged to practice at their highest level and provide support to their professional community; harnessing the utility of the role could be effective in tackling the pervasive effects of nurse burnout.

Considerations for Future QI Projects

Time to undertake project interventions was a major consideration in this project. Understanding competing priorities for nursing leadership or staff should be reflected on before undertaking a project of similar nature. Eliciting organizational support to enhance internal stakeholder engagement and buy-in could be helpful in supporting project aims. Types of interventions (e.g., online surveys vs. paper pen, on-unit review vs. strategic retreat) should all be considered. It would be interesting to explore a similar project in unionized versus non-unionized nurse settings, to explore nurse union efficacy in securing the profession's federal labor rights. Lastly, continual assessment over the course of months or years may be needed to measure a project's impact and scope.

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Appendix

Appendix A

Pre-Intervention Survey

Pre-Intervention Survey - 1/16/2024

Start of Block: Introduction

Disclaimer Thank you for participating in this survey!

Your answers will be used to inform the improvement of this clinical practice model (utilizing a collaborative CNL approach to burnout reduction on-unit).

The survey is a total of 31 questions/prompts.

Your responses will remain anonymous, secure, and utilized for quality improvement purposes only.

End of Block: Introduction

Start of Block: Demographic Information

Q1 Number of years at your organization:

Q2 Gender (optional) Select all that apply:

- Female (1)
 - Male (2)
 - Gender Non-binary / third gender (3)
 - Prefer not to say (4)
-

Q3 Race (optional). Select all that apply:

- Black/African-American (1)
- Latino/a/x (2)
- White (3)
- Asian (4)
- Native Hawaiian or Other Pacific Islander (5)
- Native American or Alaska Native (6)
- Middle Eastern/North African (7)
- Other (8)
- Prefer not to say (9)

End of Block: Demographic Information

Start of Block: Kirkpatrick Model Questions (Levels 1 and 2: Reaction + Learning) - 7 Item

Q1 In general, my knowledge of clinical nurse burnout is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q2 In general, my knowledge of evidenced-based burnout reduction techniques is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q3 My understanding of my unit/facility's approach to burnout and burnout reduction is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q4 As a unit leader, my confidence that I have an active role in how burnout is addressed on-unit is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q5 My confidence to implement burnout reduction strategies on unit is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q6 My confidence to address staff burnout (in its current state) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q7 My overall satisfaction with how burnout is being addressed on unit (in its current state) is:

- Minimal (1)
- Moderate (2)
- Significant (3)

End of Block: Kirkpatrick Model Questions (Levels 1 and 2: Reaction + Learning) - 7 Item

Start of Block: Mini - Z Assessment - 14 item

Q1 Overall, I am satisfied with my job:

- Strongly Disagree (1)
 - Disagree (2)
 - Neither agree nor disagree (3)
 - Somewhat agree (4)
 - Strongly agree (5)
-

Q2 I feel a great deal of stress from my job:

- Strongly Disagree (1)
 - Disagree (2)
 - Neither agree nor disagree (3)
 - Somewhat agree (4)
 - Strongly agree (5)
-

Q3 Using your own definition of “burnout”, please choose one of the answers below:

- I enjoy my work. I have no symptoms of burnout. (1)
 - I am under stress, and don't always have as much energy as I did, but I don't feel burned out. (2)
 - I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion. (3)
 - The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot. (4)
 - I feel completely burned out. I am at the point where I may need to seek help. (5)
-

Q4 My control over my workload is:

- Poor (1)
 - Marginal (2)
 - Satisfactory (3)
 - Good (4)
 - Optimal (5)
-

Q5 Sufficiency of time for completing my clinical documentation is:


- Poor (1)
- Marginal (2)
- Satisfactory (3)
- Good (4)
- Optimal (5)

Q6 Sufficiency of time for completing my administrative documentation is:

- Poor (1)
- Marginal (2)
- Satisfactory (3)
- Good (4)
- Optimal (5)

Q7 Which number best describes your clinical work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic)


Calm	Busy but reasonablereasonable	Busy but reasonable	Hectic, chaotic	Hectic, chaotic
1	2	3	4	5

Slide the cursor ()	
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Q8 Which number best describes your administrative work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic)

Calm	Busy but reasonablereasonable	Busy but reasonable	Hectic, chaotic	Hectic, chaotic
1	2	3	4	5

Slide the cursor ()



Q9 My professional values are well aligned with the person(s) I report to:

- Strongly Disagree (1)
 - Disagree (2)
 - Neither agree nor disagree (3)
 - Somewhat agree (4)
 - Strongly agree (5)
-

Q10 The degree to which my clinical team works efficiently together is:

- Poor (1)
 - Marginal (2)
 - Satisfactory (3)
 - Good (4)
 - Optimal (5)
-

Q11 The degree to which my administrative team works efficiently together is:

- Poor (1)
 - Marginal (2)
 - Satisfactory (3)
 - Good (4)
 - Optimal (5)
-

Q12 The amount of time I spend on work at home is:

- Excessive (1)
- Moderately High (2)
- Satisfactory (3)
- Modest (4)
- Minimal/none (5)

Q13 In my organization, there is a high degree of organizational trust.

- Not at all (1)
 - Slight (2)
 - Moderate (3)
 - Good (4)
 - To a great extent (5)
-

Q14 Describe your stresses more and what can be done to minimize them:

End of Block: Mini - Z Assessment - 14 item

Start of Block: Generalized Self-Efficacy Scale (Confidence) - 10 item

Q1 I can always manage to solve difficult problems if I try hard enough.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q2 If someone opposes me, I can find the means and ways to get what I want.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q3 It is easy for me to stick to my aims and accomplish my goals.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q4 I am confident that I could deal efficiently with unexpected events.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q5 Thanks to my resourcefulness, I know how to handle unforeseen situations.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q6 I can solve most problems if I invest the necessary effort.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q7 I can remain calm when facing difficulties because I can rely on my coping abilities.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q8 When I am confronted with a problem, I can usually find several solutions.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q9 If I am in trouble, I can usually think of a solution.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q10 I can usually handle whatever comes my way.

- Not true at all (1)
- Hardly true (2)
- Moderately true (3)
- Exactly true (4)

End of Block: Generalized Self-Efficacy Scale (Confidence) - 10 item

Appendix B*Post-Intervention Survey***Post-Intervention Survey - 3/5/2024**

Start of Block: Introduction

Disclaimer Thank you for your attendance at the educational-in service on 3/5!

This survey will evaluate your experience at the in-service and to inform the improvement of this clinical practice model (utilizing a collaborative CNL approach to burnout reduction on-unit).

Consider these questions with any insights or thoughts generated from our meeting.

The survey is a total of 31 questions/prompts.

Your responses will remain anonymous, secure, and utilized for quality improvement purposes only.

End of Block: Introduction

Start of Block: Demographic Information

Q1 Number of years at your organization:

Q2 Gender (optional) Select all that apply:

- Female (1)
 - Male (2)
 - Gender Non-binary / third gender (3)
 - Prefer not to say (4)
-

Q3 Race (optional). Select all that apply:

- Black/African-American (1)
 - Latino/a/x (2)
 - White (3)
 - Asian (4)
 - Native Hawaiian or Other Pacific Islander (5)
 - Native American or Alaska Native (6)
 - Middle Eastern/North African (7)
 - Other (8)
 - Prefer not to say (9)
-

Q4 Enter the code provided to you at the meeting:

End of Block: Demographic Information

Start of Block: Kirkpatrick Model Questions (Levels 1 and 2: Reaction + Learning) - 7 Item

Q1 In general, my knowledge of clinical nurse burnout (after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q2 In general, my knowledge of evidenced-based burnout reduction techniques (after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q3 My understanding of my unit/facility's approach to burnout and burnout reduction (after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q4 As a unit leader, my confidence that I have an active role in how burnout is addressed on-unit (after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q5 My confidence to implement burnout reduction strategies on unit (after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q6 My confidence to address staff burnout (in its current state - after completing the educational in-service on 3/5) is:

- Minimal (1)
 - Moderate (2)
 - Significant (3)
-

Q7 My overall satisfaction with how burnout is being addressed on unit (in its current state - after completing the educational in-service on 3/5) is:

- Minimal (1)
- Moderate (2)
- Significant (3)

End of Block: Kirkpatrick Model Questions (Levels 1 and 2: Reaction + Learning) - 7 Item

Start of Block: Mini - Z Assessment - 14 item

Q1 Overall, I am satisfied with my job:

- Strongly Disagree (1)
 - Disagree (2)
 - Neither agree nor disagree (3)
 - Somewhat agree (4)
 - Strongly agree (5)
-

Q2 I feel a great deal of stress from my job:

- Strongly Disagree (1)
 - Disagree (2)
 - Neither agree nor disagree (3)
 - Somewhat agree (4)
 - Strongly agree (5)
-

Q3 Using your own definition of “burnout”, please choose one of the answers below:

- I enjoy my work. I have no symptoms of burnout. (1)
 - I am under stress, and don't always have as much energy as I did, but I don't feel burned out. (2)
 - I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion. (3)
 - The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot. (4)
 - I feel completely burned out. I am at the point where I may need to seek help. (5)
-

Q4 My control over my workload is:

- Poor (1)
 - Marginal (2)
 - Satisfactory (3)
 - Good (4)
 - Optimal (5)
-

Q5 Sufficiency of time for completing my clinical documentation is:


- Poor (1)
- Marginal (2)
- Satisfactory (3)
- Good (4)
- Optimal (5)

Q6 Sufficiency of time for completing my administrative documentation is:

- Poor (1)
- Marginal (2)
- Satisfactory (3)
- Good (4)
- Optimal (5)

Q7 Which number best describes your clinical work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic)


Calm	Busy but reasonablereasonable	Busy but reasonable	Hectic, chaotic	Hectic, chaotic
1	2	3	4	5

Slide the cursor ()	
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Q8 Which number best describes your administrative work area? (1 - calm, 2-3 busy but reasonable, 4-5 hectic, chaotic)

Calm	Busy but reasonablereasonable	Busy but reasonable	Hectic, chaotic	Hectic, chaotic
1	2	3	4	5

Slide the cursor ()



Q9 My professional values are well aligned with the person(s) I report to:

- Strongly Disagree (1)
 - Disagree (2)
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-

Q10 The degree to which my clinical team works efficiently together is:

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 - Good (4)
 - Optimal (5)
-

Q11 The degree to which my administrative team works efficiently together is:

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 - Marginal (2)
 - Satisfactory (3)
 - Good (4)
 - Optimal (5)
-

Q12 The amount of time I spend on work at home is:

- Excessive (1)
- Moderately High (2)
- Satisfactory (3)
- Modest (4)
- Minimal/none (5)

Q13 In my organization, there is a high degree of organizational trust.

- Not at all (1)
 - Slight (2)
 - Moderate (3)
 - Good (4)
 - To a great extent (5)
-

Q14 Describe your stresses more and what can be done to minimize them:

End of Block: Mini - Z Assessment - 14 item

Start of Block: Generalized Self-Efficacy Scale (Confidence) - 10 item

Q1 I can always manage to solve difficult problems if I try hard enough.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q2 If someone opposes me, I can find the means and ways to get what I want.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q3 It is easy for me to stick to my aims and accomplish my goals.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q4 I am confident that I could deal efficiently with unexpected events.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q5 Thanks to my resourcefulness, I know how to handle unforeseen situations.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q6 I can solve most problems if I invest the necessary effort.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q7 I can remain calm when facing difficulties because I can rely on my coping abilities.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q8 When I am confronted with a problem, I can usually find several solutions.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q9 If I am in trouble, I can usually think of a solution.

- Not true at all (1)
 - Hardly true (2)
 - Moderately true (3)
 - Exactly true (4)
-

Q10 I can usually handle whatever comes my way.

- Not true at all (1)
- Hardly true (2)
- Moderately true (3)
- Exactly true (4)

End of Block: Generalized Self-Efficacy Scale (Confidence) - 10 item

Start of Block: Open Ended-Feedback #2

Q1 This question will serve as our open-ended feedback #2.

Please take a moment to share any feedback you have from this process. Namely, did you find this approach useful/tiresome/effective? Your response can be free-word, list, etc.

End of Block: Open Ended-Feedback #2

Appendix C

Unit Audit for Burnout

Joy in Medicine Criteria	Data Required	Response
Assessment	Please list the last dated burnout assessment within last 3 calendar years <i>Examples:</i> <i>Maslach Burnout Inventory</i> <i>Copenhagen Burnout Inventory</i> <i>Mini-Z Assessment</i>	We don't have any assessment tool for burnout per say. However, we often rely on self-reporting from employees. Over the last 3 calendar years. Only one employee has explicitly stated that they were burned out.
Commitment	If conducted, were burnout assessments offered to all levels of staff? To your knowledge, does your unit or organization have a formally established role or position dedicated to staff wellbeing?	As an organization, and XXXX as a unit, we encourage employees to participate in all the wellbeing offered. The organization also has a financial reimbursement program for employees who participate in these activities.

<p>Efficiency of the Practice Environment</p>	<p>Please list the last date of a conducted EHR time audit.</p> <p>If conducted, were results from the audit shared with unit leadership?</p>	<p>Not very sure if or when any Audit was conducted since nothing was shared by XXXX leadership.</p>
<p>Leadership</p>	<p>Please inform if your unit has engaged in any leadership listening campaigns within the last 3 calendar years</p>	<p>Not with any formal criterion but we do invite our staff to the office every now and then for an informal chat. We also take advantage of annual review for 30-45 min with every employee. We also have a monthly engagement, informal meeting with all employees less than 1 year on the unit (meant to retain staff but serves as an avenue of wellbeing)</p>
<p>Teamwork</p>	<p>Please list the last date of a conducted team safety assessment.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> • <i>TeamSTEPPS</i> • <i>Safety Attitudes Questionnaire (SAQ),</i> <p><i>or</i></p> <ul style="list-style-type: none"> • <i>AMA Organizational Biopsy Tool</i> 	<p>We have no structure in place for this kind of work</p>

<p>Support</p>	<p>Please list if your unit or organization has an established peer support program (e.g., EAP).</p> <p>Please list if your unit or organization engages in de-stigmatization of mental health and substance use disorders in their credentialing and application processes.</p>	<p>Nothing specific to the unit but we all utilize the Employee and family assistant program (EFAP) for all our mental health need</p>
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Appendix D

Educational In-Service PowerPoint Presentation

Slide 1



Let's Talk Burnout



March 5, 2024
Graduate Nursing
Spring 2024

Slide 2

A brief activity to start (OHIO)

And some housekeeping...

Slide 3

OHIO (from Ohio State University)

Ourself
How am I feeling?
Interest of Mine
Objective

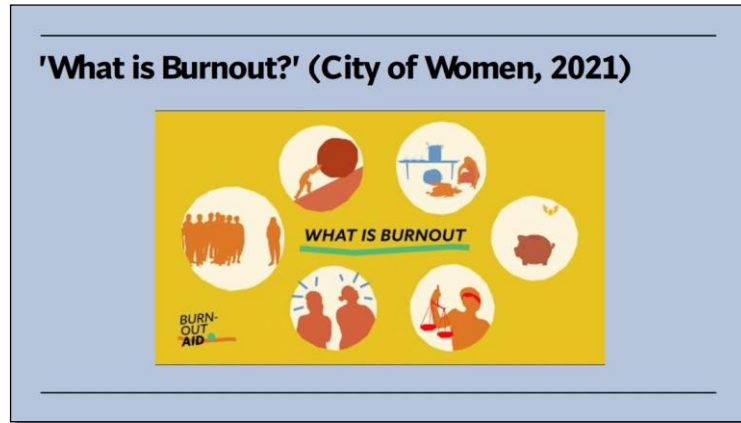
Slide 4

What is
Burnout?



A Brief (Re)Introduction

Slide 5



Slide 6

Key Symptoms of Burnout

Emotional Exhaustion	Depersonalization	Low Personal Accomplishment
"Work is too overwhelming."	"I don't care about my work."	"No one recognizes my efforts with work."

Slide 7

Burnout by the Stats

US Nurses (~3.1 million)
 Med Surg Nurses (~1.7 million)
 Reporting Burnout: (52% - 2022, up from 30% - 2020)

Sources: Bureau of Labor Statistics & American Nurses Foundation

Slide 8

Why do we care?

<u>Quality Implications</u>	<u>Social Implications</u>	<u>Financial Implications</u>
RNs are the largest providers of direct healthcare services in the US.	Burnout affects many domains of life. It's impossible to ignore those stressors.	The cost of turnover could be counteracted by low-cost preventative measures and interventions.

Slide 9

AMA Joy in Medicine

Charting Excellence	Evidence Based Practice
6 Key Areas: Assessment, Commitment, Efficiency of Practice Environment, Teamwork, Leadership, & Support Associated with burnout-related outcomes	Organizational support is required to effectively combat burnout at all levels ***Limitation: Physician-adapted approach

Slide 10

What about your team?

Results and Recommendations

Pre-Intervention Survey & Unit Audit




Slide 11

Survey Measures

<p>Assess Knowledge and competency of burnout</p> <p>Knowledge (what you know) Competency (putting knowledge to action)</p> <p>What you know matters</p>	<p>Assess clinical environment</p> <p>Assess work environment Evaluate professional experiences of burnout</p> <p>Where and how you practice matters</p>	<p>Assess self-efficacy</p> <p>Personal belief/confidence to execute a behavior</p> <p>How you feel matters</p>
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Slide 12

Results

<p>Q 1-7 </p> <p><i>100% response for minimal competency + confidence around burnout</i></p>	<p>Q 8-21 </p> <ul style="list-style-type: none"> • Feelings of high burnout (Q3) <ul style="list-style-type: none"> ○ Self-defined burnout • Satisfied with current clinical and administrative environments (Q7 + Q8) <ul style="list-style-type: none"> ○ 'Hectic' clinical environment 	<p>Q 22-31 </p> <ul style="list-style-type: none"> • Higher ratings (closer to 24) = higher ratings of self-efficacy <ul style="list-style-type: none"> ○ Confidence to take action
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Slide 13

Unit Audit on Burnout

Results and Recommendations

Slide 14

Recommendations and Strategies (Assessment)

<u>Current Process</u>	<u>Recommendations</u>
Self-reports from employees	Conduct a baseline assessment Regularly assess Use existing tools/surveys MBI, Mini-Z, or Copenhagen Exit surveys

Slide 15

Recommendations and Strategies (Commitment)

<u>Current Process</u>	<u>Recommendations</u>
Encouragement to staff to complete assessment Financial reimbursement for participation in select wellness activities	Continue encouragement Explore UVMMC's resources Advocate for a Chief Wellness Officer Informed participation for staff

Slide 16

Recommendations and Strategies (Efficiency of Practice Environment)

<u>Current Process</u>	<u>Recommendations</u>
Unsure of last EMR audit	Casual rounds IT Rounds Conduct a baseline audit GROSS

Slide 17

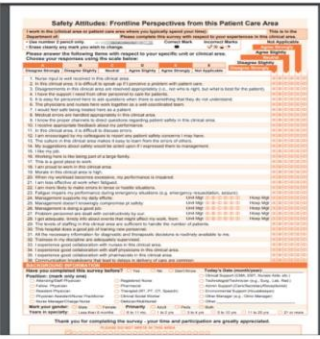
Recommendations and Strategies (Leadership)	
<u>Current Process</u>	<u>Recommendations</u>
Annual Evaluations Informal office meetings Check-ins with new staff	Develop a mission and vision statement for wellness Informal "townhalls" Balanced scorecards

Slide 18

Recommendations and Strategies (Teamwork)	
<u>Current Process</u>	<u>Recommendations</u>
None in place currently	Attend a conference on burnout Safety Attitudes Questionnaire (SAQ) TeamSTEPPS Assessment

Slide 19

Safety Attitude Questionnaire (SAQ)



- Short Form or Long Form
- UT utilizes the first 30 Qs to assess perceptions of teamwork and safety
- Likert (Strongly Disagree – Strongly Agree)
- "Nurse input is received very well in this clinical area."
- "In this care area, it is difficult to speak up if I perceive a problem with patient care."
- "I have the support I need from other personnel to care for patients."
- "Medicals errors are handled appropriately in this clinical area."
- "I receive appropriate feedback about my performance."
- "I like my job."
- "This is a good place to work."

Slide 20

TeamSTEPS 3.0

- Agency for Healthcare Research and Quality (AHRQ)
- Introduction, 4 Modules, Implementation Guide
- Great refresher

Slide 21

Recommendations and Strategies (Support)

<p><u>Current Process</u></p> <p>Utilization of EAP</p>	<p><u>Recommendations</u></p> <p>Wellness station Reviewing recruitment process Establish a peer support system</p>
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Slide 22

Brigham and Women's Hospital Program

Brigham and Women's Hospital Peer Support Program

The Brigham and Women's Hospital Peer Support Program was created to support clinicians and other Brigham faculty. Support peers reach out to impacted colleagues. Offer an empathetic, confidential, personal and/or professional listening ear, and the comfort of speaking with someone who has "been there." The program is designed to help mitigate isolation while fostering a culture of support and trust.

How the Peer Support Program Works

Peer support is generally department based, so that colleagues with similar clinical experiences are supporting one another. The peer supporter might hear about a colleague in need from a variety of sources: direct leadership, from colleagues in Risk Management, Quality and Safety, or from staff in leadership within the Peer Support Program itself. The peer supporter reaches out to the colleague over email and the support conversations usually take place by phone.

Peer Supporters

Peer supporters receive peer support training, set by our Peer Support Medical Director in collaboration with colleagues in the department of Psychiatry. Our peer supporters also come together as a group several times per year to share experiences and continue to learn together as a community. Click here for a list of current peer supporters.

Request Peer Support

If you or a colleague would like to speak with a peer supporter, contact our Medical Director or Program Manager - their contact information is at the bottom of this page. They will arrange to have a peer supporter reach out via email to set up a time to speak and provide support.

The History of Peer Support at the Brigham

The Brigham and Women's Hospital Peer Support Program was launched in 2004, modeled after pilot programs initiated by first responders to support one another through stress and trauma. The program grew and evolved over the years, most recently under the leadership of Dr. Jo Shapiro who founded and led the Brigham Center for Professionalism and Peer Support between 2010 and 2015. Since 2010 the Brigham and Women's Hospital Peer Support Program has been housed within OHSU's Office of Resilience, Coaching, Feedback and Support Services under the faculty leadership of Dr. Mariana Lacerda with program management by Farah Sabatelli.

- Established in 2004
- Department-based
- Supported by Medical Director and Psychiatry Dept

Slide 23

Big Takeaways

You all are already doing the work!
Keep what works, be curious about what doesn't.
Take care of yourselves – *now more than ever.*


Slide 24

Last 'Activity'

On a scale from 0-10, how confident are you to undertake a burnout QI project on the unit within 3-6 months?

Slide 25

Thank you for all that you do!



March 5, 2024
Graduate Nursing
Spring 2024

Slide 26

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Slide 28

Notes

***See notes/links embedded in Slide 2, 5, 7, 9, 12, 16, 18, 22
